STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Okeechobee Youth Development Center

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

Review Date(s): August 18-21, 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:

Christine Calvert-Joyner, Office of Accountability and Program Support, Lead Reviewer (Standard 1)
Paula Friedrich, Office of Accountability and Program Support, Regional Monitor (Standard 5)
Tonya Gittens, Office of Accountability and Program Support, Regional Monitor (Interviews)
Peter Keelan, Office of Education, Southeast Region Education Coordinator (Standard 2)
Shakela Minns, Office of Accountability and Program Support, Regional Monitor (Standard 4)
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 Development Center
Provider Name: TrueCore Behavioral Solutions, LLC
Location: OKeechobee County / Circuit 19
Review Date(s): August 18-21, 2020

MQI Program Code: 1160
Contract Number: 10188
Number of Beds: 32
Lead Reviewer Code: 163

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
2.06 Gang Identification: Prevention and Intervention Activities	2.22 Safety Planning Process for Youth
2.15 Treatment Team Meetings (Formal and Informal Reviews)	3.03 Non-Licensed Mental Health and Substance Abuse Clinical Staff
3.04 Mental Health and Substance Abuse Admission Screening	3.13 Suicide Prevention Training *
3.05 Mental Health and Substance Abuse Assessment/Evaluation	
3.06 Mental Health and Substance Abuse Treatment	
3.07 Treatment and Discharge Planning *	
3.08 Specialized Treatment Services*	
5.08 Contraband Procedure	
5.12 Weekly Safety and Security Audit	
5.18 Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	

Overall Rating Summary for Standard 3

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

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

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

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

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

Indicator Ratings

Standard 3 - Mental Health and Substance Abuse Services		
3.01	Designated Mental Health Clinician Authority or Clinical Coordinator	Satisfactory
3.02	Licensed Mental Health and Substance Abuse Clinical Staff *	Satisfactory
3.03	Non-Licensed Mental Health and Substance Abuse Clinical Staff	Failed
3.04	Mental Health and Substance Abuse Admission Screening	Limited
3.05	Mental Health and Substance Abuse Assessment/Evaluation	Limited
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 *	Satisfactory

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Overall Rating Summary for Standard 3

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 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 *	Satisfactory
5.02	Comprehensive and Consistent Implementation of the Behavior Mgt System and Staff Training	Satisfactory
5.03	Behavior Management System Infractions and System Monitoring	Satisfactory
5.04	Ten Minute Checks *	Satisfactory
5.05	Census, Counts, and Tracking	Satisfactory
5.06	Logbook Entries and Shift Report Review	Satisfactory
5.07	Key Control*	Satisfactory
5.08	Contraband Procedure	Limited
5.09	Searches and Full Body Visual Searches	Satisfactory
5.10	Vehicals and Maintenance	Satisfactory
5.11	Transportation of Youth	Satisfactory
5.12	Weekly Safety and Security Audit	Limited
5.13	Tool Inventory and Mangement	Satisfactory
5.14	Youth Tool Handling and Supervision	Satisfactory
5.15	Outside Contractors	Satisfactory
5.16	Fire, Safety, and Evacuation Drills	Satisfactory
5.17	Disaster and Continuity of Operations Planning (COOP)	Satisfactory
5.18	Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	Limited
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 Development Center is a thirty-two-bed program, for thirteen to twenty-one-year-old males, located in Okeechobee, Florida. The program is operated by TrueCore Behavioral Solutions, LLC through a contract with the Department. The program provides mental health overlay services (MHOS), substance abuse prevention services, case management, transition planning, recreational therapy, and behavior modification. The program's contract outlines MHOS provided shall include Anger Management for Substance Abuse and Mental Health Clients, Strategies for Anger Management, Skillstreaming the Adolescent, Young Men's Work, 24:7 Fathering Handbook, and Thinking, Feeling, Behaving. In addition, MHOS includes The Teen Relationship, Passport Program, Living in Balance, Seeking Safety, and Toward No Drugs. Youth targeted needs are fostered through the Impact of Crime restorative justice programming and the Thinking for Change evidenced-based curriculum. The program is situated on a property comprised of five programs. The program's administration is comprised of a campus-wide superintendent, a campus-wide assistant superintendent, a campus-wide director of treatment services, the facility administrator, a unit manager, the designated mental health clinician authority, and the director of case management. Case management services are provided by one director of case management, three case managers, and one transition service manager. Mental health staff at the program include one designated mental health clinician authority, four therapists, and one campus-wide director of treatment services. Medical services are offered twenty-four hours a day, seven days a week and are provided by the designated health authority, one health service administrator, and four registered nurses. Educational services are provided by the Okeechobee County School District. The layout of the program includes one administration building, one youth housing building, the program school area, and an attached cafeteria. The case management and therapist offices are located within the administrative building, and the medical clinic is located within the youth housing building. The program has a total of ninety-eight video cameras from which video recordings are maintained for at least forty-five days. At the time of the annual compliance review, the program had twenty-three vacant positions. Vacancies included one campus-wide receptionist, one campus-wide physical plant worker, two non-licensed therapists, one shift supervisor, one master control staff, two youth care worker II positions, twelve youth care worker I positions, two registered nurse positions, and one designated mental health clinician authority. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site; therefore, observations of specific indicators or elements were unable to be completed, during this fiscal year. Off-site supplemental reviews will be conducted as desk audits throughout the remainder of this fiscal year.

Strengths and Innovative Approaches

- In January 2020, program youth completed a “Wall of Inspirations.” This six-by-six-foot puzzle contained more than fifty-five youth-made puzzle pieces. Each piece reflected a positive saying created by the youth.

- In February 2020, the youth made Valentine’s Day cards for seniors at a local nursing home.

- In March 2020, the program began conducting weekly education mutual accountability meetings. Attendees included representatives from the program, the Okeechobee County School District, and Department program operations and education staff. Topics include classroom cleanliness, internal academic competitions, project-based learning initiatives, the incorporation of recreation into the school day, and virtual field trips. The program initiated a project-based learning calendar. Project-based learning activities included thank you cards, recreation challenges, crafts, poetry, and trivia competitions.

- The program held a basketball tournament in March 2020. Teams from two programs competed for trophies and ribbons, enhancing self-esteem and encouraging teamwork.

- The program partnered with the Treasure Coast Food Bank in April 2020. The youth prepared food baskets for distribution to the residents of Okeechobee County. This activity allowed the youth to assist the local community with an emphasis on social responsibility.

- In April 2020, the program held an Easter egg hunt competition activity. Youth practiced teamwork while completing a series of challenging and fun activities.

- In April 2020, the youth created paper flower pins and donated them to nurses at the local hospital.

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 ensuring initial background screenings are conducted on all newly hired staff and volunteers. A review of program staff, contracted staff, mentors, and volunteers reflected five program staff were applicable for an initial background screening since the last annual compliance review. Each of the five records contained a background screening completed prior to hire. None of the records were applicable for an exemption obtained due to an ineligibility rating or a break in service, as indicated in the Department's Staff Verification System (SVS). Each record documented the review of a criminal history report, and the addition to the Clearinghouse employment roster. Three of the five program staff were applicable for a pre-employment suitability assessment. All three records documented a passing score, obtained prior to hire, within the employment record. An interview with the campus-wide assistant superintendent reported there were no intermittent volunteers, mentors, or interns visiting the program more than once a quarter since the last annual compliance review. The program and the Okeechobee County School Board completed and submitted Annual Affidavits of Compliance with Level 2 Screening Standards to the Department's Background Screening Unit (BSU)/Clearinghouse on December 30, 2019, meeting the annual requirement.

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

The program maintains a written policy and procedures outlining the background rescreening process. Staff are rescreened every five years based upon the original date of hire. Background rescreening documentation must be submitted to the Department's Background Screening Unit (BSU) and Clearinghouse at least ten days prior to the staff's five-year anniversary date. The program maintains a staff roster which is reviewed routinely by the program's human resource manager to determine when a five-year background rescreening is required. The tracking of contracted staff background rescreenings are completed by the program's corporate office. Five-year background rescreenings shall not be completed more than twelve months prior to the staff's anniversary date. A review of program staff, contracted staff, mentors, and volunteers reflected three program staff and two contracted staff were applicable for the completion of a

five-year rescreening. Four of the five background rescreenings were completed prior to the anniversary date. One rescreening was completed forty-three days late.

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 ensuring an environment free of abuse and neglect and in which youth and staff feel safe and secure. The policy reflects youth and staff have unhindered access to reporting alleged abuse to the Florida Abuse Hotline. The policy outlines the reporting procedures for staff to follow when youth request to make an abuse call. The program maintains a staff handbook which outlines the program's code of conduct. All staff are required to sign and acknowledge receipt of the staff handbook and code of conduct during the hiring process. The program had four allegations of abuse against staff since the last annual compliance review. Three were applicable for reporting to the Florida Abuse Hotline and the Department's Central Communications Center (CCC) and one was applicable for a report to the CCC, since the youth was over the age of eighteen. One case has been closed unsubstantiated for abuse and three remain under investigation. Postings of the CCC and Florida Abuse Hotline numbers were noted during the program tour. An interview with the facility administrator (FA) reported the staff code of conduct includes regular attendance, no gambling on the premises, dress code, safe work practices, no dating between staff, and reporting any arrests. The FA added staff must not violate program rules for safety and security, not bring contraband into the program, not purposely damage program property, not physically assault youth or staff, and not sleep while on-duty. It was reported consequences and monitoring include coaching sessions, written warnings, suspensions, and can include termination. The program practice for reporting incidents to the Florida Abuse Hotline and/or the CCC is to immediately notify the shift supervisor of any on-duty incidents. The shift supervisor is then responsible for contacting the FA and completing an incident report. The FA and/or designee will then report all applicable incidents to the CCC within two hours. The FA explained staff are trained about the Florida Abuse Hotline during in-service and pre-service trainings. All staff and

youth are permitted to call upon request and the master control staff document when calls are made. All calls are discussed during the program's morning management meetings. The program completed Trauma Responsive and Caring Environment (TRACE) youth and staff surveys on March 26, 2020; however, the program has not yet completed an action plan based on the survey results. Three interviewed youth reported they have never exchanged personal contact or social media information with staff. Each youth reported never hearing staff use profanity when speaking to youth, and staff are respectful when talking to youth. Each of the youth reported never having been stopped from reporting abuse to the CCC or the Florida Abuse Hotline and reported feeling safe at the program. Three interviewed staff reported youth have unimpeded access to abuse reporting. Staff reported when a youth requests to call, they will notify a supervisor or allow the youth to make the call. All three staff reported they have never observed a co-worker use profanity, intimidation, or threaten youth. Three staff also reported they have never observed a co-worker disallow a youth access to the Florida Abuse Hotline.

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. Corrective action may include oral warnings, written disciplinary actions, suspension, and/or termination for any substantiated incidents. The program had four allegations of abuse against staff since the last annual compliance review. One incident report was closed unsubstantiated for abuse and three remain under investigation. Each incident was reported to the Department's Central Communications Center and/or the Florida Abuse Hotline, as required. Each incident resulted in the immediate removal of staff from youth contact and the initiation of an internal investigation. The closed incident was applicable for improper conduct and the staff member was terminated. The program's chief of security position also serves as the program's internal investigator.

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 ensuring the program reports incidents to the Department's Central Communications Center (CCC) within the required time frames. The program shall notify the CCC within two hours of a reportable incident or within two hours of becoming aware of the reportable incident. There were forty-six incidents reported to the CCC since the last annual compliance review. A review of logbooks, youth records, grievances, and internal incidents during the annual compliance review did not result in the discovery of any incidents which should have been reported and were not. A review of five randomly chosen CCC reports reflected each was reported within two hours, as required. Two reviewed incidents were for a youth mental health incident, one was for a youth medical incident, one was for a youth on staff battery, and the last was for youth property destruction resulting in an arrest.

Each reported incident was documented in the program's master control logbook. The program had an increase of reportable incidents compared to the previous year. An interview with the campus-wide superintendent attributed the increased incidents to the COVID-19 pandemic. An interview with the facility administrator (FA) revealed all incidents requiring notification to the Florida Abuse Hotline and/or the CCC are immediately shared with the shift supervisor. The shift supervisor is then responsible for contacting the FA and completing an incident report. The FA and/or designee with then report all applicable incidents to the CCC within two hours.

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

The program maintains a written policy and procedures, as well as a written plan, ensuring the utilization of Protective Action Response (PAR) techniques. All direct care staff shall be trained in PAR and a PAR report shall be completed any time a PAR incident occurs. Each PAR report shall include statements by all persons involved, a review by a PAR certified instructor/supervisory staff, post-PAR interview with the youth, and a review of the PAR incident report by a facility administrator (FA) or designee within seventy-two hours of the incident. The program's PAR Plan was approved by the Department's Office of Staff Development and Training on January 10, 2020. The program had twenty-three PAR events since the last annual compliance review. A review of five randomly chosen PAR events was conducted. Each reviewed PAR incident documented completion by the end of the staff member's work shift and included statements from all staff involved. None of the reviewed events were applicable for a Level 3 response requiring the completion of a Mechanical Restraint Supervision Log. None of the reviewed PARs were applicable for a youth alleging abuse requiring a call to the Florida Abuse Hotline. Each reviewed report documented review by a PAR certified instructor/supervisory staff and a post-PAR interview conducted within the required time frames. One incident was applicable for the need of a post-PAR Medical Review. The medical review was completed by a registered nurse immediately following the incident. Each of the five reviewed reports documented review by an administrator within seventy-two hours. An interview with the campus-wide assistant superintendent reported the program practice is to place all PAR reports in a binder located in the FA's office immediately following administrative review. A review of the PAR binder documented the reporting of all PAR incidents to the Department's regional office by the fifteenth of each month as required. The program's PAR rate has increased since the last annual compliance review. The program's PAR rate during the annual compliance review period was 2.33, which is above the statewide Residential PAR rate of 2.28. An interview with the campus-wide assistant superintendent attributed the increase to combative youth behaviors, high risk youth transfers, and gang activity. Three interviewed direct care staff explained the program's PAR process. Each staff reiterated the need for verbal de-escalation techniques prior to the use of any physical intervention techniques.

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

The program has a written policy and procedures regarding pre-service training. The program maintains a pre-service training plan and calendar for all new staff. The plan was submitted and 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 classes, web-based courses, and on-the-job training. A review of three staff records for pre-service training was conducted. Documentation reflected each staff member exceeded the required 120 hours of pre-service training to be completed within 180 days of hire. Each record documented the completion of Protective Action Response (PAR), first aid, cardiopulmonary resuscitation (CPR), and automated external defibrillator (AED) prior to any contact with youth. Documentation supported all in-person trainings were led by facilitators qualified to deliver the provided trainings. Each of the three reviewed training records documented the completion of suicide prevention and intervention, emergency procedures, child abuse reporting, Prison Rape Elimination Act (PREA), human trafficking, active shooter training, the grievance process, infection control, the exposure control plan, the behavior management system, safety, the program's mental health overlay services, and ethics, including standards of conduct. The three records documented the completion of training in the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) screening, and information security awareness. Two records documented the completion of Health Insurance Portability and Accountability Act (HIPPA) training. One record documented the completion of training in assisting youth with the self-administration of medication/medication pass. All required trainings were completed and documented in the Department's Learning Management System (SkillPro) within thirty days of completion, as required.

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 ensuring in-service training is conducted annually. An in-service training plan was submitted to the Department's Office of Staff Development and Training on February 7, 2020 and approved on February 17, 2020. The program has an annual in-service training calendar, which is updated as changes occur. Three staff records, inclusive of one supervisor, were reviewed for the completion of in-service training. Each record documented the staff exceeded the required twenty-four hours of required annual training. Each record documented the completion of Protective Action Response (PAR), first aid, cardiopulmonary resuscitation (CPR), and automated external defibrillator (AED) training updates. All three records documented the completion of six hours of suicide prevention. Each record also documented training completed in human trafficking, active shooter preparedness, the program's behavior management system, an overview of medical services, safety and security, Prison Rape Elimination Act (PREA), emergency response, infection control, blood born pathogens, exposure control, behavior management system, the program's mental health overlay services, and ethics, including standards of conduct. The

reviewed record applicable for supervisory training documented the completion of twelve training hours in management, leadership, personal accountability, employee relations, communication skills, and fiscal. The reviewed supervisory training record also included training in trauma practices and the Department's outcome based corrective action plans. A review of all medical staff training reflected all program nurses had current certifications in CPR, first aid, and AED. All required trainings were completed and documented in the Department's Learning Management System (SkillPro) within thirty days of completion, as required. All floor staff, inclusive of supervisory staff, are considered direct care staff and are counted in the staff-to-youth ratio. Documentation supported all in-person trainings were led by facilitators qualified to deliver the provided trainings.

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 outlining the grievance process. Staff must adhere to a formal and informal grievance process. Youth are oriented to the grievance process during admission into the program. The program maintains a written plan for all pre-service training which includes the program's grievance process and procedures. The program's grievance process outlines an informal, formal, and appeal phase. The program allows youth to use "Let's Talk" forms prior to submitting a formal grievance. "Let's Talk" forms allow youth to voice concerns and informally file an issue or complaint prior to submitting a formal grievance. All informal grievances must be responded to within forty-eight hours. The program maintains a binder maintaining "Let's Talk" and grievance forms for at least twelve months. There were two formal grievances and fifteen "Let's Talk" forms submitted throughout the previous twelve months. A review of the two applicable grievance submissions verified each grievance was resolved at the formal level and within the required seventy-two-hour time frame. The reviewed grievances did not require an appeal. Each grievance and "Let's Talk" form showed documentation of youth participation, supervisory oversight, and final outcomes. Three interviewed youth reported grievance forms are available and any youth may complete a grievance and place it in a grievance box. The program's grievance box is affixed to the wall outside of the cafeteria. Three interviewed youth reported they can ask for assistance when completing a grievance form.

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

The program maintains a written policy and procedures ensuring youth are provided interventions through evidence-based principles. A review of the program's contract confirmed the program utilizes Impact of Crime (IOC) and Thinking for a Change (T4C) as the delinquency intervention programs. A review of the program's activity schedule reflected IOC and T4C are each scheduled for one hour, twice a week, along with other structured activities. The program

has three trained IOC facilitators and two T4C facilitators. Intervention groups are facilitated by case managers or shift supervisors. A review of facilitator training records found trainings in each applicable intervention were completed, and each staff had the appropriate education and experience to facilitate. An interview with the campus-wide director of treatment services explained IOC and T4C interventions were prescribed to youth based on identified needs. Additionally, the program considers staff's intervention training, education, and work experience to determine which staff deliver the delinquency intervention services. A review of three youth records and group sign-in sheets confirmed each of the youth completed T4C and one youth was currently participating in IOC. Delinquency service interventions, and the intervention service goals were included as part of each youth's individualized performance plan. Three interviewed youth confirmed delinquency prevention groups included T4C and IOC at the program.

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

The program maintains a written policy and procedures ensuring youth receive life and social skills training. The program's policy ensures the youth receive life and social skills training to include decision making, communication, interpersonal relationships and interaction, non-violent conflict resolution, anger management, critical thinking, and problem solving. A review of the program's contract reflected SkillStreaming the Adolescent and Independent Living Skills as required social skills groups. The program utilizes the Daniel Memorial Independent Living transition focused living skills program for all youth. A review of the program's activity schedule, documentation of group sign-in sheets, and youth portfolios confirmed youth receive these services and participate in groups. Reviewed group activities included worksheets and role-play activities. A review of staff training validated facilitators were trained to deliver groups. An interview with the program's campus-wide director of treatment services reported the program considers a staff's intervention training, education, and work experience to determine which staff deliver the life and social skills groups to the youth. An informal interview with the campus-wide assistant superintendent supported youth also participate in life skills and career building through education assignments, therapeutic interventions, and restorative justice opportunities at the program. Three interviewed youth reported participating in groups and having opportunities to practice newly acquired skills.

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

The program maintains a written policy and procedures ensuring youth are provided activities or instruction to increase youth awareness and empathy for crime victims and survivors. A review of the program's contract identified the Impact of Crime (IOC) curriculum as the restorative justice programming. The IOC curriculum includes victim impact, personal accountability, consequences of actions, introduction to harm, managing conflict, effects of crime, and the road to reparation. A review of the program's activity schedule confirmed IOC groups are scheduled for one hour, twice a week. A review of group sign-in sheets validated groups were held according to the dates on the activity schedule. The program conducted one cohort of IOC

September 2019 through January 2020, and a second cohort January through May 2020. A review of staff training records reflected facilitators of IOC were trained in the curriculum. An interview with the director of case management revealed youth participate in activities which include positive affirmations for youth, cards for seniors, a partnership with the local foodbank, and health care worker recognition activities as part of the restorative justice programming. During an interview, facility administrator explained youth participate in IOC and community service projects. Youth are also encouraged to participate in on-site cleanup projects and activities. Documentation confirmed the program utilizes videos to expose youth to victim's perspectives. A review of three youth records and IOC sign-in sheets confirmed each youth was participating in restorative justice programming, as outlined in their individual performance plan. Three interviewed youth confirmed group participation and community service project offerings at the program. In accordance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site; therefore, observations of youth participating in restorative justice activities was not possible.

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

The program maintains a written policy and procedures outlining youth participation in gender-specific programming. The program provides delinquency interventions and treatment services which are gender-specific and focus on preparing youth to live responsibly in the community upon release. A review of the provider's contract identified Young Men's Work and 24:7 Dad Fatherhood Handbook for gender-specific programming. The Young Men's Work group is a group for males ages fourteen to nineteen. The group is designed to teach young men to work together to solve problems without violence. Topics covered in the group include what it means to be a man, communication, discipline, co-parenting, handling feelings, and family history. Handouts, videos, and group discussions are utilized in both groups to help instruct youth on gender-specific issues. Groups are facilitated by trained facilitators. A review of the program's daily schedule indicated Young Men's Work group was scheduled once a week for one hour. A review of group sign-in sheets and handouts confirmed gender-specific programming was delivered according to the program's group schedule. The program did not offer 24:7 Dad Fathering handbook during the review period; however, a youth identified to be a father was provided individual instruction utilizing the Arise Fatherhood workbook. The Arise Fatherhood workbook contains sixty pages of activities, three section quizzes, four short stories, and three biographies of inspiring fathers. An interview with the campus-wide assistant superintendent and the director of case management confirmed youth participation in gender-specific groups and hygiene activities while at the program. Three interviewed youth reported participating in groups and having opportunities to practice newly acquired skills.

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 written policy and procedures ensuring alerts are entered in the Department's Juvenile Justice Information System (JJIS) and maintained in the program's internal alert system. Critical and special alerts are reviewed, updated, and responded to appropriately. The program maintains an alert board in master control, an internal medical alert list, and JJIS alert printouts. The master control board includes security, gang, and suicide risk alerts. The internal medical alert list includes medical grade, medication, the Department's Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) results, food and dietary, physical limitation, and complication information. The program also utilizes JJIS alert printouts which are inclusive of all alerts. Printouts are located in master control and accessible to all staff. All alerts are updated in real time and reviewed daily by program staff. A review of logbook entries, daily shift reports, and morning management meeting minutes verified the regular updating and sharing of youth alerts at the program. A review of three youth records determined the youth were applicable for seventeen separate alerts while at the program. Each reviewed alert was verified prior to placement in JJIS, coincided with the internal alert system, and was entered and removed by the appropriate staff member. Eleven of the reviewed alerts were applicable for documentation within the program's logbook. Each alert was found to be documented upon the start and completion of the youth's alert status. An interview with the facility administrator (FA) revealed all alert rosters are reviewed and updated daily. The program practice is for the FA, health services administrator, and campus-wide director of treatment services to discuss risk factors of youth and set alerts based on individual needs. These alerts are discussed during the morning management meetings, are labeled on the housing roster in master control, and the JJIS alert system accordingly. Three interviewed staff reported alerts are located in master control, updated daily, and shift supervisors will notify staff of alert changes.

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 a written policy and procedures ensuring the maintenance, creation, and storage of individual healthcare, mental health, substance abuse, and case management records for each youth. The program maintains individual, color-coded, hardbound binders for case management, healthcare, and mental health and substance abuse records. Observations of the records determined each record had the required documentation on the spine and the

front of the binder, to include the youth's name, date of birth, county of residence, date of admission, committing offense, and the Department's identification number. Observations of the records found each record was marked "confidential" and secured in file cabinets in assigned offices not accessible to youth. Reviewed records were organized into required sections with tabs. Sections included legal information, demographic and chronological information, correspondence, case management, treatment team activities, and miscellaneous. All documentation was organized in chronological order.

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

The program maintains a written policy and procedures ensuring youth have the opportunity to provide constructive feedback. The program maintains a youth advisory board comprised of youth enrolled in the program, giving the youth the opportunity to have verbal contact with the program's administration regarding program operational issues, complaints, and/or suggestions. The program utilizes "Let's Talk" forms, giving youth an opportunity to address both positive and negative issues which may arise. Additionally, the program administration conducts quarterly surveys with randomly selected youth to obtain feedback regarding the program. The results of the interviews are sent to the corporate office for review and then utilized to initiate changes to the program, if needed. The program also elicits youth feedback in decision making through the youth advisory board. The youth advisory board meets at least once a month under the supervision of the facility administrator (FA) or designee and various staff, as available. A review of the youth advisory board meeting binder confirmed meetings were held at least once a month. Documentation confirmed each meeting followed an individual agenda which addressed each request or complaint accordingly, either during the following month's youth advisory meeting or with program leadership. Three youth were interviewed, each of whom stated they were allowed to provide feedback and input, if desired. One youth identified "Let's Talk" forms as a way to provide input, and two youth identified the student council/advisory board. An interview with the FA confirmed the program's practice for promoting constructive input from youth.

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 participate in. 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). A letter and an e-mail were sent out to all advisory board members on August 7, 2020 to conduct the last quarterly meeting

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 for ensuring the program's planning, adequate staffing, staff appreciation, and recognition. The program conducts mandatory monthly All-Staff meetings. Documentation of the monthly staff meeting agendas and sign-in sheets for the past six months supported meetings were conducted as planned. A review of the monthly staff meeting agendas showed documentation addressing topics inclusive of training, performance guidelines, communication with staff and youth, staff dress code, safety and security, staff recognition, proper logbook documentation, policies and procedures, and youth supervision. All-Staff meetings include important updates from each department. The program has daily morning management meetings. Morning management meetings are conducted at the start of each day to discuss youth behaviors, alerts, Protective Action Response (PAR) incidents, Florida Abuse Hotline calls, calls to the Department's Central Communications Center (CCC), intakes, discharges, and any other important upcoming activities. The program has a recognition program called the TrueCore Way which is designed to help motivate, retain, and increase staff morale. The program provides gift cards to staff as incentives for performance and leadership. The program also has a staff of the month program and offers referral bonuses to staff, along with tuition assistance. The program reviews the Department's Comprehensive Accountability Report (CAR) with staff during staff meetings and utilizes the CAR for strategic planning. The program conducts quarterly surveys with staff and youth. The program provides parent/guardian surveys to each parent/guardian who attend visitation quarterly. The results of the surveys are incorporated into the program's planning process and recommendations for the program. The program also utilizes "Let's Talk" forms as an informal process to provide suggestions to the program. Three staff were interviewed regarding the frequency of meetings. Two staff reported meetings are held daily and one staff reported meetings are held monthly. Interviewed staff reported meetings are informative and include a review of the previous shift, youth information, supervision requirements, and mental health training. One interviewed staff reported communication is very good at the program, one staff said it is fair, and one rated communication as poor. The staff who rated communication as fair reported staff do not communicate with each other. The staff member who rated communication as poor reported information is very selective. Each of the staff reported they can provide feedback into program operations by talking to their supervisor. An informal interview with the campus-wide assistant superintendent reported the program has been actively recruiting staff through online advertising and has an open-door policy regarding staff input. The campus-wide assistant superintendent also reported attempts to improve staff morale include celebrations, food trucks, and contests with staff. The facility administrator confirmed staff meetings are held monthly.

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

The program maintains a written policy and procedures ensuring the evaluation of staff performance. Performance evaluations are completed annually for all staff by department heads, as well as an initial ninety-day evaluation for newly hired staff. An interview with the facility administrator (FA) revealed each department head meets with staff annually to review performance and provide feedback on goals and performance. Program evaluations are specific to different categories or staff positions. Staff can be rated as exemplary, commendable, acceptable, or unacceptable. Each performance evaluation provides an overall numeric rating at the end of the evaluation. Three staff records were reviewed for a ninety-day evaluation and three were reviewed for an annual performance evaluation. Each record included the specific job description. Each reviewed record contained the applicable performance evaluation completed within the required time frames. The program's contract was reviewed for required positions. At the time of the annual compliance review, the program had twenty-three vacant positions. Vacancies included one campus-wide receptionist, one campus-wide physical plant worker, two non-licensed therapists, one shift supervisor, one master control staff, two youth care worker II positions, twelve youth care worker I positions, two registered nurse positions, and one designated mental health clinician authority. The program's designated mental health clinician authority position became vacant the week of the annual compliance review. Three randomly selected staff were interviewed. One staff reported they receive an evaluation monthly, one reported they receive an evaluation annually, and the third staff reported they just received an initial ninety-day evaluation.

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 ensuring the active participation in a variety of structured recreation and leisure activities. Youth shall have the opportunity to make choices, assume meaningful roles, including team memberships and leadership roles, and give input into the roles and operation of the residential community. 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 under the original contract requirement. A review of the program's activity schedule found recreational time is scheduled for one hour each day. The recreational calendar included indoor and outdoor scheduled activities. Documentation supported activities were planned to support social and cognitive skill development, creativity, teamwork, healthy competition, mental stimulation, and physical fitness. A review of the program's logbooks found the program inconsistently documented recreation time in the logbook. The program takes precautionary measures to prevent over-exertion, heat stress dehydration, frostbite, hypothermia, and exacerbation of existing illness or physical injury. The program completes individualized wellness plans which focus on weight, stress management, and impulse control goals. A review of three youth records found each record contained a completed individual wellness plan. The program has a formal process in place which allows youth to provide constructive input and feedback to the recreation programming. Additionally, the youth's advisory board meets monthly to provide suggestions and recommendations on recreation and leisure activities. Three interviewed staff reported youth

receive an hour of recreation and leisure time each day. Interviewed staff reported activities can include basketball, races, running, puzzles, cards, and board games. Three interviewed youth confirmed the program provided opportunities to exercise, play outside, read a book, or play a board game. Each youth reported receiving at least one hour of recreation/leisure time each day. Interviewed youth reported participating in basketball, football, and playing card activities at the program.

Standard 2: Assessment and Performance Plan

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

The program has a policy and procedures addressing initial contact to parents/guardians and court notification upon each youth's admission. Three reviewed case management records found each parent/guardian was notified by telephone and in writing of the youth's admission within twenty-four hours of arrival to the program. Each of the three reviewed records confirmed youth were provided a telephone call to the parent/guardian at the time of admission. Each record documented an admission letter and an input questionnaire sent to the parent/guardian within forty-eight hours of each youth's admission. Each of the three reviewed youth case management records documented the program's practice of sending a notification letter to the youth's committing court. The written notification was mailed to the committing court within twenty-four hours of each youth's admission to the program and a copy was sent to each assigned juvenile probation officer. None of the reviewed records documented the youth were assigned to a post-residential counselor at the time of admission and the program had no youth 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. A review of three case management records supported each youth was provided an orientation within twenty-four hours of admission. Each reviewed record documented a signed checklist acknowledging the youth received an orientation packet and information regarding 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) telephone numbers, contraband, dress code and 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 program and designated areas which are not accessible to youth. The reviewed records validated each youth received a copy of the youth handbook which outlined the program rules governing conduct and positive/negative consequences for behavior. Two interviewed youth reported orientation included program rules, procedures, schedules, and all other pertinent information. One youth stated they could not remember the process. Three interviewed youth confirmed the orientation was conducted on the day of admission to the program.

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

The program has a policy and procedures which addresses obtaining written consent of youth who are eighteen years of age or older. One of the three reviewed records 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 to the program. There were no additional records applicable for youth over the age of eighteen during the annual compliance review.

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

The program has a policy and procedures 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 three case management records found each youth had an admission classification completed for the purposes of assigning youth to a living/sleeping area and staff advisor. Each reviewed admission classification form was completed on the date of admission for each youth. During an interview, the program's facility administrator (FA) reported all classification factors are taken into consideration when deciding where to place the youth. Three admission classification forms were reviewed, and each was applicable for having an alert entered into the Department's Juvenile Justice Information System (JJIS). Documentation confirmed the appropriate alerts were entered for each of 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. The program's policy and procedures addressing reassessment and reclassification of youth prior to an increase of a youth's privileges or freedom of movement, participation on work projects or other activities which involve the use of tools, and a youth's participation in any off-campus activities. Three reviewed case management records indicated each youth was applicable for reassessment prior to participation in activities, work projects, consideration for an increase in privileges, or freedom of movement. Each reviewed record documented the completion of a reassessment which included review of the program's policy and procedures, each youth's individual performance plan, treatment team notes, and performance summaries. Documentation confirmed reassessment results were discussed at treatment team meetings. It is the program's practice to complete a reassessment each month

for each youth and documentation supported this was completed in each of the three youth case management records reviewed.

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). Three case management records were reviewed, and each was applicable for gang involvement or association. Documentation validated the program notified the local law enforcement's gang liaison by electronic mail of each youth's gang affiliation. 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 also shared with the educational staff at the program, the youth's juvenile probation officer (JPO), and the post-residential services counselor, if applicable. The program has identified each case manager as the gang liaisons.

2.06 Gang Identification: Prevention and Intervention Activities	Limited 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. Each of the three reviewed youth case management records applicable for participation in gang prevention and intervention activities. Documentation supported each of the three youth were documented in the gang binder as associated with or a member of a gang and each had a performance plan which included gang prevention and intervention strategies. The program utilizes the Gang Resistance and Drug Education (GRADE) and Gangs: 50+ Stories of Fractured Lives curricula. Each 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; however, the policy does not include procedures to ensure the youth have the opportunity, if they desire, to disaffiliate from a street gang. In an interview, the campus-wide assistant superintendent stated if a youth wishes to disaffiliate from a street gang, the youth would notify the transitional service manager and the assigned juvenile probation officer; however, the program could not show any practice. The program updated the policy and procedures to include this element during the annual compliance review week.

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 three case management records found each contained a Residential Assessment for Youth (RAY) completed within thirty days of each youth's admission 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. Three reviewed case management records found each was applicable for a RAY Reassessment. Documentation supported two of the three RAY Reassessments were completed within ninety-days of the initial RAY. One RAY Reassessment was completed twelve days late. 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.	

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

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

The program has a policy and procedures 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. Three youth case management records were reviewed, and two documented the IPP was developed within thirty days of the youth's admission. One IPP was completed one day late. The treatment team members who participated in the development of the IPP for each youth included the case management representative, youth, administration representative, living unit representative, mental health treatment staff, and education staff. This was verified by each member's signature and date on the IPP. The reviewed performance plans for each youth was developed after the initial assessment. Interviews conducted with three youth confirmed each participated in the development and received a copy of their IPP. 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. Three youth IPPs were reviewed and each included individualized goals based on prioritization needs. All goals included specific interventions which were measurable, included youth and staff responsibilities to complete the goals, and included projected target dates for completion. A review of three youth disposition court orders indicated one was applicable for additional court-ordered sanctions besides court fees. The additional targeted court-ordered sanctions were not included in the youth's IPP. All three reviewed records indicated each youth was enrolled in educational programing. Each of the three reviewed IPPs addressed the youth's top three criminogenic needs of the youth. 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 their initial IPP. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site and one day on-site; therefore, observations of a treatment team meeting was unable to be conducted, as there were no treatment team meetings during the time the team was on-site. Within ten working days of completion of the IPP, the program sends a transmittal letter, and a copy of the IPP to the youth's committing court, juvenile probation officer (JPO), and each parent/guardian. Three youth case management records were reviewed, and two indicated a transmittal letter and a copy of the performance plan was sent within ten working days to the committing judge, JPO, and parent/guardian. One transmittal was sent one day late to all parties. All three IPPs were signed by the youth, treatment team leader, and all significant parties responsible for the goal completion. The program mailed all three IPPs to the parents/guardians to sign and return to the program. Reviewed documentation indicated one of the signature pages were returned to the program. Informal interviews with three youth confirmed each received a copy of their IPP.

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

The program has a policy and procedures addressing performance plan revisions. Three 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 ~~of~~ for Youth (RAY) Reassessment results, newly acquired information, demonstrating lack of progress toward completing a goal, demonstrated progress toward completing a goal, and 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 found each IPP was revised to facilitate transition activities during the last sixty days of each youth's stay in the program.

2.11 Performance Summaries and Transmittals	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. Three case management records were reviewed, and each was applicable for requiring a performance summary. Documentation validated each performance summary was completed every ninety-days following the signing of the initial performance plan. Two of the three youth records supported the Individualized Performance Plan (IPP) was updated every ninety days, and one IPP was updated thirty-one days late. All performance summaries included the youth's overall progress on the IPP, academic status, behavior, level of readiness to change, interactions with peers and staff, the status of each goal, and significant positive or negative events. Each reviewed performance summary was signed and included comments by each youth, and each original performance summary was filed in the youth's case management record. Three interviewed youth reported receiving a copy of their performance summary. Each of the three reviewed case management records contained performance summary transmittal letters supporting each performance summary was forwarded to the youth's committing judge, the assigned juvenile probation officer (JPO), and the parent/guardian. 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 days 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) or 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. Each parent/guardian is contacted by telephone by the case manager upon each youth's admission to the program, and a welcome letter is mailed within forty-eight hours of admission. The welcome letter includes a calendar of all treatment team meetings and parents/guardians are encouraged to participate in person or by telephone. Parents/guardians are involved in the assessment process, the development of the youth's performance plan, and progress reviews. The program also 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 days were suspended as of March 2020. Three interviewed youth reported their parent/guardian is involved in their case

management process and treatment team meetings. In addition, three youth stated their parent/guardian participates regularly in family therapy. Each youth reported all participation is conducted over the telephone and/or through virtual meetings. 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, and others responsible for providing or overseeing the provision of intervention and treatment services. Three youth case management records were reviewed, and each contained an initial individual performance plan 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. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site and one day on-site; therefore, observations of a treatment team meeting was unable to be conducted, as there were no treatment team meetings during the time the annual compliance review team was on-site.

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

2.15 Treatment Team Meetings (Formal and Informal Reviews)	Limited Compliance
A residential commitment program shall ensure the intervention and treatment team meets every thirty days to review each youth's performance, to include 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. Three case management records were reviewed, and documentation supported formal treatment team reviews were conducted at least once every thirty days for two of the three youth. One youth was missing two formal treatment team reviews during the time frame of

February 6, 2020 to March 6, 2020 and March 6, 2020 to April 6, 2020. The program provided case notes entered into the Department's Juvenile Justice Information System (JJIS) by the youth's assigned juvenile probation officer (JPO), indicating the JPO participated in a treatment team meeting during this time frame, as well as a chronological case note indicating a formal treatment team review was conducted on April 2, 2020; however, the program was unable to provide any other supporting documentation inclusive of a performance plan review form, and/or a signature page confirming the attendees. Three case management records were review for informal treatment team reviews, and documentation supported informal treatment team reviews were conducted at least once within thirty-days for two of the three youth. One youth was missing informal treatment team reviews for the months of March 2020 and May 2020. 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 consisted of the youth, case management staff who act as the treatment team leader, clinical staff, education, and a program administration representative. Each youth's JPO, parent(s)/ guardian(s), and other pertinent parties were invited to participate in person, by telephone, and/or provide written input. The treatment team members reviewed the progress of each youth's goals, behaviors, physical interventions, treatment progress, and Residential Assessment of Youth (RAY) reassessment results. All staff provided relevant input on the youth and agreed on how to proceed to formal treatment team. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site and one day on-site; therefore, observations of a treatment team meeting was unable to be conducted, as there were no treatment team meetings during the time the annual compliance review team was on-site. 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 to address career education. The program provides instruction in career education which is supervised and supported by the Okeechobee County School District, the program's education component. This offering teaches interpersonal communication skills, decision-making skills, and behaviors which are appropriate for youth in all age groups, and ability levels. The curriculum incorporates activities which contribute to learning positive work habits which will support and maintain positive employment and living standards. The program offers Type 3 career education services. This identified career education programming type combines instruction of personal accountabilities while providing program content directly related to the prerequisites for entry into a specific occupation. Additionally, within this programming type, the youth are given an orientation to the broad scope of career choices based upon personal abilities, aptitudes, and interests. Youth are instructed how to create résumés, learn how to correctly fill-out an employment application, and participate in mock interviews. For youth looking to further their education post-secondary, the opportunity is available to become aware of the college application process. A review of three closed youth records found each contained a sample of completed employment applications, a résumé, and a post-release calendar of appointments. Each calendar also contained contact information of a Career Source Center in the community where the youth will reside post-release. Two of the three reviewed youth records contained appropriate documentation to gain employment

inclusive of a birth certificate, Social Security card, and a State of Florida Identification card. The remaining record contained a birth certificate and Social Security card. Documentation reflected the youth was scheduled to obtain a State of Florida Identification card; however, the appointment was cancelled due to the COVID-19 pandemic. Each reviewed closed record contained documentation verifying the youth's parent/guardian, the youth's assigned juvenile probation officer (JPO), case manager, and other participating parties were aware of the youth's vocational plan and discharge plan.

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's educational programming is directly supervised and managed by the Okeechobee County School District. Reviewed documentation and an interview with the current dean of students indicated each youth is provided a minimum of 250 days of instruction during the calendar year, with a minimum of twenty-five hours of instruction weekly. Ten days are incorporated into the annual education calendar to provide for teacher planning and professional development. A review of the program's daily academic schedule reflected the hours of instruction are from 8:00 a.m. to 2:37 p.m. with a thirty-minute lunch and a fifty-minute teacher planning period Monday through Friday. A review of the program's logbooks documented classes operate with minimal interruptions. The master control logbook entries and the school weekly attendance sheets further documented youth attended school during the times indicated on the activity schedule. Three reviewed youth records indicated educational staff attend and/or submit written input during formal treatment team meetings, transition conferences, and the exit conference for each youth. Three interviewed youth reported there are minimal interruptions during educational instruction. The interviewed dean of students stated the program adheres to the educational instruction schedule.

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. The program completes educational transition plans for each youth which includes provisions for either continuation of education or employment after release. Three closed youth case management records were reviewed, and each contained a completed educational transition plan. All reviewed plans were based upon each youth's specific individualized post-release goals which were created upon admission and revised during the youth's stay at the program. Each record contained evidence of services and interventions based upon the youth's assessed education needs. Documentation supported all required parties involved in the youth's transition provided input into completed plans. Participants included the youth, the youth's parent/guardian, the youth's assigned juvenile probation officer (JPO), a representative of the program's instructional team, a representative from the post-release school district, and a representative from the program's treatment team. Three interviewed youth reported being part of the planning process.

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 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 all three transition conferences supported the youth, case manager (who also acted as the treatment team leader), the facility administrator or designee, educational staff, mental health staff, and medical staff participated in person, and the youth's parent/guardian, and 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 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. Two of the three reviewed closed records contained documentation supporting a CRT meeting was conducted. Both reviewed records documented the youth and case manager's participation in the CRT meetings. One youth record did not contain an invitation from the JPO to the CRT meeting and there was no documentation indicating when it occurred.

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 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; 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	Failed 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 where able to identify the location of all safety plans. A review of three case management records supported one initial safety plan was completed within fourteen days of the youth's admission. One initial safety plan was completed fifteen days late and one was completed twenty-nine days late. Documentation in the three reviewed records indicated all safety plans were jointly prepared by the youth, parent/guardian, and clinical staff. Three interviewed youth confirmed they contributed to their safety plans. One of the three reviewed case management records documented safety plan updates were made every thirty-days. One youth was missing a safety plan update for March 2020, and one youth was missing safety plan updates for the months of March, April, and May 2020. Three interviewed staff were unsure of how safety plans were reviewed. One staff reported mental health staff discuss the safety plans with the facility administrator. One staff reported the case manager reviews the safety plans with the youth, and one staff did not know the process.

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 clinical social worker (LCSW) 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 approximately 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 staff. 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 four non-licensed master's-level therapists; however, at the time of the annual compliance review there were two therapist vacancies. The program was utilizing a master's-level therapist from Okeechobee Intensive Halfway House. The therapist carried a caseload in both programs. In addition, the DMHCA supervises one 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 indicates they provide 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 position became vacant one day prior to the annual compliance review; therefore, interviews could not be conducted. The DMHCA serves as the mental health and substance abuse authority and is responsible for ensuring compliance with the mental health overlay services (MHOS), 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 intervention, diagnostic assessments, interview 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. Since the program's DMHCA position was vacant at the time of the annual compliance review, the campus-wide director of treatment services stepped in as the interim DMHCA until the position is filled. 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)	Satisfactory Compliance
The program director is responsible for ensuring mental health and substance abuse services are provided by individuals with appropriate qualifications. Clinical supervisors shall ensure clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience.	

The program 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 clinical social worker (LCSW) and the director of treatment services is a licensed mental health counselor (LMHC) and each staff's license is clear and active 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 located on the property under the shared contract number. 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 also 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 maintains a comprehensive plan for mental health and substance abuse services. The procedures documented a review by the DMHCA on January 10, 2020. The program maintains an agreement for professional services with a State of Florida certified American Board of Psychiatry and Neurology licensed psychiatrist who is scheduled to be on-site weekly. A review of the license reflected the psychiatrist's license was free and clear in the State of Florida with an expiration date of January 31, 2021. The director of clinical services and assistant facility administrator verified both the psychiatrist and DMHCA are on-call for emergencies and consultation twenty-four hours a day, seven days a week. The program also maintains an independent contractor agreement with a State of Florida licensed psychologist to provide services on an as-needed basis. 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 completes assessments, intelligence quotient (IQ) tests, provides consultation of youth who may be experiencing crisis-related situations, and communicates with the director of treatment services. Interview with the campus-wide assistant superintendent and director of treatment services indicated the program utilized the psychologist's services in the last twelve months only in May 2020.

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

The program is required to have four master's-level non-licensed therapists; however, at the time of the annual compliance review the program had two vacant positions. The program was utilizing a master's-level therapist from Okeechobee Intensive Halfway House where they carried caseloads at both programs. One therapist's degree was in mental health counseling

and one was a doctoral-level therapist with a degree in clinical psychology. The borrowed therapist's degree was in counseling. At the time of the annual compliance review, the program had nine youth in the population. One therapist was assigned to four youth, one to three youth, and the borrowed therapist was assigned to two youth. A review of caseload assignments reflected each was below sixteen, as contractually required. The program has a contracted board-certified behavior analyst (CBA). Youth identified with exhibiting self-destructive or violent behavior such as self-mutilation 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 providing 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 school teachers. The CBA maintains monthly data sheets on each youth to document the progress of each youth and provides weekly incentives and monthly incentives. At the time of the annual compliance review, the CBA was not providing services, as none of the 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 sixteen weeks of face-to-face supervision missing. Reviewed supervision found on the weeks there was a face-to-face clinical supervision conducted, it did not include all three applicable therapists nor was it 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 was unable to provide training documentation to validate all three 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 and crisis assessments were completed by a licensed mental health counselor.

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

The program ensures mental health and substance abuse 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). 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. Immediately, 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 three mental health and substance abuse records indicated the program administered a MAYSI-2 screening on the day of admission for two of the three youth. A review of JJIS found one youth's last MAYSI-2 was conducted by the Juvenile Assessment Center (JAC) and not on-site by the program. Another youth had a copy of the completed MAYSI-2 in the youth mental health and substance abuse record completed by the JAC; however, a review of JJIS supported the MAYSI-2 was completed by the program upon admission. The program did not provide training documentation for the staff member who completed the MAYSI-2 for both youth. Each reviewed MAYSI-2 reflected the screening was completed in full in JJIS. 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 also includes youth history of drug, alcohol, 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. One MAYSI-2 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. The campus-wide superintendent and assistant superintendent reported upon intake the program completes the MAYSI-2 and ASR to address any risks the youth might have for suicide and drug use. The superintendent also reported if the youth verbalizes or exhibits any suicide gestures or ideations while in the program an ASR is completed, and the youth is immediately placed on suicide alert.

3.05 Mental Health and Substance Abuse Assessment/Evaluation	**Limited 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, to 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 indicating a statement of concurrence or provision of alternative treatment recommendations based upon the findings of the review. A review of three mental health and substance abuse records supported the practice. Reviewed practice supported the program assesses each youth utilizing the Department's Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB), Adolescent

Psychopathology Scale™ – Short Form (APS-SF), Massachusetts Youth Screening Instrument – Second Version (MAYSI-2), and the Adolescent Substance Abuse Subtle Screening Inventory (SASSI-A2). Two of the three reviewed youth mental health and substance abuse records contained an evaluation completed within thirty days of admission by a non-licensed therapist. The remaining evaluation was completed ten days late. Reviewed practice supported the licensed clinical therapist reviewed and signed the evaluation within the required ten calendar days for two of the three evaluations. The remaining evaluation was signed two days late. Each 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 each youth had a properly executed Authority for Evaluation and Treatment (AET) form. Each 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. Each youth signed a client rights and responsibilities form, consent for urine collection and analysis, and signed for a list of telephone numbers which included the Florida Abuse Hotline, Department's Central Communications Center, local Department of Children and Families office, and the Poison Control.

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. Each assigned primary therapist develops the youth's individualized treatment plan based on identified needs, and treatment is provided by staff trained to perform the services provided. A review of three youth mental health and substance abuse records documented each youth was assigned to a treatment team upon arrival to the program. Each youth record contained an Admission Card and an Initial Mental Health and Substance Abuse Treatment Plan created on the day of admission. The program's Admission Card identifies the case manager and the primary therapist and not all other multidisciplinary treatment team members. Three reviewed mental health and substance abuse records supported each youth was assigned to a treatment team; however, they did not include all treatment team members participating. One reviewed record indicated the initial treatment plan had only youth and therapist signatures and was missing the program's administration, residential living unit representative, case manager, and all other staff responsible for delinquency intervention and treatment services. The second reviewed initial treatment plan indicated signatures from the youth, program's administration, and therapist and all others were missing. The third reviewed initial treatment plan indicated

signatures from the youth, program's administration, therapist, and case manager and all others were missing. None of the three reviewed initial treatment plans validated education, vocational training, transition coordinator, medical staff, and the youth's parent/guardian were part of the treatment team and the development of the initial treatment plan. The program indicated due to the COVID-19 pandemic signatures were unavailable to obtain; however, the program did not provide signatures or attempts to receive after the fact. A review of case notes for all three 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. A review of mental health and substance abuse group sign-in sheets supported groups were provided daily to youth. 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 non-licensed master's-level therapists facilitate mental health and substance abuse groups. Three youth were interviewed regarding participation in individual and family therapy. Each youth reported participating at least monthly. Three program staff were interviewed regarding mental health and substance abuse groups at the program. Each interviewed staff reported the clinical therapists facilitate groups; however, some trained staff facilitate delinquency intervention groups. An interview with the assistant 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 (MHSA) services. All MHSA 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 clinical social worker (LCSW), 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 MHSA Treatment Plan and an Individualized MHSA Treatment Plan. Upon release from the program, all youth shall have a discharge summary completed documenting the focus and course of the youth's treatment and recommendations for mental health and/or substance abuse services. Three mental health and substance abuse records were reviewed for an initial treatment plan. Each reviewed youth record contained an initial mental health substance abuse treatment plan on the Department's Initial Mental Health/Substance Abuse (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. All three reviewed plans were missing a combination of treatment team members. One of the three reviewed youth mental health and substance abuse records was applicable for the

youth admitted to the program on prescribed psychotropic medication; however, the initial plan did not include the youth's psychiatric needs. All three reviewed youth mental health and substance abuse records contained a completed Individualized Mental Health and Substance Abuse Treatment Plan. Two of the three individualized plans were developed within thirty days of each youth's admission. One plan was completed sixteen days late. 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. Two of the three reviewed plan were signed by the non-licensed therapist creating the plan. One plan was missing the non-licensed therapist's signature. The licensed therapist reviewed and signed the plans within ten days, as required. All three reviewed plans documented signature of treatment team members who participated in the development of the plan; however, the education staff did not document their participation in the development of the plan, as each reviewed plan was missing an education staff signature. None of the reviewed plans documented the parent/guardian participated in plan development. The program indicated due to the COVID-19 pandemic signatures were unavailable to obtain; however, the program did not provide signatures or attempts to receive after the fact. One applicable plan included provision for psychiatric services. Each plan documented prescribed services to include individual therapy once a month, group therapy once a day, and family therapy once each month for two youth and seven times a month for one youth. Reviewed weekly progress notes validated each youth received the prescribed services, as outlined on the individualized plan with the exception of one youth prescribed family therapy seven times a month. Documentation supported the youth received family therapy once a month. All three reviewed youth mental health and substance abuse records documented the multi-disciplinary treatment team conducted a treatment plan review at least every thirty days with the exception of one youth's reviews which were conducted late. One review was conducted two days late and the other was conducted four days late. Three closed records were reviewed for the completion of a mental health and substance abuse discharge summary. Each record contained a summary documented on the program's form containing all elements in the Department's Mental Health/Substance Abuse Treatment Discharge Summary form. None of the three reviewed discharge summaries were applicable for a youth released on suicide precautions. Each reviewed discharge summary documented services needed for daily maintenance of positive improvement in behavioral, emotional, and social skills made by the youth during treatment. Each reviewed discharge summary documented the beginning and ending diagnoses with the presenting symptoms to support the diagnostic criteria. Each reviewed discharge summary documented a discussion of the plan and recommendations with the youth's juvenile probation officer (JPO) and applicable parent/guardian during the exit conference, as required. The program practice is to obtain the parent/guardian signature upon release and to send the discharge summary to the JPO by mail. Reviewed documentation supported this practice for each of the three reviewed records

3.08 Specialized Treatment Services (Critical)	**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 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 are guided by an individualized mental health and substance abuse treatment plan addressing

the youth's needs in accordance with 63N-1, Florida Administrative Code. Treatment is provided by the licensed clinical social worker (LCSW) who serves as the program's designated mental health clinician authority (DMHCA) or 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 two non-licensed therapist vacancies. The program was utilizing a non-licensed therapist was Okeechobee Intensive Halfway House. 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). At the time of the annual compliance review, the program had nine youth in the census. The program provides each youth with group therapy services seven days a week. The program's contract outlines MHOS provided include Anger Management for Substance Abuse and Mental Health Clients, Strategies for Anger Management, Skillstreaming the Adolescent, Young Men's Work, 24:7 Fathering Handbook, and Thinking, Feeling, Behaving. In addition, MHOS include The Teen Relationship, Passport Program, Living in Balance, Seeking Safety, and Toward No Drugs. There was no documentation indicating Strategies for Anger Management or 24:7 Fathering Handbook groups were conducted during the annual compliance review period. The Passport Program was last conducted on December 29, 2019, Seeking Safety was last conducted on November 17, 2019, and Toward No Drugs was last conducted on December 29, 2019. The program's contract requires the utilization of a certified behavior analyst (CBA). The program utilizes a contracted part-time 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 school teachers. 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. 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. The program also maintains an independent contractor agreement with a State of Florida licensed psychologist to provide services on an as-needed basis. 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 supported the psychologist completed assessments, intelligence quotient (IQ) tests, provided consultation of youth who may have experienced crisis-related situations, and communicated 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, which includes daily therapeutic groups along with monthly individual and family therapy.

3.09 Psychiatric Services (Critical)	Satisfactory Compliance
Psychiatric services include psychiatric evaluation, psychiatric consultation, medication management, and medical supportive counseling provided to youth with a diagnosed DSM-IV-TR or DSM-5 mental disorder and each youth receiving psychotropic medication in the program as set forth in Rule 63N-1, F.A.C. ****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 with the psychiatrist revealed the psychiatrist is to be on-site weekly to provide psychiatric services, in addition to being on-call for emergencies and consultation twenty-four hours a day, seven days a week. The psychiatrist has a back-up clinician to provide coverage while on vacation or leave; however, no back-up coverage was required 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 psychiatrist sign-in sheets since the last annual compliance review supported the psychiatrist is on-site weekly, as required. 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. A review of three mental health and substance abuse records indicated one youth was admitted on prescribed psychotropic medications. However, program practice is to complete a psychiatric initial diagnostic interview within seven days of admission on all youth. Subsequent to admission, the other two youth were also prescribed psychotropic medications. Each diagnostic interview documented the youth's history, Mental Status Examination, Diagnostics and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, applicable prescribed medications, and frequency of medication monitoring. Each reviewed record 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. All three applicable youth were assessed by the psychiatrist at least every thirty days. The review was documented on the program's Medication Management form and page three of the Department's CPPN was attached to each form completed in full. There were no documented lapses in psychiatrist services for the records reviewed. Reviewed documentation supported there were no standing orders for psychotropic medications and there were no emergency treatment orders for psychotropic medications. An interview with the program's psychiatrist supported participation in weekly treatment team meetings and weekly on-site visits. The psychiatrist reported 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 meets with the clinical treatment team members and the DMHCA every week 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. Included in medication management is prescribing and adjusting medication regimens, as well as ordering lab tests, medical levels, administering Abnormal Involuntary Movement Scale (AIMS), referring to specialists, as necessary, depending on the particular medication each youth is prescribed, and the youth's specific medical and/or neurologic condition.

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 designated mental health clinician authority (DMHCA) on August 20, 2019. The plan was reviewed and updated during the annual compliance review week and signed by the campus-wide director of treatment services on August 20, 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 assistant facility administrator 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 procedure. The program's suicide prevention plan outlines an established review process for every serious suicide attempt or serious self-inflicted injury requiring hospitalization or medical attention. A representative from program administration and each department review 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 one complete suicide response kit located in sub-control. The program does have access to an extra kit located in the campus-wide master control center, should the need arise. 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 three youth mental health and substance abuse records found each youth was screened upon admission utilizing the Department's ASR form. Two of the three reviewed ASRs determined the youth were not at risk of suicide and were placed on standard supervision. According to an interview with the assistant facility administrator (AFA), the program had one youth who was placed on precautionary observation (PO) on three separate occasions within the last twelve months. One was during the admission screening and two subsequent times. Each time the youth was placed on PO was due to expressing suicidal ideations to staff. A review of the applicable ASRs found the forms were completed by the licensed clinical social worker (LCSW). The youth was referred and assessed on the same day 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 precautionary observation status, the completion of a suicide precautions observation log, 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 the completion of a mental status examination and transitioned to standard supervision. Each 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 AFA 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 three youth mental health and substance abuse records found one was applicable for placement on PO three separate times. According to an interview with the assistant facility administrator (AFA), 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 expressing suicidal ideations to staff. Three applicable PO records 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.

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 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 monthly drills on each shift during the past twelve months. Three interviewed staff indicated drills are conducted monthly. Three of the completed 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. A review of the program's staff roster indicated thirty-four staff were required to have participated in mock suicide drills; however, documentation clearly reflected only six staff participated in suicide drills at least semi-annually.

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

The program maintains a written 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 also maintains a written crisis intervention plan. The plan was reviewed, approved, signed, and dated by the campus-wide director of treatment services on August 11, 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 three youth mental health and substance abuse records found one instance requiring the completion of a Crisis Assessment. An interview with the assistant facility administrator (AFA) indicated the program had 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 Assessment was completed in full by a clinical mental health counselor and was reviewed and signed by the licensed clinical social worker (LCSW) the same day. The program was unable to provide proof the non-licensed therapist completed the required training prior to completing the Crisis Assessment. Reviewed documentation supported the crisis assessment was warranted and specific treatment recommendations were made for the applicable youth. 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 August 20, 2019 and then during the annual compliance review week on August 20, 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 facility administrator and the DMHCA indicated there were no youth applicable for emergency mental health and/or substance abuse services since the last annual compliance review. The program transports youth in need of emergency mental health evaluation and treatment for Baker Act to New Horizon's of the Treasure Coast and Okeechobee in Fort Pierce, Florida. The program utilizes the emergency services through Raulerson Medical Center in Okeechobee, Florida for substance abuse Marchman Act. The program's policy states all program staff have the right to immediately

contact 9-1-1 and have access to rescue tools in case of an emergency. 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)	Satisfactory Compliance
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 maintains a written policy and procedures for ensuring emergency mental health and substance abuse services are provided to all youth. The program's emergency care plan outlines the process for Marchman Act and Baker Act proceedings. The program had two Baker Acts and no Marchman Act proceedings since the last annual compliance review. A review of two Baker Act records found the campus-wide director of treatment services, who is a licensed mental health counselor, completed the required Certificate of Professional Initiating Involuntary Examination of Baker Act proceedings for both youth. A review of the two Baker Act records showed both youth were placed on one-to-one supervision at the time of discovery and prior to transport to Raulerson Hospital. One youth was transported by emergency medical services (EMS) and the other youth was transported by the program. A review of the records for the Baker Act incident and the program's logbooks confirmed the youth was placed on constant supervision, as required, upon return to the program. The other youth was securely detained and did not return to the program. The one applicable youth record indicated an Assessment of Suicide Risk (ASR) and mental health status examination was completed, prior to lowering the youth's supervision level, as required.

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 has a written policy and procedures which requires a contracted heath authority to provide on-site medical services to youth in the program. The program currently has an independent contract with a State of Florida board-certified licensed osteopathic physician (DO) who has a specialty training in family practice to serve as the designated health authority (DHA). The DHA has a clear and active license to practice in the State of Florida, which is effective through March 31, 2022. 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. The program has a contract with a licensed medical doctor (MD) for backup coverage for scheduled absences, emergencies, and vacations. The backup MD has an active license to practice in the State of Florida with an expiration date of January 31, 2021. The DHA is available twenty-four hours a day, seven days a week for acute medical concerns, emergency care, and coordination of off-site care. Documentation related to healthcare services and the review of youth healthcare records reflected the DHA provides oversite for medical screenings, assessments and evaluations, provide medication evaluation and on-going monitoring of medications and chronic medical conditions. An interview was not provided by the DHA during the annual compliance review.

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

The program has a written policy and procedures for all health-related procedures and protocols utilized at the program. The program's assigned designated health authority (DHA) conducts an annual review of all health-related policies, procedures, and protocols. The DHA reviewed, signed, and dated the facility operating procedures (FOPs) on September 23, 2019. The facility administrator (FA) signed on June 6, 2019. Reviewed documentation validated the DHA and FA conducted an annual review of the healthcare policies, procedures, and protocols on June 16, 2020 and June 17, 2020. The program maintains an independent contractor agreement with a State of Florida licensed psychiatrist with specialty training in child and adolescent psychiatry. The current license expires on January 31, 2021. The psychiatrist signed the healthcare polices on July 5, 2018 and June 22, 2020. New policies, or changes in policies, made during the year are reviewed, signed, and dated by each nurse on the facility operating procedures cover-page which occurs between annual compliance reviews. The facility operating procedures and protocols are reviewed annually. The program's health services administrator (HSA) reported there have been no new medical staff since the last annual compliance review; however, the program does maintain a training requirement which requires newly employed healthcare staff to complete a comprehensive clinical orientation to the Department's healthcare policies and procedures.

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

The program has a written policy and procedures regarding the authorization of treatment (AET) for all youth admitted into the program. The AET form is signed by the parent/guardian and serves as informed consent for non-invasive medical procedures or for minor illnesses requiring over-the-counter (OTC) medications which can be treated by healthcare staff. The program also utilizes a separate form for youth eighteen years of age or older providing consent for release of specific information as noted on the Release of Information Authorization for Youth Eighteen Years of Age and Older form and to whom the information can be released and shared. Three youth Individual Healthcare Records (IHCRs) were reviewed for an AET. Two of the three reviewed youth IHCRs contained a copy of the signed AET and the word, “Copy” was clearly stamped on each. Each applicable AET had a witness signature. Each applicable IHCR included a copy of a completed parental notification behind the AET. One youth was over the age of eighteen and the youth signed a Release of Information Authorization Form for youth eighteen years of age or older. There were no youth who were in the care of the Department of Children and Families (DCF) at the time of the annual compliance review. An interview with the program’s lead registered nurse revealed the program’s policy is to obtain a signed AET from the parent/guardian and witnessed by a Department staff. The program obtains a court order for youth in the care of the Florida Department of Children and Families (DCF).

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 has a written policy and procedures ensuring the parent/guardian is informed of significant changes in the youth’s medical and/or mental health condition and to obtain consent when new medications and treatments are prescribed. Procedures also ensure the parent/guardian is notified to obtain consent of new psychotropic medications, discontinuances, or psychotropic medication adjustments. A review of three youth Individual Healthcare Records (IHCRs) validated each maintained documented practice of parental/guardian notification. One of the three youth were eighteen years of age or older. The youth’s record contained a Release of Information Authorization form for youth eighteen years of age or older. A review of three youth IHCRs found all three had significant changes to existing medications. Each applicable youth records requiring parental notification for over-the-counter (OTC) medication beyond those covered by the Authority for Evaluation and Treatment (AET) documented parental notification was sent. One reviewed IHCR was applicable for off-site emergency care and reviewed documentation supported the parent/guardian was notified. Nursing notes documented verbal parental notification in each case, as well as documented a witness to the verbal notification. Each applicable record contained documentation indicating the program obtained consent prior to administering psychotropic medications. Telephone consent conducted by the psychiatrist and witnessed by the nurse was documented, when applicable. The parent/guardian received a written follow-up of a copy of the Department’s Clinical Psychotropic Progress Note (CPPN) outlining the medication prescribed and reasons for the medication with the Acknowledgement of Receipt of Clinical Psychotropic Progress Note. Copies of all correspondence were maintained in the applicable IHCRs. All three youth IHCRs reflected vaccinations were verified within thirty days of the youth’s admission. Each record contained a copy of the youth’s immunization record received from the Department, the Florida

Shots website, and/or school records. There was no evidence of a youth's parent/guardian refusing to consent to a vaccination for medical reasons and/or any exemptions due to religious beliefs since the last annual compliance review. An interview with the nursing staff confirmed this practice. There were no applicable youth in the custody of the Florida Department of Children and Families (DCF).

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 has a written policy and procedures in place ensuring every youth receives a screening for health concerns upon admission, or at a minimum, each time the physical custody of the youth changes and they are returned or readmitted to the program. The program's practice is to complete a rescreening and complete the Department's Facility Entry Physical Health Screening (FEPHS) form anytime a youth is admitted into the program or returns to the program following a physical custody change. A review of three youth Individual Healthcare Records validated each youth received an admission screening utilizing the Department's FEPHS form upon admission into the program. All admission screenings were completed by a registered nurse (RN) on the date of the youth's admission. One youth in the program was applicable for a rescreening due to a change in custody, and a new FEPHS form was immediately completed by the program's RN upon the youth's return to the program. An interview with the program's lead RN confirmed the program's practice.

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 has a written policy and procedures to ensure each youth admitted into the program receives a healthcare orientation. The program's practice is to have the nurse or a medical staff knowledgeable with the health care delivery system provide healthcare orientation upon each youth's admission. A review of three youth Individual Healthcare Records (IHCRs) validated each youth received a healthcare orientation on the day of admission. Each healthcare orientation was documented on the Department's Health Education Record form. Reviewed documentation in each IHCR validated a health education packet was provided and discussed with the youth. The healthcare topics included access to medical care, sick call process, emergency situations, medication process, right to refuse care, what to do in case of sexual assault or attempted sexual assault, non-disciplinary role of healthcare staff, a review of healthcare contacts, and the role of the healthcare providers. 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 documented in the healthcare record. Each reviewed healthcare record 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 has a written policy and procedures to notify the designated health authority (DHA) of all youth admitted into the program identified with chronic health conditions or youth in need of emergency care. In addition, when a youth is admitted on prescribed psychotropic medications, the psychiatrist is also notified by telephone. The DHA is notified by telephone, text message, or verbally, if on-site, of all admissions. Three youth Individual Healthcare Records (IHCRs) were reviewed. Three youth IHCRs reflected telephonic notification to the DHA of the youth admissions into the program. None of the youth presented a condition requiring an emergency response. All records reflected notification documented in the youth's chronological progress notes/IHCRs. Reviewed documentation confirmed nursing staff updated the Chronic Conditions Log after the notification was completed.

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 has a written policy and procedures to address the completion of the Health-Related History (HRH) form prior to the completion of the Comprehensive Physical Assessment (CPA) upon each youth's admission to the program. A review of three youth Individual Healthcare Records found a new HRH form was completed within seven days of the youth's admission. Reviewed documentation supported the HRH form was completed on the day of admission. The nursing staff provided their electronic signature on the HRH form. Documentation further reflected the designated health authority (DHA) reviewed the HRH for each of the three youth. All three HRH forms were completed prior to the CPA. An interview with the program's lead registered nurse confirmed this practice.

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 has a written policy and procedures ensuring each youth receives or has on file a current Comprehensive Physical Assessment (CPA) no later than seven calendar days of admission into the program. A review of three youth Individual Healthcare Records (IHCRs) validated the program utilizes the Department's standardized CPA form. All CPAs were completed by the designated health authority (DHA) and/or designee. All sections of the CPA were completed in full utilizing "O" with no applicable "X" and included the appropriate medical grade of one through five. All reviewed CPAs did not complete section numbers nineteen through twenty-two, twenty-five, and twenty-six and the DHA documented "Deferred, age inappropriate." None of the youth refused any portion of the examination. A review of each youth IHCR validated each youth had at least one verified tuberculin skin test (TST) documented on the CPA within the last year to determine exposure to tuberculosis (TB). In addition, as part of the healthcare admission screening, nursing staff utilize the Department's Facility Entry Physical Health Screening (FEPHS) form to conduct a tier I TB screening. All tier I TB screenings were conducted on the day of admission for each youth. Reviewed documented 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. There were no current youth with symptoms suggestive of active TB. The program's policy indicates youth will not be placed into the general population until their healthcare needs identified are deemed to not require immediate medical attention and/or a referral for further assessment by healthcare staff. Reviewed documentation validated the Department's Problem List was updated for each youth throughout their stay, when applicable. An interview with the program's lead registered nurse confirmed this practice.

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 has a written policy and procedures in place ensuring all youth entering the program are clinically screened, evaluated, and treated (if necessary) for sexually transmitted infections (STIs) and Human Immunodeficiency Virus (HIV). A review of three youth Individual Healthcare Records (IHCRs) found each youth was identified as sexually active and was clinically screened and evaluated for STIs utilizing the Department's Sexually Transmitted Infections Screening form. Each youth was referred to the designated health authority (DHA) for further evaluation. Testing was ordered and was performed for each youth within twenty-four hours. Test results were filed in the lab section of the healthcare record and the screening results were documented on the Department's Infectious and Communicable Disease (ICD) form. There were no applicable youth who were out of the Department's custody for over thirty days and/or required a rescreening due to symptoms present. The program has a written policy and procedures ensuring all youth at risk for HIV infection are offered counseling, testing, education, prevention counseling, and a referral for medical treatment, as indicated. A review of three youth IHCRs supported each youth was offered the opportunity to receive counseling and testing for HIV. The program utilizes a site-specific HIV Risk Assessment and a referral for testing is based on the assessment results. Youth who consent to receive counseling and testing sign the Department's Human Immunodeficiency Virus (HIV) Antibody Test Youth Consent form. None of the youth in the sample consented to have HIV testing completed; therefore, three additional applicable records were reviewed. The program utilizes the DHA to provide pre and post-counseling. Reviewed IHCRs validated when youth receive pre-counseling, testing, and post-counseling provided by the DHA, the youth's health education record was updated in the healthcare record. The results were placed in a sealed envelope marked "Confidential" with the youth's name, program name and address, date of test, and youth signature documented on the outside of the envelope. The program maintains a HIV Testing Tracking Log for all youth who received testing. The program does not include HIV status as part of the internal alert system. Three interviewed youth indicated they could request a HIV test.

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 has a written policy and procedures to ensure all youth are be able to submit sick call requests and have complaints treated appropriately through the sick call system. Sick call

care is provided by licensed medical staff, pursuant to their scope of practice and according to the protocols approved by the designated health authority (DHA). Youth are informed of the sick call process at the time of admission to the program during orientation. The program's living unit has sick call forms located on the wall and a deposit box is located outside of the cafeteria accessible to all youth. The program's practice is to check the boxes every two hours. Sick calls are scheduled Monday through Friday at 6:00 a.m. and 12:00 p.m., and Saturday and Sunday at 8:50 a.m. and 5:30 p.m. The program offers youth the opportunity to make a Sick Call Request seven days a week. All scheduled sick calls are conducted by a licensed registered nurse (RN). The program also maintains an independent contractor agreement with a State of Florida licensed dentist and a State of Florida licensed optometrist. The dentist and license optometrist hold an unrestricted clear and active license in the State of Florida with expiration dates of February 28, 2022 and February 28, 2021 respectively. Two of three Individual Healthcare Records (IHCRs) were applicable for submitting a Sick Call Request Form; therefore, one additional applicable record was reviewed. Each applicable IHCR found the youth completed a Sick Call Request form at least once during their stay. The registered nurse (RN) documented the treatment and/or services provided to the youth during the sick call event on the Sick Call Request form. One youth presented a similar sick call complaint three or more times within a two-week period. Reviewed documentation confirmed the youth was referred and seen by the DHA. All reviewed sick call incidents were documented on the Sick Call Index and Sick Call Referral Log and the completed forms were filed electronically in the program's electronic medical record, as well as the healthcare record. When a licensed healthcare staff is not on-site, all Sick Call Request forms shall be turned into the shift supervisor for review. The supervisor is required to review the sick call complaint promptly, but no longer than two hours after the request was submitted. The supervisor will then determine if the sick call requires immediate attention. The DHA and/or designee are on-call and available for consultation to determine if the sick call requires immediate attention and/or for instructions. Any youth complaining of severe pain, including dental, which a staff member is unfamiliar and cannot determine the severity, shall be treated as emergencies and require immediate referrals to a licensed healthcare professional. Reviewed documentation confirmed all supervisors received medical technician training delivered by the program's RN. An observation of one sick call encounter indicated youth was assessed in the medical clinic by the RN. The youth provided verbal consent and initialed consent for the annual compliance review team member to observe the sick call process. The youth was seen in a private area within the medical clinic. The direct care staff stood outside of the open door during the sick call process. Three interviewed staff indicated nursing staff review and conduct sick call. One interviewed youth indicated they can see the nurse immediately and two youth reported within one day of submitting a 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. Episodic care is provided by the nurse and documented in the progress chronological notes and tracked on the Episodic Care Log. The log documents the date and time of the treatment, nature of the complaint, person rendering aid, treatment, and if off-site care is needed. Any episodic care provided by a non-licensed staff must have a follow-up evaluation by a licensed healthcare professional the next time the staff is on-site, or sooner, if indicated. A review of three youth Individual Healthcare Records found all three youth required episodic

and/or first aid care. 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 documented all episodic, first aid, and emergency 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) on the log. An interview with the program's nursing staff confirmed this practice.

The program maintains an automated external defibrillator (AED), suicide kit, and a knife-for-life located in various locations. The first aid kits, AED, and suicide response kits are checked monthly by nursing staff to ensure they are fully stocked and do not have any issues. The program maintains two AEDs located in the master control and sub-master control. The AED located in the master control battery expires in July 2022. The date the battery was last changed could not be determined. The AED pads expire in April 2021 and were last changed February 2019. The AED located in sub-control battery expires October 2022. The date the battery was last changed could not be determined. The AED pads expire in December 2020. The date the pads were last changed could not be determined. The program conducts announced and unannounced mock emergency medical drills monthly on each shift. A review of emergency drills for the last twelve months supported emergency drills were conducted at a minimum quarterly for each shift. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site; therefore; limited observations of the program were conducted during the annual compliance review. Three staff were interviewed. One staff reported notifying master control to contact 9-1-1. Another staff reported notifying the shift supervisor who will then call 9-1-1. Follow-up with the program found this was due to staff not having cell phones unless the staff was a supervisor or working on the mod. The last staff reported they are allowed to call 9-1-1 if a youth has a medical emergency. Three interviewed youth indicated they can see a doctor and/or dentist if needed.

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 has a written policy and procedures ensuring 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 three Youth Individual Healthcare Records (IHCR) found one youth requiring off-site care and/or emergency care; therefore, two additional applicable IHCRs were reviewed. Reviewed documentation supported the parents/guardians were notified, as required. The Department's Summary of Off-Site Care form was completed for each youth and was filed in the appropriate section of the IHCR. Reviewed documentation supported the DHA reviewed each completed Summary of Off-Site Care form and discharge paperwork, as evidenced by signature and date. All three applicable youth required follow-up care and there was evidence the referrals were tracked, and the youth received the appropriate care as needed. An interview with the lead registered nurse confirmed this practice.

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 has a written policy and procedures ensuring youth who have been identified with a chronic illness or who experience changes in condition or treatment regimen are adequately monitored. The frequency of the period evaluation is determined by the youth's condition, clinical needs, and clinically appropriate medical standards. A review of three youth Individual Healthcare Records (IHCR) indicated one youth was admitted with an identified chronic condition, as documented on the Facility Entry Physical Health Screening form; therefore, two additional applicable IHCRs were reviewed. Each applicable youth was classified with a medical grade of two through five. One applicable youth was undergoing treatment for a physical health condition which included a body mass index (BMI) greater than thirty. The program maintains a youth roster of youth requiring periodic evaluations which documents the youth's name, date of admission, whether the youth was admitted with prescribed medications, chronic condition, date of last visit, and next visit date. Reviewed records supported each youth received periodic evaluations, as required. An interview with the lead registered nurse confirmed this practice. There was no indication of lapses in care or missed periodic evaluations in each of the reviewed records. All on-site evaluations were maintained in the IHCR chronological progress notes and treatment orders were clearly written. All three IHCRs documented updating of the Department's Problem List as changes occurred. An interview was not provided by the DHA during the annual compliance review.

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 has a written policy and procedures ensuring medical staff verify any medications arriving with a newly admitted youth and continue all currently prescribed medications. When a youth arrives to the program with medication(s) or order/prescriptions for medication(s), the healthcare staff will conduct a preliminary assessment and interview to determine the medication is verified and indicated. Nursing staff complete the Facility Entry Physical Health Screening to determine medical needs. The signed Authority for Evaluation and Treatment (AET) serves as the authority to continue the present medication(s) and administer the medication(s) as ordered. A review of three youth Individual Healthcare Records (IHCR) found one youth was admitted into the program on prescribed medication. Two youth were later placed on medication after being admitted into the program. Two additional IHCRs were requested for youth admitted with medication during the annual compliance review. A review of the nursing admission notes documented the youth's current medication and the Designated Health Authority (DHA) Notification of Admission form documented current prescribed medications. Reviewed documentation confirmed the nursing staff verbally notified the DHA of each admission on the youth's day of admission. Documentation showed the DHA or psychiatrist resumed the prescribed medication for each youth. Reviewed Medication Administration Records (MARs) validated the continuation of medications. The program sends a Pharmacy Notification identifying the prescribed medications to contracted pharmacy. There were no instances when a youth's medication could not be verified and had to be returned to the youth's parent/guardian. The registered nurse (RN) completed the Prescription Medication Verification Checklist and Medication Receipt, Transfer, and Disposition form when youth were

admitted with current prescribed medications ensuring all medications have a current and valid order and were given pursuant to a current prescription. 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. The initial MAR for each record matched the medication(s) listed.

The medications are maintained in blister packs documenting the number of pills in each prescription order. Procured medications are administered by nursing staff and 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 registered nurses. The MAR clearly indicated medication start and stop dates. Licensed staff initialed the MAR for each administered medication entry. There were no indications of lapses and/or errors in the medication administration. Nursing staff documented side effect monitoring on each MAR daily each time medication was administered. The program's nursing staff maintain a locked tackle box within the clinic with over-the-counter (OTC) medications listed on the AET form for the trained non-licensed staff to utilize when nursing staff are not on-site. The trained non-licensed staff are permitted to assist youth in OTC medications when nursing staff are not on-site. The program's practice is to ensure the Six Rights of Medication Delivery/Administration is maintained for the youth. When applicable, the nurse and youth signed a Refusal of Care form indicating when a youth refuses treatment and the refusal would also be documented on the applicable MAR.

The program maintains a written policy and procedures ensuring all controlled substances shall be inventoried, stored, and documented, as required, by the Board of Pharmacy and Department requirements. The program's process for the disposal of medication is for all medications to be disposed in the physical presence of the consultant pharmacist utilizing the Rx Destroyer Pharmaceutical Disposal System. The program's procedures further outline all controlled substances are to be maintained in the securely locked box within the securely locked medication cart located in the medical clinic. Observations found all medications securely stored in the medical clinic, inaccessible to youth. All non-controlled medications were stored in a separate, secure, locked medication cart and a small amount of OTC medications were placed in a locked box on the wall of the clinic. Observations made during the annual compliance review revealed oral medications were not stored with injectable or topical medications. The program maintains one refrigerator in the medical clinic for the storage of medication and nursing staff reported the temperature is monitored daily. One medication pass was observed during the annual compliance review and no issues were identified. Three staff were interviewed and all three confirmed the nurses provide youth with medication. Three youth were interviewed and reported medication is administered by the nurse.

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 has a written policy and procedures ensuring medical equipment classified as medications/sharps are secured and inventoried by using a routine perpetual inventory. Narcotics and other controlled medications are securely stored in a locked box located within the medication cart. Medications such as injectables, topicals, drops, and liquids are stored separately. The program maintains one refrigerator for medications. The program securely stores sharps and syringes separate from medications. The program's practice is for over-the-

counter (OTC) medications to be inventoried using a perpetual inventory daily and verified weekly. Perpetual inventories with running balances are maintained on all controlled substances with a shift-to-shift inventory conducted by the program's registered nurses. Syringes and sharps are counted through a perpetual inventory and are verified weekly. Observations conducted during the annual compliance review week supported three youth prescribed medication inventories were accurate. Three OTC medications and three sharps were reviewed, and inventories were determined to be accurate. A review of the program's counts from the past six months validated no discrepancies were identified with inventory counts. The program contracts with a pharmacy and a State of Florida licensed consultant pharmacist. The consultant pharmacist license expires December 31, 2020. The program's process for the disposal of medication is for all medications to be disposed in the physical presence of the consultant pharmacist utilizing the Rx Destroyer Pharmaceutical Disposal System. Reviewed documentation and nursing interviews confirm all OTC medications are inventoried perpetually and weekly. The program also maintains an agreement with Stericycle, Inc. for biomedical waste treatment with a certificate of exemption issued on October 19, 2019 with the State of Florida, Department of Health. A contracted provider picks up medical waste weighing less than twenty-five pounds monthly for proper disposal.

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 has a written policy and procedures ensuring there is an approved plan for infection control and exposure control to ensure staff, youth, and visitors are not exposed to infectious and communicable diseases. The program's Exposure Control Plan/Infection Control Plan includes prevention, containment, treatment, and reporting requirements related to infectious diseases, as outlined in the guidelines and recommendations of the Occupational Safety and Health Administration (OSHA) federal regulations and the Centers for Disease Control and Prevention (CDC) guidelines. The plan also includes common infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, tuberculosis, Hepatitis A, B, and C and Human Immunodeficiency Virus (HIV) infectious diseases caused by blood-borne pathogens, other outbreaks or epidemics caused by any other infectious agent, outbreaks of lice or scabies, Methicillin-Resistant Staphylococcus Aureus (MRSA) and other anti-biotic resistant micro-organisms, food-borne illnesses, bio-terrorist agents, and chemical exposures. The plan was reviewed and approved by the facility administrator (FA) on July 1, 2019, designated health authority (DHA) September 23, 2019, and the corporate staff on July 10, 2017. The program maintains procedures for staff to adhere to universal precautions, and the program provides staff with the opportunity for Hepatitis B immunizations and access to protective equipment. The program also maintains a written biomedical waste plan for staff to utilize for any threat of infection due to solid waste or liquid waste which may present a threat of infection to humans. The program maintains monthly receipts of medical waste pick-up through Stericycle, Inc. The program reported applicable incidents to the Department's Central Communications Center (CCC) involving a contagious disease requiring the quarantining or hospitalization of at least ten percent of the total population of youth or staff or six individuals, which ever number is less. The program's

Exposure Control Plan/Infection Control Plan is written in accordance with the OSHA standards. The program's plan has a comprehensive process for needle stick post-exposure evaluation. The plan includes risk assessment and methods of compliance. In the event of an incident, the FA has a process in place to establish a separate file containing all documents for youth and staff who have experienced a facility or occupational exposure. The FA reported a copy of the program's exposure control and infection control plans are maintained in the medical clinic and master control.

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 Designated Health Authority (DHA) is clinically responsible for all healthcare services provide to youth at the program. Daily clinical care shall be performed by licensed medical staff (RN, LPN) according to developed and authorized protocols. This includes the intake evaluations, assessments, health education, medication management and other assigned duties according DJJ Rule as well as Facility operating procedures and nursing protocols approved by the DHA.	

The program has a written policy and procedures which requires a contracted health authority to provide on-site medical services to youth in the program. Daily clinical care is performed by licensed medical staff such as a registered nurse (RN), or a licensed practitioner nurse in accordance to developed authorized protocols. An interview with the program's medical staff confirmed this practice. At the time of the annual compliance review, the program had two RNs, and one health service administrator (HSA). The program reported two vacant RN position at the time of the annual compliance review. Reviewed documentation confirmed all licensed nursing staff holds an unrestricted clear and active license in the State of Florida. A review of all nurses training records confirmed each nurse maintains a current cardiopulmonary resuscitation (CPR) certification.

Standard 5: Safety and Security

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

The program maintains a written policy and procedures to ensure youth are supervised and the required staff-to-youth ratio is maintained. The program policy promotes safety and security by requiring staff to provide active supervision of youth inclusive of positive interaction with youth, engaging youth in a full schedule of constructive activities, closely observing the behavior of youth, redirecting inappropriate behavior, and consistently applying the program's positive performance system. Observations of staff supervision during the annual compliance review week included group activity on the living module, and movement to medication pass in the medical office. Prior to any movement, staff are to inform master control, by way of two-way radio, of the starting location, the number of youth being moved, and the group's destination. Staff were observed actively supervising youth and were well positioned to observe all youth. The program's contract requires a staff-to-youth ratio of one-to-eight during awake hours and observations confirmed the program was in compliance with the required ratio. The program conducts a minimum of six formal counts within each twenty-four-hour period, as well as additional informal head counts throughout the day. A review of master control logbooks for the previous six months confirmed head counts and movements were conducted, as required. Three interviewed staff explained when youth counts are conducted and what happens when there is a discrepancy, including emergency counts. An informal interview with direct care staff revealed each was immediately able to correctly identify the number of youth under their supervision without having to count youth. Additionally, each interviewed staff explained the process should a count not reconcile.

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) which has not undergone any changes since the last annual compliance review. The program utilizes a clearly written, multi-level BMS designed to enhance the youth treatment, to increase healthy pro-social behavior using positive reinforcement and to decrease unhealthy behaviors through natural consequences. A review of three staff pre-service training records and three staff in-service training records indicated all completed training on the BMS. The program's Youth Handbook includes an explanation of the BMS. A review of three youth case management records indicated each received an orientation to the program which included training on the program's BMS, as well as an explanation of youth expectations, responsibilities, and consequences. Observations of the youth living unit

revealed a BMS tracking sheet was posted to document the youth who earned daily and weekly incentives. Observations indicated staff adhered to the BMS when interacting with youth and adhered to a ratio of four-to-one positive-to-negative consequences when redirecting the youth, as indicated in the program's policy. During an interview, the facility administrator indicated youth receive an informal and formal treatment team meeting each month. Youth receive referrals for inappropriate behaviors and those who require a referral receive a special treatment team for program violations. The BMS is implemented during school hours by the direct care staff; however, the program's teachers also completed training in the BMS. Three interviewed staff explained the program's BMS and knew what type of rewards the program provided as a part of the BMS. Two interviewed staff indicated if a youth breaks a television, the broken television is removed and results in the natural consequence of loss of television privileges. Three interviewed 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, as well as describing the process for receiving 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 solely to increase a youth's length of stay, denial of basic rights or services, and does not 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 also given an opportunity during this process to explain their behavior. A special treatment team meeting is held for 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. An interview with the facility administrator (FA) indicated the BMS is monitored to ensure all staff having direct contact with youth have access to a youth handbook which describes the positive performance system, program rules, and the progressive disciplinary system for the youth. The youth handbook is updated, as necessary, when changes or modifications are made to the system. Staff with direct youth contact are trained in the implementation of the positive performance system, including the principles serving as the basis for the BMS. On-going training is provided related to the BMS during monthly all staff meetings and as-needed. Three youth were interviewed, and each stated youth are not allowed to punish other youth. All three youth indicated all staff are consistent in the use of rewards. Two interviewed youth rated the BMS as very good, while one youth rated is as good. An interview with the FA indicated the program utilizes fidelity checks to ensure the staff are adhering to the BMS system and it is fairly administered. Additionally, ninety-day and annual

performance evaluations are utilized to ensure consistency with staff implementation of the BMS. Three staff were interviewed and asked how supervisors provide feedback regarding the implementation of the BMS. Two staff stated feedback is given either directly or during staff meetings, while the third staff did not know how supervisors provide feedback.

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

The program maintains a written policy and procedures requiring staff to conduct visual checks of each occupied room at least every ten-minutes when youth are in sleeping quarters. Staff are not allowed in a youth's room; however, staff are to ensure skin, or a body part is seen to confirm the youth's presence. Staff are to document the actual time room checks are conducted and initial the Ten-Minute Check Log sheet to document who completed each room check. If a youth is not in their room, an "X" is to be marked in the box. The living units consist of two dormitories which are named Omega and Campanella, with each containing camera surveillance. The program has a total of ninety-eight recording video cameras from which video recordings are maintained for at least forty-five days. A review was conducted of Ten-Minute Check Logs of five selected dates and times, with the corresponding video footage recordings. The review indicated checks were consistently conducted, as documented on the Ten-Minute Check Logs. Three interviewed staff indicated room checks are conducted at least every ten minutes.

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 accurately determine and document the total number and location of youth at all times. The program tracks daily census information including the daily census count, new admissions, releases, youth temporarily away from the program, transfers, and direct discharges. Youth are accounted for at all times by a physical count. Both scheduled and informal head counts are requested by master control. A review of facility logbooks for the previous six months documented youth counts conducted at the

beginning of each shift, after outdoor activities, and upon the movement of youth to/from school, groups, and medication pass. The logbooks also documented the reconciliation of counts and recorded youth who were temporarily away from the program. The program maintains an approved escape response plan which requires maintenance of appropriate levels of supervision to provide adequate safety and security necessary to prevent escapes. The plan was last approved by the facility administrator on March 1, 2019. The program's escape response plan is reviewed with staff to ensure the procedures are followed in the event of a youth escape. Observations made during the annual compliance review week validated counts were conducted prior to any youth movement, and staff contact master control using a two-way radio to communicate the number of youth being moved and the destination. An informal interview with two staff was conducted and each staff immediately knew how many youth they were supervising without performing a count. Three staff were interviewed and were able to explain when youth counts are conducted and what happens when there is a discrepancy, including emergency counts. All three staff indicated when the count is not reconciled, all movement stops until the count is cleared.

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 through the use of logbooks. Master control maintains a permanently bound logbook with pre-printed, sequentially numbered pages. The master control operator is to 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), Florida Abuse Hotline, special instructions for the supervision and monitoring of youth, and unannounced program tours by supervisors. Each entry is to be made in ink with no erasures or white-out. The campus wide superintendent stated in an interview, the program does not maintain living unit logbooks. A review of logbooks from the previous six months found minimal issues. Errors were not consistently struck through with a single line and initialed by the staff correcting the error, as required. Overwriting was observed to change the time of logbook entries, staff names, the number of youth in a movement, and the starting point and the destination to/from which youth were being moved. Some entries for transports omitted the destination. One logbook entry for a drill conducted on June 25, 2020 included multiple errors, including the word "drill" which was stricken through and initialed, relabeled as "actual," and the entire entry was written over with "void." Supervisors conduct staff briefings prior to the beginning of each shift, which are documented on the daily shift report. Incoming staff are briefed on the previous shift and are to sign the shift report to acknowledge receipt of the information. A review of randomly selected program shift reports indicated information is shared with incoming staff prior to the beginning of the shift. Interviews conducted with three staff validated this practice.

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

The program maintains a written policy and procedures for the assignment, inventory, tracking, storage, and accountability of all keys used in the program. The program utilizes a Daily Key Log to track keys. The log indicates the name of staff and what type of key assigned according to the staff's position. Program keys are maintained in the master control office within a locked, wall-mounted 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 to the program, 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 surrendered and 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 to be turned over to maintenance staff to have the key replaced. The program maintains a list of staff who are assigned permanent keys. When permanent keys are issued, staff sign an acknowledgment form confirming receipt of the key identification number and the number of keys issued. Master control staff complete a daily inventory of program keys. A random review of key inventory documentation for the previous six months confirmed this practice. A random check of three staff determined none of the staff had personal keys on their person. An interview with the master control operator indicated if any keys are reported lost or missing, all program movement is stopped, and a search is conducted. If the keys are not found within two hours, a call is placed to the Department's Central Communications Center (CCC). A review of CCC incident reports since the last annual compliance review verified there were no incidents where program keys were lost Three interviewed staff explained the program's key control process including how keys are assigned and reconciled, as well as the processes for missing, lost keys, and damaged keys.

5.08 Contraband Procedure	Limited 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. The policy details the list of items considered as contraband and unauthorized items, as well as the consequences for possessing contraband. 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 also provided a parent handbook which explains the items considered to be unauthorized and prohibited contraband at the program. Program visitors are also notified of unauthorized and prohibited contraband during visitation. A review of the program's policy, the youth handbook and parent handbook, and written rules for visitation confirmed the list of unauthorized and contraband items was included. Unannounced, random youth room searches are 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. However, a review of sixty-six daily shift reports covering July 23, 2020 through August 13, 2020, revealed twenty-nine of the reports noted there were no utensils collected after a meal or snack when the documentation indicated seventeen or eighteen utensils had been passed out. Additionally, during the tour of the program, one youth was observed walking in Omega dormitory after the completion of group while chewing on a white plastic eating utensil. All incoming and outgoing correspondence is to be searched to control the introduction of contraband into the program and to detect information which could present a threat to the security of safety of the program. The program's perimeter security is also to be checked on each shift and 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 no illegal contraband confiscated. The program's policy and procedures prohibit any movies or games rated "R" without written approval by the facility administrator (FA). An interview with the FA and the assistant facility administrator indicated the program no longer maintains a DVD movie or video game library. However, during review of 10-minute check video's as part of the annual compliance review it was observed the shift manager was watching an "R" rated movie on Omega dormitory directly opposite a youth's assigned sleeping room. Three staff were interviewed and stated youth searches are conducted anytime a youth is

moved from one area to another. An interview with the FA indicated if there is any contraband found, the items can be sent home, stored in youth property until the youth is released, returned to owner, or disposed. Illegal contraband is stored in the FA's office until it is handed over to law enforcement. If applicable, the CCC will be informed of the findings and all documentation is forwarded to the facility investigator/chief of security, who initiates an internal investigation.

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

The program 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 after visitation. Youth searches are conducted by a staff of the same gender as the youth. Parents/guardians are notified of the search requirement during visitation by way of a 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 validated searches are only 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. Three interviewed youth indicated searches are conducted after outdoor activities and at every movement. Three interviewed staff each 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 two operable vans to transport youth during half of the annual compliance review period; however, one vehicle was sold at auction on June 12, 2020 prior to the annual compliance review. Inspection of the remaining vehicle confirmed the vehicle 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 through June 30, 2022 to conduct auto maintenance and light repairs. Reviewed documentation for both vehicles indicated the vehicle which was previously sold passed an annual safety inspection on April 27, 2020 and the remaining van completed an annual inspection during the week of the annual compliance review, 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 six personal

vehicles parked in the staff parking lot outside of the secure fenced perimeter validated each was locked and secured.

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 the program or staff vehicles. Observation of a transport was not possible during the week of the annual compliance review. Interviews were conducted with three staff, and all staff indicated transporters are provided a fully charged cellular telephone to communicate during youth transport, although one staff reported not having personally conducted transports. The program requires a ratio of one staff to a maximum of five youth during transport; however, one interviewed staff indicated the staff-to-youth ratios during transport is two staff to one youth, and two interviewed staff indicated the ratio during transport is two staff to two youth. All three interviewed staff confirmed they are not allowed to use their personal vehicles to transport youth. The program's policy requires maintenance of a list of program staff holding an eligible driver's license which is to be updated monthly and signed by a human resource representative and the facility administrator. The program provided copies of signed approved drivers lists for the months of February through May 2020. The program advised May was the last month the required list was completed; however, there was no explanation as to why the monthly license check and approved list was not completed in June or July 2020. An unsigned list for the month of August 2020 was provided during the annual compliance review. Documentation indicated the program had a total of thirty-two youth transports during the previous six months and two staff were present on each documented transport, at least one of which was included on the program's approved drivers list.

5.12 Weekly Safety and Security Audits	Limited 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 the responsible parties 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 or designee and documented on the Department's Facility Security Audit and Safety Inspection form. The program's practice was to have the unit manager complete the weekly inspections. A review of documentation for the previous six months revealed there was no documentation to indicate a weekly inspection was conducted during the week of July 12-18, 2020. Deficiencies are to be identified on the form and a work order approved by the facility administrator (FA) is to be submitted to the appropriate staff for corrections. An interview with the FA indicated identified deficiencies are discussed during daily morning management meetings to ensure each is addressed and have the FA follow up on the completion of the repairs. A review of Facility Security Audit and Safety Inspections for the prior six months indicated there were repeated deficient inspection items which continued to be noted on subsequent inspections without completed corrections. The program's policy and procedures for preventive and corrective maintenance require continuous maintenance of a two-month supply of essential spare parts for general plumbing, air conditioning, refrigeration and electrical needs. However, identified deficiencies included the

video surveillance camera system in one dormitory not functioning for the previous nineteen weeks, twenty-seven lights throughout the compound not working for more than fourteen weeks, the Florida Abuse Hotline telephones in two dormitories not functioning for more than six weeks, and the air grate in one dormitory needing to be cleaned out for at least six weeks. Shift supervisors conduct perimeter security checks on each shift which were documented in the program's logbook. A random review of the program's logbooks verified this practice. The program's preventive and corrective maintenance policy and procedures require weekly inspections of the fire safety systems and equipment; however, the program provided documentation indicating fire safety inspections were conducted only monthly in January, February, May, and June 2020. Additionally, the program's four documented monthly fire safety inspections included comments notating emergency lights were not working and alarms were inoperable in at least nine buildings campus wide which were repeated each month. Florida Administrative Code 63E-7.107 (5) requires the program to verify deficiencies are corrected, and existing systems are improved, or new systems are instituted as needed to maintain compliance. However, the program documented repeated submission of work orders for issues left unaddressed for weeks or months with completion dates "to be determined."

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 to address the proper control and management of tools used within the program. The policy encompasses the storage and inventory of tools as well as tool class type. Tools are maintained in the carpentry and mechanic shops which are located outside of the program's secured fenced perimeter and inaccessible to youth. Tools are stored on shadow boards, within 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, each drawer of which is organized by wooden inserts with tool cut-outs for each stored implement. All tools are classified as Class A list tools by the program and each is labeled and inventoried daily. 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 tool areas confirmed the areas were neat and clean. Interviews conducted with three staff, three youth and one maintenance staff confirmed youth are not allowed to utilize the tools. Class B tools, including brooms, mops, and toilet brushes are stored in each living cottage in a designated locked closet with an inventory list posted on the interior of the door to identify 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, and brooms. The program maintains Class B Tool and Chemical Logs to document which tools are signed out of storage inclusive of the staff name and time of removal and return of the tools. The log for each living unit documented sign out of brooms, dustpan, mop, and mop bucket daily for the prior six months; however, the logs indicated no toilet brushes were ever signed out in either living unit on any date in the previous six months.

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

The program maintains a written policy and procedures to ensure youth use tools safely and are supervised appropriately in order to prevent injuries to themselves, other youth and staff. Each of the living cottages has a closet designated for the secure storage of non-hazardous Class B tools, which by policy include mops, brooms, and scrub brushes with handles. 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 are completed and identify whether the youth is eligible to handle tools. A review of three staff in-service training records indicated each staff completed training in the appropriate use of tools. The program also has a vocational program operated by the Home Builders Institute (HBI) were youth utilize Class A tools. Three interviewed staff stated youth are allowed to use scrub brushes, mops, and brooms. Three interviewed youth each stated they are allowed to use mops and brooms.

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

The program maintains a written policy and procedures which establish parameters for outside contractors prior to workers initiating any on-site work at the program. Personal cell phones, and electronic devices capable of taking pictures or audio/video recording are prohibited; however, the program's approved policy did not specifically prohibit contractors from bringing smart watches into the secure area. Additionally, the contraband guidelines which are signed by each contractor did not prohibit smart watches, as required by Department guidelines relating to contraband in residential facilities. When a contractor arrives on campus, the workers are to sign-in on the log, be 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 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 five invoices for contractor services rendered at the program in March 2020 revealed the contracted workers signed both in and out of the program on the dates of services performed.

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 at least 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. Program staff document drills on Facility Drill forms which include the beginning and

ending time of the drill, the nature of the drill, the participants, a brief scenario description, and the findings/recommendations. The facility administrator indicated in an interview the program completes fire drills once a month on each shift and COOP drills are completed quarterly. The program maintains an annual drill schedule with slated scenarios for fire, medical, mental health and COOP drills to take place each month. Reviewed documentation validated the program completed drills as required with monthly COOP drills on each shift relating to safety and/or evacuation. COOP drill scenarios included a tornado, attempted escape, power outages, gang riots, bomb threat, lightning in the area, chemical spill, use of chemical as a weapon, and terrorist threats. Reviewed documentation reflected the program completed both fire and COOP drills monthly on each shift. Three interviewed youth each confirmed they had been instructed on what to do in the case of a fire. An interview with three staff revealed they participated on various drills within the last six months including drill scenarios involving 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 original hard-copy records which are accessible and mobile in the event of an emergency. An interview with the facility administrator (FA) 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. Three staff were interviewed and stated they were involved in drills related to weather, a major disturbance, bomb threat, hostage situation, flooding, escape, fire, suicide, and medical scenarios at the program within the last twelve months.

5.18 Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	Limited 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 youth. 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. Additionally, all of the chemicals are inventoried once a week by the program's physical plant worker. The observed storage area was neat and well-organized. Chemicals used to clean the living cottages are stored in a program central location with limited access. The program's policy and procedures stipulate the facility administrator (FA), unit manager, physical plant manager, dietary manager, and shift supervisors may draw and utilize chemicals. Additionally, 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. An interview with the FA indicated the program does not maintain documentation of chemicals signed-out for use or signed-in when returned to storage after use. When a cleaning chemical is needed, an authorized staff supplies the chemical to the living unit. The program maintained two inventories; one for the dormitory which included hand soap, an all-purpose cleaner, and detergent, and one for medical which listed only bleach. The dormitory chemical inventory items were reported to be stored on an open bookshelf in the secured unit managers office and the medical chemical inventory items were stored in a locked metal cabinet within the locked medical office. However, observations made during the week of the annual compliance review indicated the chemicals included on the dormitory inventory were stored in the medical office cabinet. The program rectified this exception during the week of the annual compliance review by moving the dormitory chemical inventory items to the unit manager's office. The program's policy for the control of hazardous materials stipulates orders placed for chemicals are to be documented on the inventory sheets. It was the program's practice to document the change in quantity of chemicals with a "plus" or "minus" notation with the number of bottles added to or deleted from the inventory and the total count for the date adjusted to include the added quantity. However, the chemical logs inconsistently documented when chemicals were replenished or depleted. The inventories also did not document when bottles of chemicals were emptied during use and not returned to the inventory. There was one instance of a chemical noted as depleted with "-1" along with a corresponding reduction in the quantity total despite the logs regularly showing reduced quantities. An interview with the FA clarified any reduction in the inventory quantity was to be assumed the chemical was depleted during use. Both inventories documented quantities of chemicals on the last date of some months which did not reconcile with the inventory for the first date of the next month, including the inventory on July 1, 2020 reflecting three fewer gallons of bleach than were recorded on the inventory on June 30, 2020. The program response acknowledged the inventory lists were not properly notated to show the amount used or replaced.

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), unit manager, physical plant manager, dietary manager and shift supervisors may draw and utilize chemicals. Additionally, 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 are to maintain control over all flammable, poisonous, toxic items off-site and must be secure the chemicals when not in the immediate hands of staff. When needed, authorized staff will obtain a supply of chemicals used to clean the living units from the supply closet, although a chemical sign-out log is not maintained. Youth are not allowed to possess flammable, poisonous, toxic and 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 waist. Three youth were interviewed and all three confirmed they do not use any chemicals or cleaning products.

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

The maintenance personnel, or other trained staff who have the safety equipment for diluting, handling, and disposing of hazardous waste and/or solid waste, shall be responsible for disposing of hazardous items and toxic materials.

The program 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, 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 such 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.

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 record and updated as needed. Additionally, 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. Visitation is held in the cafeteria on Saturdays from 1:00 p.m. to 4:00 p.m. Special visitations are also provided for those parent/guardians who are unable to participate in the regularly scheduled visitation day. Due to the COVID-19 pandemic and in adherence to the guidelines of the Centers for Disease Control (CDC), on-site visitation at the program was suspended at the Department's direction effective March 13, 2020. Youth are also provided writing materials, and a self-addressed stamped envelope to send letters to approved family members. Youth have unimpeded access with the courts, attorneys, their assigned juvenile probation officer (JPO), and/or their Florida Department of Children and Families case worker. Observations of the living units indicated the visitation and telephone schedules were visibly posted. Three interviewed youth confirmed they are provided the opportunity to communicate with family members by telephone.

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

The program maintains a written policy and procedures to address searches and inspections of the controlled observations room. The program's controlled observation room meets the requirements of having a minimum of thirty-five unencumbered feet, with a metal door with a shatter resistant window. Air conditioning vents within the room are not easily accessible and there are no electrical outlets in the room. During the previous six months, the program utilized Controlled Observation eighteen times. Five Controlled Observation Reports were reviewed, and each documented staff completed an inspection of the room prior to placing youth inside or leaving them alone in the room. All five reports showed youth searches were completed by a staff the same gender as the youth prior to placing a youth in controlled observation. On-site observations showed the rooms meet the size and other requirements for controlled observation.

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 when staff cannot control a youth's highly aggressive and violent behavior with less restrictive measures, or when less restrictive measures are inappropriate. The program utilized controlled observation eighteen times within the previous six months. A review of five Controlled Observation Reports was conducted and each validated the youth was not exhibiting behaviors indicative of a mental health crisis or suicide attempt. Reviewed documentation reflected controlled observation was authorized by a supervisory staff prior to placement. All five youth were placed in controlled observation due to active aggression towards others, and/or violent behavior, which if continued, would likely result in immediate injury to self or others. Reviewed documentation indicated staff discussed the reason for placement in controlled observation with the youth as well as the expected behavior for removal. One of the five reports indicated the Health Status Checklist was completed by the campus-wide assistant superintendent. This did not meet the requirement of the Health Status Checklist conducted by a health care professional or a staff of the same gender as the youth. Two of the five reviewed placements lasted longer than two hours and three were for less than two hours. Both controlled observations applicable

for lasting more than two hours were authorized for an extension by the facility administrator or designee as required. Each approval was for a continuation of the placement for at least two hours. Neither instance required another extension for the placement to continue. An interview with three youth reported they have not been sent to their room for punishment reasons.

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

The program maintains a written policy and procedures for the use of Controlled Observation Safety Checks and releasing youth from controlled observation. The policy requires safety checks to be completed at least every fifteen minutes on all youth placed in controlled observation. A review of five Controlled Observation Safety Check forms was conducted. Each reviewed Controlled Observation Report indicated the staff making placement completed the first page of the Controlled Observation Report which was submitted to a supervisor. Documentation showed staff conducted and documented safety checks in all five Controlled Observation Reports every fifteen minutes or less. Each entry documented the time, a code to explain the youth's behavior at the time of each observation, and the staff's initials who observed the youth. All five reviewed reports showed the facility administrator's (FA's) authorization of the youth's release from controlled observation was based upon the determination the youth's verbal and physical behavior was no longer an imminent threat to himself or others. Each report was reviewed and approved by the FA within fourteen days of the youth's release from controlled observation and determined the placements were warranted and each was handled appropriately. Documentation showed an in-house alert was warranted for one of the five youth and the alert was entered into the Department's Juvenile Justice Information System (JJIS), while four youth were not applicable for in-house alerts when the youth was released from controlled observation.