STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Okeechobee Youth Treatment Center

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

Review Date(s): August 11-14, 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:

Nicos Antonakos, Office of Accountability and Program Support, Lead Reviewer (Standard1)
Rosa Flores, Office of Accountability and Program Support, Regional Monitor (Standard 2)
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, Education Coordinator, South Region (Standard 2)
Shakela Minns, Office of Accountability and Program Support, Regional Monitor (Standard 4)
Patrick Morse, Office of Accountability and Program Support, South Regional Supervisor (Standard 3)

Program Name: Okeechobee Youth Treatment Center
Provider Name: TrueCore Behavioral Solutions, LLC
Location: Okeechobee County / Circuit 19
Review Date(s): August 11-14, 2020

MQI Program Code: 1325
Contract Number: 10188
Number of Beds: 80
Lead Reviewer Code: 180

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
3.08 Specialized Treatment Services*	5.18 Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials
5.12 Weekly Safety and Security Audit	
5.15 Outside Contractors	

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	Satisfactory
2.07	Residential Assessment for Youth (RAY)	Satisfactory
2.08	Youth Needs Assessment Summary (YNAS)	Satisfactory
2.09	Performance Plan Development, Goals and Transmittal *	Satisfactory
2.10	Performance Plan Revisions	Satisfactory
2.11	Performance Summaries and Transmittals	Satisfactory
2.12	Parent/Guardian Involvement in Case Management Services	Satisfactory
2.13	Members of Treatment Team	Satisfactory
2.14	Incorporation of Other Plans Into Performance Plan	Satisfactory
2.15	Treatment Team Meetings (Formal and Informal Reviews)	Satisfactory
2.16	Career Education	Satisfactory
2.17	Educational Access	Satisfactory
2.18	Education Transitions Plan	Satisfactory
2.19	Transitions Planning, Conference, and Community Re-entry Team Meeting (CRT)	Satisfactory
2.20	Exit Portfolio	Satisfactory
2.21	Exit Conference	Satisfactory
2.22	Safety Planning Process for Youth	Satisfactory

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

Indicator Ratings

Standard 3 - Mental Health and Substance Abuse Services		
3.01	Designated Mental Health Clinician Authority or Clinical Coordinator	Satisfactory
3.02	Licensed Mental Health and Substance Abuse Clinical Staff *	Satisfactory
3.03	Non-Licensed Mental Health and Substance Abuse Clinical Staff	Satisfactory
3.04	Mental Health and Substance Abuse Admission Screening	Satisfactory
3.05	Mental Health and Substance Abuse Assessment/Evaluation	Satisfactory
3.06	Mental Health and Substance Abuse Treatment	Satisfactory
3.07	Treatment and Discharge Planning *	Satisfactory
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 *	Satisfactory
3.14	Mental Health Crisis Intervention Services *	Satisfactory
3.15	Crisis Assessments *	Satisfactory
3.16	Emergency Mental Health and Substance Abuse Services *	Satisfactory
3.17	Baker and Marchman Acts *	Non-Applicable

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Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

Standard 4 - Health Services		
4.01	Designated Health Authority/Designee *	Satisfactory
4.02	Facility Operating Procedures	Satisfactory
4.03	Authority for Evaluation and Treatment	Satisfactory
4.04	Parental Notification/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	Satisfactory
5.09	Searches and Full Body Visual Searches	Satisfactory
5.10	Vehicals and Maintenance	Satisfactory
5.11	Transportation of Youth	Satisfactory
5.12	Weekly Safety and Security Audit	Limited
5.13	Tool Inventory and Mangement	Satisfactory
5.14	Youth Tool Handling and Supervision	Satisfactory
5.15	Outside Contractors	Limited
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	Failed
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	Non-Applicable
5.24	Controlled Observation	Non-Applicable
5.25	Controlled Observation Safety Checks and Release Procedures	Non-Applicable

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Program Overview

The Okeechobee Youth Treatment Center is an eighty-bed program, for thirteen to eighteen-year-old males located in Okeechobee, Florida. The program is operated by TrueCore Behavioral Solutions, LLC, through a contract with the Department. The program provides mental health overlay services (MHOS) and substance abuse treatment overlay services (SAOS). The program fosters each youth by providing Thinking for a Change (T4C), Teen Relationships, and Impact of Crime (IOC) restorative justice programming. Additional treatment services provided include daily group therapy, monthly family and individual therapy, and recreational therapy. The program utilizes a variety of group curricula to include Strategies for Anger management, Anger Management for Substance Abuse Clients, Skillstreaming the Adolescent, Young Men's Work, Fathering Handbook, Thinking Feeling Behaving, Cannabis Youth Treatment, The Passport Program, Living in Balance, Pathways to Self-Discovery and Change, and Towards No Drugs.

An interview with the campus-wide facility administrator reported the program administration is comprised of a campus-wide facility administrator, campus-wide assistant facility administrator, facility administrator, cottage managers, shift supervisors, a health services administrator, a director of treatment services, a director of case management, a designated mental health clinician authority (DMHCA), regional compliance managers, a regional director, regional mental health and medical staff, one physical plant manager, and one human resources manager. Case management services are provided by a director of case management, two transitional service managers, four case managers, and a file clerk. Mental health staff at the program include a campus-wide director of treatment services, a DMHCA, a recreation therapist, one lead non-licensed therapist, six non-licensed therapists, and a file clerk. The program contracts with a psychologist, certified behavior analyst, and a licensed psychiatrist. Medical services are offered twenty-four hours a day, seven days a week. Sick call is offered daily for youth who have health concerns. Medical services are provided by one lead registered nurse (RN), a health services administrator, and a licensed medical doctor, who serves as the designated health authority (DHA). Educational services are provided by the Okeechobee County School District.

The layout of the program includes six cottages, one medical building, one administration building, a gymnasium, a cafeteria, school areas, a vocational building, maintenance buildings, and a master control building. The program has a total of fifty-two recording video cameras from which video recordings are maintained for at least thirty days. An interview with the campus-wide facility administrator indicated forty-four cameras were functional during the week of the annual compliance review. Eight cameras located, in the Johnson Cottage, were operational for viewing live video only, as the video recording ability for the eight cameras was non-functional since August 3, 2020.

At the time of the annual compliance review, the program had thirty-eight vacant positions: one registered nurse, one shift supervisor, and thirty-six youth care worker I positions. The program is slated to close by December 31, 2020 and the youth population is reduced to nine youth. 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 limited or 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

- On February 3, 2020, youth from the program helped organized a Semi-Final District game for the Okeechobee High School basketball team. The youth learned how to work collectively as a group among parents/guardians and students of Okeechobee High School to ensure the game was fully prepared.

- The program partnered with Raulerson Hospital on April 15, 2020 after COVID-19 had become a global pandemic. The youth worked diligently on creating Thank You cards for all first responders of Raulerson Hospital to thank them for the hard work and dedication while putting their lives at risk helping others.

- The program partnered with Martha's House to provide gift baskets to mothers at the shelter for Mother's Day on May 7, 2020. The youth organized and personalized each basket to fit each mother's need.

- The program partnered with The Home Depot and Okeechobee County School Board in planting trees and flowers for the passing of a program staff on June 12, 2020. Through this process, the youth learned about planting trees and memorializing the life of the program staff.

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. The program had three newly hired staff and no applicable volunteers or contracted staff since the last annual compliance review. Reviewed documentation supported the three newly hired staff received background screenings completed by the Department's Background Screening Unit (BSU) and Clearinghouse, prior to each individual's date of hire and/or contact with youth or access to confidential information. The newly hired staff did not require an exemption. Each newly hired staff's Florida Department of Law Enforcement (FDLE) criminal history, Staff Verification System (SVS) module, and the Department's Central Communications Center (CCC) Person Involvement Report were reviewed. Each newly hired staff was added to the Clearinghouse roster, and none were applicable for breaks in service. The program did not have any applicable direct-care staff who required a pre-employment assessment since the last annual compliance review. An Affidavit of Compliance with Level 2 Screening Standards, along with the school board's annual screening, was submitted to the Department's BSU 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 for staff every five years based upon the original date of hire. 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 resources manager to determine when a five-year background rescreening is required. The tracking of contracted staff background rescreenings is 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 and at least ten business days prior to the anniversary date. A review of the program's staff roster indicated three staff were applicable for a five-year background rescreening. Two of the three background rescreenings were completed and submitted to the

Department's BSU prior to the staff's anniversary dates. Reviewed documentation found one staff background rescreening was submitted late to the Department's BSU which resulted in the rescreening being completed sixteen days late. Reviewed documentation supported there were no volunteers or mentors applicable for a five-year background rescreening.

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 access to report alleged abuse to the Florida Abuse Hotline. The policy outlines the reporting procedures for staff to follow when a youth would like to make an abuse call. The program provides an employee handbook to all staff 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 which outlines the grievance policies and the staff's understanding of the program's code of conduct. A review of three staff records found each record contained documentation of acknowledgement, receipt, and review of the program's code of conduct.

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 were limited. An observation was conducted during the annual compliance review and verified the postings of the Florida Abuse Hotline and the Department's Central Communications Center (CCC) throughout the program. Each youth cottage has a telephone which has direct access to the Florida Abuse Hotline. The program's current practice is once the youth requests to make an abuse call, the youth is instructed to pick up the telephone in the cottage and make the call to the Florida Abuse Hotline. The youth can also be taken directly to the administration building or the case manager's office to place the call. If a youth requests to make a CCC call, the youth will notify the youth care worker, who will contact the shift supervisor and/or unit manager on-duty to request the call be made. The shift supervisor and/or

unit manager will take the youth to the administration building or case manager's office to place the call. The program's policy requires all staff to place abuse calls to the Florida Abuse Hotline if an allegation is suspected and a youth refuses to make the call. All allegations of abuse or neglect, as well as CCC reports, are logged and maintained in the program's logbook. All abuse calls and CCC calls are reviewed daily during morning management meetings. The Trauma Responsive and Caring Environment (TRACE) assessment was scheduled to be completed on August 13, 2020.

A review of all incidents since the last annual compliance review found there was two incidents which involved complaints of abuse against staff. One incident was substantiated for abuse by the administration and the staff was placed on corrective and/or disciplinary action. The Florida Abuse Hotline and the Department's CCC were notified, as required, for each reviewed incident. Three youth interviews were conducted. All three youth stated they felt safe at the program, have never been stopped from reporting abuse, have never exchanged contact information with staff, and staff are respectful when addressing youth. Three staff interviews were conducted. All three interviewed staff stated they would notify the supervisor and allow a youth to make an abuse call. The interviewed staff never witnessed another co-worker threatening youth or refusing youth from reporting abuse. The interviewed facility administrator stated the program's code of conduct outlines the program's progressive discipline process. The code of conduct explains the steps to take when a staff physically abuses, threatens, or uses profanity towards a youth. The progressive discipline process starts with coaching, performance improvement plans, oral warnings, written warnings, corrective action, and separation. In addition, staff receive pre-service and in-service training and at the all staff meetings. The abuse and CCC calls are logged into the master call logbook and reported in the morning management meetings.

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. An interview with the facility administrator confirmed this practice. A review of all incidents since the last annual compliance review found one incident which involved a complaint against staff for physical or mental abuse. Reviewed documentation of each report found management took appropriate and immediate action by initiating an internal investigation regarding staff on each allegation of abuse. Documentation confirmed staff was removed from youth contact, as appropriate. Documentation confirmed one staff was placed on corrective and/or disciplinary action based on the outcome of the internal investigation.

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 frame. The program shall notify the CCC within two hours of a reportable incident or within two hours of becoming aware of the reportable incident. The program had forty-six reportable incidents since the last annual compliance review, of which five were reviewed. All five reviewed CCC incidents were reported to the CCC within the mandatory two-hour time frame. A review of internal incidents and grievances verified there were no applicable incidents or grievances which should have been reported to the CCC and were not. The program has not experienced an increase in the number of reportable incidents to the CCC in comparison to the last annual compliance review period. The program's facility administrator stated if a youth believes they have been abused or neglected, there is a telephone in the cottages with a direct line to the Florida Abuse Hotline and/or the CCC for youth eighteen years old and over.

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 everyone involved, a review by a PAR certified instructor and/or 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. An interview with the program's FA confirmed the program's policy. The program's PAR plan was approved by the Department's Office of Staff Development and Training on January 10, 2020. The program had six PAR reports completed within the last six months, of which five reports were reviewed. Reviewed documentation confirmed each report included statements from all staff involved and completion by the end of the staff member's workday. Each report contained a documented review by a PAR certified instructor and was processed within the seventy-two-hour time frame by all required parties. A review of the PAR incident reports and written comments by the facility administrator and/or designee within seventy-two hours of the incident, was found in each PAR report. The reviewed reports did not require a Mechanical Restraint Supervision Log to be completed. One of the five reviewed PAR reports included an alleged injury. All five reports documented a post-PAR interview with the youth was conducted within thirty minutes of the incident. One of the five post-PAR interviews did indicate a need for a medical review. Documentation confirmed each report was processed by a supervisor and a PAR instructor to determine if use of force was consistent with the policy in each PAR report. One of the five reviewed PAR incidents resulted in an injury to the youth and the program contacted the Department's Central Communications Center (CCC) within two hours of the incident. There was no documentation to support any involved youth alleged abuse and needed

to call the Florida Abuse Hotline. The program maintains a PAR binder which contains all PAR reports and PAR monthly summary reports, which were submitted to the Department monthly. The program's PAR rate has decreased since the last annual compliance review. The program's PAR rate during the annual compliance review period was 0.46, which is below the statewide Residential PAR rate of 2.28. According to the FA interview, staff are required to complete all PAR reports before leaving shift. The report is then signed off by the shift manager who will review the document and submit the report for administrative review. If there are any issues where corrective action is needed the FA will report to the human resources manager.

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 to the Department's Office of Staff Development and Training on February 7, 2020 and approved on February 17, 2020. A review of the pre-service training plan included Protective Action Response (PAR), first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), professionalism and ethics, suicide prevention, emergency procedures, child abuse reporting, human trafficking, and Prison Rape Elimination Act (PREA). Active shooter training is optional. In addition, staff are to receive training in the grievance process, infection control, exposure control plan, behavior management system, and safe use of tools. Pre-service training is provided through a combination of instructor-led classes, web-based courses, and on the job training.

Since the last annual compliance review, there were no applicable newly hired staff for pre-service training. Documentation verified all instructors were qualified to deliver the training provided. A review of the program's contract found staff are additionally required to complete training in stress management, gender responsiveness, positive reinforcement techniques and strategies, post-traumatic stress disorder, restorative justice programing, risk factors for delinquency, the program's treatment model, and emergency evacuation procedures training.

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. Three staff records were reviewed for in-service training. The reviewed staff records included two youth care workers II and one shift supervisor. Each reviewed staff training record documented the staff exceeded the twenty-four hours of in-service training requirements. All three staff completed trainings in first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), active shooter, and eight hours Protective Action Response (PAR) update. Staff completed training in professionalism and ethics, standards of conduct, active shooter,

human trafficking, and six hours of suicide prevention training. Three staff records verified staff completed eight hours of management and supervisory training inclusive of management, leadership, personal accountability, employee relations, and communications skills. Staff completed training in the grievance process, six hours of suicide prevention, emergency response and drills, infection control, blood-borne pathogens, behavior management system, and exposure control plan. All trainings were conducted by certified trainers and documented in the Department's Learning Management System (SkillPro) within thirty days of training completion. There are no additional in-service training requirements outlined in the program's contract. The program maintains an annual training calendar which is updated to reflect any changes. All floor staff, inclusive of supervisory staff, are considered direct care staff and are counted in the staff-to-youth ratio. A review of the lead registered nurse's training records verified the lead nurse had a current CPR and AED certification with an expiration date of June 13, 2021.

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 receive training in the program's formal and informal grievance process. Youth are oriented to the grievance process during admission to the program. The program maintains a written plan for all pre-service training which includes the program's grievance process and procedures. Three staff training records were reviewed and verified all staff received grievance process training. The program's grievance process outlines an informal, formal, and appeal phase. The program allows youth to use "Let's Talk" forms prior to filing a formal grievance. "Let's Talk" forms allow youth to voice concerns and informally file an issue or complaint prior to filing a formal grievance. All informal grievances must be responded to within forty-eight hours. The program maintains binders which includes "Let's Talk" and grievance forms for at least twelve months. There were five formal grievances and eleven "Let's Talk" forms filed since the last annual compliance review period. A review of five grievance submissions verified each grievance was resolved at the formal level and within the required seventy-two-hour time frame. Each grievance and "Let's Talk" forms documented youth participation, supervisory oversight, and final outcomes. The reviewed grievances did not require an appeal.

Three staff interviews were conducted, and each staff reported they were aware of the three-phase grievance process, forms are placed throughout the program, and a supervisor or the facility administrator (FA) reviews the grievances daily. One staff reported the youth can request assistance in completing the form. Three youth were interviewed, and two youth stated they were aware of the grievance process and knew where the grievance forms were located. One youth stated they never had to fill out a grievance form and was not sure of the process. All three interviewed youth stated they can ask for assistance completing the grievance form. During an interview, the FA stated the grievance forms are made available to the youth in each cottage. Youth can fill out a grievance for any issue the youth may be having. The grievance form is placed in the grievance box and is checked daily by administration. The grievances are then reviewed in the morning meeting with the management team and addressed within seventy-two hours.

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 has a written policy and procedures regarding interventions and facilitator training. A review of the program's contract of required services identified Thinking for a Change (T4C) as an evidenced-based intervention curriculum and identified the staff to be trained to facilitate groups. During the annual compliance review period, the program facilitated all required groups included in the contract, with the exception of Cannabis Youth treatment (CYT). Six current staff training records were reviewed. Two staff were trained to facilitate T4C and four staff were trained to facilitate Impact of Crime (IOC). Four facilitators have bachelor's-level degrees and two staff have master's-level degrees. All six reviewed staff are experienced in working with youth. An interview with the facility administrator (FA) indicated the contract requires a bachelor's-level degree to facilitate T4C and IOC groups. A master's degree is required for a therapist which conducts life skills groups. Education and work experience are considered by the program when determining staff delivery of delinquency interventions. Three youth records were reviewed which indicated all three youth successfully completed a T4C group. All three youth had completed Residential Assessment for Youth (RAY) assessments which identified the delinquency intervention as a priority need. All three youth performance plans included T4C goals and identified it as a priority need. A review of the sign–in sheets verified a T4C group was conducted during the annual compliance review period. The program's activity schedule determined youth did spend at least sixty percent of awake hours in structured, planned programing and/or activities.

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 has a written policy and procedures regarding the provision of life skills training to the youth. Youth participate in life skills groups, such as Skillstreaming the Adolescent and Independent Living, as outlined in the program's contract. The life skills groups specifically address communication, interpersonal relationships and interactions, non-violent conflict resolution, anger management, and critical thinking. Therapists facilitate Skillstreaming once a week for one hour. Youth are assessed during the intake process and placed in groups. A review of the program's activity schedule and group attendance sign-in sheets verified youth received life skills training. All staff facilitating groups have been trained in the curriculum by a certified trainer. During an interview, the designated mental health clinician authority (DMHCA) stated the program provides mental health overlay services and substance abuse treatment overlay services, to include, but not limited to, behavior modification, cognitive behavioral therapy, individual and group services, assessment, and diagnostic services. Three interviewed youth confirmed they were able to demonstrate the life skills learned by practicing during role play activities. The youth stated they are participating in mental health, substance abuse, life skills, and anger management groups.

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 has a written policy and procedures regarding the provision of restorative justice awareness to the youth. A review of the program's contract indicates the Impact of Crime (IOC) curriculum is utilized to provide restorative justice awareness for youth. IOC is designed to assist youth to accept responsibility for harm they have caused by their past criminal actions. The curriculum teaches youth about the impact of crime on their victims, families, and communities. IOC exposes youth to victim's perspectives through victim speakers, in person or through digital video disc (DVD) videos. IOC provides ideas and opportunities for youth to participate in reparation activities, such as community service projects. A review of training records verified staff facilitating IOC groups were trained by a certified trainer. 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 and observations of an IOC group was not conducted. A review of the program's activity schedule and sign-in sheets verified restorative justice and activity groups were provided during the annual compliance review period. Sign-in sheets indicated the program completed four cohorts of IOC during the annual compliance review period. During an interview, the campus-wide assistant facility administrator stated the youth participated in several restorative justice projects. The program partnered with Raulerson Hospital on April 15, 2020 after COVID-19 had become a global pandemic. The youth worked diligently on creating thank you cards for all first responders of Raulerson Hospital to thank them for all the hard work and dedication while putting their lives at risk. On May 7, 2020 the program partnered with Martha's House in providing gift baskets to mothers at the shelter for Mother's Day. Youth organized each basket and personalized them to fit each mother's need at the time. The program also partnered with The Home Depot and Okeechobee County School Board in planting trees and flowers to commemorate the passing of a beloved program staff on June 12, 2020. Through the process the youths learned about planting trees, beautifying the school grounds and remembering the life of the staff.

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 encouraging youth to participate 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 the program utilizes the Young Men's Work and 24:7 Dad Fathering Handbook for gender-specific programming. Young Men's Work 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. The 24:7 Dad Fathering Handbook is a group designed to teach young men how to be good fathers. 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 indicator both Young Men's Work group and 24:7 Dad Fathering Handbook are each 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. In addition, the Teen Relationships and Skillstreaming groups are adjusted to address specific gender issues, when necessary. An interview with the director of treatment services and facility administrator confirmed youth participate in gender-specific groups while at the program.

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 has a policy and procedures addressing youth alerts. The program enters an alert into the Department's Juvenile Justice Information System (JJIS) for youth requiring an alert which may not have been previously entered prior to the youth's admission. The program has an alert board in master control which identifies each youth's special alerts, escape risk, and/or gang affiliation. The alert board also identifies youth placed on any type of mental health alert. Reviewed documentation indicated the program's internal alert report is reviewed daily during shift briefings by the program's shift supervisory staff. Three youth records were reviewed for case management, medical, mental health, and substance abuse alerts, and all applicable alerts were accurately entered into JJIS. The program's medical staff can remove or downgrade a medical alert and only licensed mental health staff are able to remove or downgrade a mental health alert. All internal and JJIS case management alerts are downgraded or discontinued by the director of case management.

Three staff were interviewed, which included one supervisor. Each staff reported they are informed of youth alerts during shift meetings and by reviewing the program's alert board located in master control. The facility administrator (FA) reported medical staff are part of the morning management meetings where medical issues are discussed with the management team. A quarterly meeting is also held with the pharmacist, psychologist, mental health therapist, and the FA to discuss the youth's treatment in the program. All internal alerts are entered into JJIS by the department managers. This information is then sent to the other departments during the morning management meeting. The information is also reported to master control, where the controller will update the alert board for the program. Medical alerts are distributed daily to staff.

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. A review of three youth individual management records showed each was marked "Confidential" and each record file tab contained the youth's name, Department identification number (DJJID), the youth's date of birth, county of youth's residence, date of admission, and committing offense. The individual management records sections contained legal information, demographic and chronological information, correspondence, case management, and treatment team activities along with additional pertinent information. An interview with the campus-wide assistant facility administrator verified all individual healthcare records, mental health and substance abuse records, and case management records were secured in a locked room, which are not accessible to youth.

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 a formal process to provide constructive input. 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 youth advisory board meets twice a month under the supervision of the facility administrator (FA) or designee and various staff as available. Reviewed 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. Additionally, the program utilizes "Let's Talk" forms, which gives each youth an opportunity to address both issues and concerns they may have. The FA stated during a formal interview, the youth advisory meetings are held twice each month conducted with the youth to address concerns and for youth to provide input regarding issues within the program. The youth are encouraged to give feedback on ways to improve the incentives, the culture, and the environment of the program. Youth use Let's Talk forms to submit opinions or concerns with the program. Three youth were interviewed and one youth stated they do not care about the program and did not give input. One youth stated they can fill out a form during treatment team meetings to give input about the program and one youth did not know how to give input.

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 meeting 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 officials, 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, the meeting 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.

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 regarding staff retention and ensuring provisions for staffing. The program administration conducts monthly youth surveys and quarterly parent/guardian surveys during family visitation. The program's quarterly family day was cancelled due to the COVID-19 pandemic and the Department canceling all visitation; therefore, a parent/guardian survey was not completed according to the facility administrator (FA). The program conducts monthly staff meetings for each shift. Documentation of the monthly staff meeting agenda sign-in sheets for All-Staff meetings for the past six months indicated staff meetings were conducted for each shift, as planned; however the sign-in sheet for the month of May 2020 was missing. A review of the monthly staff meeting agendas documented topics including 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 were discussed.

Each department has the opportunity to share with staff important updates. The program also has daily shift management meetings. Shift management meetings are conducted at the start of each shift 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 for the day. The program has a recognition program called the TrueCore Way which is designed to help motivate, retain, and increase staff morale. The program provides items such as company polo shirts to staff as incentives for performance and leadership. The program reviews the Department's Comprehensive Accountability Report (CAR), Monitoring and Quality Improvement results, and youth and parent/guardian surveys with staff during staff meetings and utilizes the results for strategic planning.

The program conducts quarterly surveys with staff and the results of the surveys are incorporated into the program's planning process and recommendations for the program. Three staff were interviewed, and each staff reported staff meetings are held weekly and monthly. The staff stated the meetings are informative and topics discussed include new information, scheduling information, and safety and security. All three staff stated they did not know what the CAR reports were and communication at the program is poor. Two of three staff stated they can give input or feedback about program operations; however, one staff stated they could not give

input. Interviewed staff stated they receive a formal evaluation of performance based on staff performance standards annually. Staff interview responses were addressed with the program during the annual compliance review. A formal interview with the FA was conducted. The FA stated the program has an active morale committee team which plans activities and other events to improve staff morale in the program. Administration reviews the data during morning meetings and with staff during All-Staff meetings. The program uses the data collected to reduce incidents within the program, and to improve youth and parent/guardian satisfaction. The FA verified meetings are held regularly which include daily management meetings, staff briefings, clinical supervision, monthly All-Staff meetings, monthly coaching, and yearly in-service training.

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) found each department head meets with staff annually to review performance and provide feedback on goals and performance. Each staff is given the opportunity to provide comments and written input during this time. Performance evaluations address performance standards to include job duties, job knowledge, and competency, teamwork, professionalism, and goals achieved at least annually. 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 and each included the specific job description. Two of the three reviewed records contained the applicable performance evaluation completed within the required time frames. One annual performance evaluation was completed eight months late. A review of the program's contract was compared against the program's vacancy report to ensure all specifically required positions are maintained. A review of the program's contract indicated the contract requires a registered nurse. The nursing position is an essential position has been vacant since June 5, 2020. Three staff were interviewed and each reported receiving an annual evaluation. The interviewed FA stated staff are evaluated by the supervisor annually. The evaluation is reviewed with the employee to discuss areas in which they excel and areas which need improvement.

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 contract indicated the contract requires a recreational therapist with a bachelor's-level degree in recreational therapy or related field with at least one-year experience working with youth. A review of the program's recreational therapist's record confirmed the recreational therapist has met the required educational and work experience requirements. A review of the program's

indoor recreation, outdoor recreation, and gymnasium schedules found large muscle activities are scheduled for at least one hour daily.

A review of the program's logbooks found the program consistently documents recreation time in the logbook. The program has a pre-generated daily schedule which lists a variety of different activities scheduled throughout the month for youth to participate activities such as basketball, core workouts, kick ball, and football. Documentation supported activities were planned to support social and cognitive skill development, creativity, teamwork, healthy competition, mental stimulation, and physical fitness. 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. The program has a formal process which allows youth to provide constructive input and feedback to the program. The youth's advisory board meets monthly to provide suggestions and recommendations on recreation and leisure activities. The "Let's Talk" forms are utilized to bring concerns or issues to the attention of staff. Surveys are given to youth quarterly, as well.

Three staff were interviewed, and each staff reported all youth receive an hour of recreation and leisure time each day. Youth receive both outdoor and indoor recreational time. Each interviewed staff reported outdoor activities can include basketball, football, kick ball, and general exercise. Indoor activities include playing cards, reading books, and self-workouts. Three interviewed youth revealed youth participate in football, basketball, kickball, cards, and board game activities. Each interviewed youth reported participating in at least one hour of recreation activities daily.

Standard 2: Assessment and Performance Plan

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

The program has a written policy and procedures regarding the notification of parents/guardians, as well as notification to the youth's committing court upon admission. The program requires telephone contact with the parent/guardian within twenty-four hours, a written correspondence to the parent/guardian mailed within forty-eight hours, and notification to the committing court within five days of admission. Three youth records were reviewed, and each contained documentation indicating the program notified each parent/guardian by telephone, within twenty-four hours of the youth's admission. Each of the three reviewed records included documentation indicating the program notified the court in writing within forty-eight hours of the youth's admission. Three youth records contained supporting documentation to confirm the youth's juvenile probation officer (JPO), committing court, and all required parties were notified within five working days.

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 written policy and procedures to ensure each youth entering the program receives an orientation of the program's rules, goals, and expectations of behavior. The program orientation includes the description of program services available, the program's daily schedule, and the program's behavioral expectations and consequences of not meeting the established behavioral expectations. Orientation includes the description of the staff's use of Protective Action Response (PAR), the physical layout of the program, the program's disaster readiness, the code of staff conduct, the rights of the youth while in residence at the program, reporting of grievances, a detailed description of how to utilize the Florida Abuse Hotline, how to utilize the Department's Central Communications Center for youth over eighteen years of age, the introduction and description of the Prison Rape Elimination Act, and how to report sexual misconduct. This orientation details the services provided to youth. Three youth case management records were reviewed, and each record documented evidence showing the youth participated in the program's orientation. The documentation revealed the orientation included a review of the program's search policy, the performance and treatment planning process, dress code requirements, the established hygiene expectations, the process to obtain medical and dental care, the program's visitation policy, and a review of the telephone and correspondence policy. Each reviewed youth record contained a signed orientation checklist documenting the youth's participation in the orientation process and the receipt of an orientation packet, as well as a copy of the program's youth handbook. 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 and an observation of an admission could not be conducted. Three youth were interviewed, and each youth confirmed the orientation was conducted on the day they were admitted 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. Two of the three reviewed records were applicable for written consent of youth over the age of eighteen before providing or discussing information with the parent/guardian; therefore, one additional applicable record was reviewed. Each of the three applicable youth records contained consent forms signed by the youth allowing the program to share with the parent/guardian any information related to the youth's physical or mental health screening, assessment, or treatment.

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

The program has a written policy and procedures outlining the classification process for each newly admitted youth. The program's classification system promotes safety and security, as well as effective delivery of treatment services. The program's classification factors include physical characteristics, age, maturity level, history of violence, gang affiliation, criminal behavior, physical and sexual aggression level, and suicide risk, as well as the youth's current risk to reoffend. Three youth case management records were reviewed. Each reviewed record had an initial classification which was completed on the day of admission. The initial classification forms included a review of the youth's physical characteristics, age, maturity, a history of violence, gang affiliation, criminal behavior, and sexual aggression or a vulnerability to victimization. Each completed classification form included the identification of the youth's suicidal, mental, behavioral, medical, or security risks, if applicable.

A review of three youth case management records reflected each youth had an initial classification and Vulnerability to Sexual Aggressive Behavior (VSAB) assessment completed upon admission. The classification process takes into consideration a review of alerts entered into the Department's Juvenile Justice Information System (JJIS). Each youth record indicated the youth's alerts were entered in JJIS, as required. Three of the active youth records were not applicable for reassessments. Two additional youth records were reviewed for reassessments and showed each youth had an increase in individual privileges or freedom of movement, and an increase of work privileges or activities involving the use of tools or instruments. It is the program's practice to complete a reassessment each month for each youth. Reviewed documentation supported monthly reassessments were completed in each of the two 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 and notification. The policy includes the notification to the local law enforcement agency and the youth's home county law enforcement agency. Two of the three reviewed youth records were applicable for gang identification; therefore, one additional applicable record was reviewed. Each of the three applicable youth records confirmed the notification to the law enforcement was made to the identified local law enforcement agency and the youth's home county law enforcement agency. Documentation supported the educational staff and the youth's assigned juvenile probation officer were also notified. Each youth's record contained a documented alert in the Department's Juvenile Justice Information System.

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

The program has a written policy and procedures to ensure youth identified with gang affiliations are provided gang prevention and intervention activities. In addition, the policy and procedures ensure a plan can be developed for youth who wish to dis-associate with a criminal street gang. The program maintains gang prevention and intervention information in two binders. One binder contains the names of the youth identified as members of or affiliated with a criminal street gang, and the other binder contains curriculum and activities centering on gang prevention. The program's gang prevention and intervention curriculum utilized is Gangs: Stories of Fractured Lives. The program maintains sign-in sheets documenting youth participation in the intervention activities. Two of the three reviewed youth records were applicable for gang affiliation; therefore, one additional applicable record was reviewed. Each of the three applicable youth records documented the youth participated in or were currently participating in the anti-gang program. Each of the youth records contained supporting documentation indicating the participation of each youth in gang prevention or intervention strategies.

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.	

The program has a written policy and procedures which outlines all initial Residential Assessments for Youth (RAY) are to be completed within thirty days of admission. Three youth case management records were reviewed. Each youth case management record indicated the RAY was completed within thirty days of each youth's admission to the program. Each youth's initial RAY was maintained in each youth's case management record and completed in the Department's Juvenile Justice Information System. Each of the three records were applicable

for a RAY Reassessment. All three RAY Reassessments were completed within ninety days of the initial assessment, as required.

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.	

The program has a written policy and procedures to ensure a Youth Needs Assessment Summary (YNAS) is completed within thirty days of a youth's admission to the program. Three reviewed case management records contained a completed YNAS. All three of the records documented the YNAS was completed within thirty days of the youth's admission, as required. Each youth's YNAS was completed within the required thirty-day period. All three records indicated the YNAS was documented in the Department's Juvenile Justice Information System.

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 written policy and procedures in place regarding the development of an Individual Performance Plan (IPP) within thirty days of each youth's admission. A review of three youth case management records revealed all records contained an IPP created within thirty days of the youth's admission. All three of the youth records documented the youth's plan was developed with participation with the treatment leader, youth, parent/guardian, medical representative, living unit representative, administrative representative, mental health representative, and education staff. Each youth's IPP outlined all required elements, such as the youth's individualized goals, top three criminogenic needs, youth and staff responsibilities, delinquency interventions, court sanctions, target dates completion, and goals for transition. None of the reviewed youth record contained the youth's recreation plan within the youth's IPP. All three reviewed IPPs outlined staff and youth responsibilities to accomplish the goals. All three of the youth case management records contained documentation indicating a copy of the IPP was sent to the committing court, assigned juvenile probation officer (JPO), and parent/guardian. There were no applicable youth receiving services from the Agency for Persons with Disabilities (APD) and there was one applicable youth under the guardianship of the Department of Children and Families (DCF). The DCF caseworker was involved, as required, in the development of the youth's IPP. Three youth were interviewed. Each youth indicated participating in the development of the IPP. Each of the youth indicated they were provided 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 written policy and procedures to address the revision of each youth's performance plan based upon the Residential Assessment for Youth (RAY). Three reviewed youth case management records found performance plan revisions for each of the three records. Revisions were made to each of the youth's Individual Performance Plans (IPP) due to failure to progress with goals. Two IPPs were updated due to transition services rendered. A review of three closed case management records indicated, revisions were made based on the transition conference, the intervention and treatment team revised the youth's IPP, as needed, to facilitate transition activities targeted for completion during the last sixty days of the youth 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 written policy and procedures to address the completion of performance summaries and the transmittal of the summaries. Summaries included reports on mental health, education, performance plan goals progress, staff and peer interactions, significant events, the youth's level of motivation to change, and anti and pro-social behaviors. Three open youth case management records were reviewed, and each record was applicable for the completion of a ninety-day summary. All three youth were provided the opportunity to review the performance plans and add comments. Three closed case management records were reviewed, and each contained a release summary sent to the committing court within the required time frame. Each of the reviewed records reflected the required signatures of the youth, treatment team leader, the staff whom prepared the summary, and the facility administrator (FA) or designee. Each record documented copies of the summary were sent to the youth's committing court, juvenile probation officer (JPO), and parent/guardian within ten-days, as required. Each youth's performance summary was completed at least every ninety days. All three records showed a summary with justification for release was sent with a Pre-Release Notification to the youth's assigned JPO. The reviewed records did not contain an objection by the court. None of the reviewed records were applicable for the sexually violent predator program (SVPP).

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 extends invitations to each youth's parent/guardian, encouraging participation in the intervention and treatment team meetings for the purpose of developing the youth's

Individual Performance Plans (IPP). Three case management records were reviewed, and each case management record contained documentation indicating the parent/guardian participated in the development of the IPP and treatment team meetings. Each record contained documentation of attempts through telephone contacts and mail to involve the parent/guardian in the case management process. The program gives the parent/guardian the opportunity to participate by telephone or provide written input prior to the meeting if unable to attend.

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, a treatment team meeting was not observed. The youth are allowed telephone calls on a weekly basis and the parents/guardians are encouraged to call the conference line during treatment team meetings every month. Two of the three interviewed youth confirmed their parents/guardians are involved in the case management, treatment team, and treatment plan process. The remaining youth indicated he did not want the parents/guardians to participate.

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 written policy and procedures in place which addresses the treatment team process and the members of the treatment team. The program's treatment team members consist of the case manager, who serves as the treatment team leader, the youth, representatives of program administration, the youth's living unit representative, clinical/medical staff, education staff, the youth's juvenile probation officer (JPO), parent/guardian or Department of Children and Families (DCF) case worker, and when applicable, the program's gang prevention specialist. Formal treatment team meetings are held for each youth at least once every thirty days and informal treatment teams are held on a biweekly basis. Three youth case management records were reviewed and contained supporting documentation indicating each of the treatment team members participated in the youth's treatment team meetings, as documented by signature. Reviewed documentation confirmed the parent/guardian and JPO participated by telephone or if an attempt was made. One youth record required DCF to be a part of the youth's treatment team. Documentation verified the DCF caseworker was invited to participate in the youth's treatment team meetings. The program's practice is to send an invitation in advance to the DCF representatives to participate in the meetings. During the annual compliance review, a treatment team meeting was not observed, as there were no treatment team meetings scheduled for the week of the annual compliance review..

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

The program has a written policy and procedures for the intervention and treatment team to reference or incorporate each youth's treatment plan into the youth's Individual Performance Plan (IPP). Each of the three reviewed records documented incorporation of the youth's treatment and education plans into the IPP. All three youth records indicated the program incorporates therapeutic activity into the youth's treatment plan based on the development levels and needs of the youth. At the time of the annual compliance review, the program had one youth involved with the Department of Children and Families (DCF). A review of the applicable youth's record confirmed the youth did not have an active behavior/case plan with

DCF. There were no applicable youth receiving services from the Agency for Persons with Disabilities (APD).

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

The program has a written policy and procedures in place regarding formal and informal treatment team meetings. Each of the three reviewed youth records documented formal treatment team meetings were conducted at least once every thirty days. Informal treatment team meetings were held with each youth bi-weekly to review each youth's performance, including progress on the individual performance plan goals. The performance plans included the youth's name, date of review, meeting attendees, comments from treatment team members, youth's progress, and any revisions based on the initial Residential Assessment for Youth (RAY) tool. The youth's juvenile probation officer (JPO), parent/guardian, and other pertinent parties were encouraged to participate and were notified in advance of the treatment team meetings. The youth's JPO, parent/guardian, or other pertinent parties were invited to participate by telephone or provide written input prior to the meetings, if unable to attend. 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, a treatment team meeting was unable to be observed. Three interviewed youth confirmed the program provides opportunities for youth to demonstrate acquired skills from the program during treatment team meetings. Each youth confirmed staff review their performance plan during treatment team meetings, including their progress on goals, positive and negative behaviors, and progress in treatment.

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

The program provides and implements a vocational competency development program overseen by the Okeechobee County School District. The program offers Type 2 educational programming. Programming includes personal accountability skills and behaviors which develop and support appropriate work habits for both employment and living. The content of this program includes teaching effective communication skills, and useful interpersonal skills, as well as valuable decision-making skills. The career education component allows youth to investigate possible career choices which would be aligned to the youth's skill set and intellectual ability. Course work includes, but is not limited to, completing job applications, creating résumés, and participating in mock interviews. The program also offers training and upon completion, certificates in the field of Home Builders Institute (HBI) Pre-Apprentice Training/building and construction technology.

A review of three closed youth case management records showed youth participated in a vocational employability course. Each reviewed record contained résumés, job applications, documentation indicating the location of the local Career Source Center, appropriate documents essential to obtaining employment and a valid Florida identification card. Documentation supported each assigned juvenile probation officer and parent/guardian were aware of the plan.

The interviewed facility administrator (FA) stated the program offers career and vocational services such as HBI's Pre-Apprenticeship Certificate Training (PACT) curriculum, which is recognized by the U.S. Department of Labor and included as a preapproved curriculum by the Department of Education. The HBI program integrates work-based learning with vocational and academic skills training and includes job readiness, employability skills, career development, life skills and on-the-job training.

The PACT curriculum is aligned with HBI's Residential Construction Academy (RCA) Series, the only set of textbooks and instructional aids based on the National Construction Skills Standards for residential construction. Further it offers in-depth instruction on green building practices are in accordance with the 2012 International Code Council 700 National Green Building Standard™ (NGBS). The PACT certification is offered when the participant successfully completes certification testing conducted by the National Occupational Competency Testing Institute (NOCTI), a national third-party online testing platform recognized by the American National Standards Institute (ANSI) when the participant successfully completes certification testing. Youth are provided expanded trades instruction opportunities focusing on technology in partnership with C-Tech to provide youth with training programs may include: Introduction to Telecommunication Technologies, Introduction to Home Entertainment, and ASI Grounding/Bonding. Educational instruction through PACT Math for numeracy remediation, PACT Comm for improving communication skills, PACT Placement for facilitating job and career placement, PACT Works for young entrepreneurs, MyPEP (Personal Employability Plan), and HBI Safety Talks (as part of the PACT portfolio). The interviewed dean of students stated youth are enrolled in a PLATO vocational course where they learn job exploration and job-hunting skills. The education department coordinates with the the transition specialist to have the students develop career portfolios. In addition, students completed career interest surveys.

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 education component is provided by the Okeechobee County School District on a year-round basis. Youth are required to receive a minimum of twenty-five hours of instruction weekly. The program offers 300 minutes of academic instruction daily totaling to 250 academic days during the calendar year. 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 dean of students stated the program adheres to the educational instruction schedule. The program's educational instruction schedule includes five sixty-minute periods, three before lunch and two after lunch.

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 purpose of the educational transition plan is to prepare the youth to successfully participate in academics or employment within the community following release from the program. Transition planning begins upon the youth's entry into the program and is continually updated during the youth's stay. Three closed youth case management records were reviewed, and each contained a detailed transition plan. Each plan was developed with the youth, program staff, education, and after-care staff with specific plans for continuation of education and/or employment. The education transition plan was based on the youth's assessed educational needs and post-release educational plans. The education plans identified key personnel from the youth's school district and specified the responsibilities of individuals who are responsible to reintegrate and provide support services to the youth upon release from the program.

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

The program has a written policy and procedures regarding transition planning and transition conference requirements. Three closed youth records were reviewed. The reviewed documentation validated a transition conference was held at least sixty days prior to the youth's targeted release date. All three youth records documented the program sent written notification to all required participants including the parents/guardians, the youth's juvenile probation officer (JPO), educational staff, and other pertinent parties. All youth records documented the youth, treatment team leader, clinical, medical, and education staff participated in the transition conference as evidenced by the signatures on the transition plan signature page. The JPOs and parents/guardians participated by telephone. Each youth's JPO, parent/guardian, education staff and any other pertinent parties were invited to provide written input if unable to participate in person. All reviewed records identified the target completion dates and identified the individuals responsible for completion of the transition goals. Each of the three closed youth records contained documentation indicating the invitation to a Community Re-Entry Team (CRT) meeting. Each of the three closed youth records confirmed the youth participated in a CRT meeting prior to release from the program.

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 has a written policy and procedures pertaining to exit portfolios. All three reviewed youth records contained documentation indicating the exit portfolios were discussed and started at or prior to each youth's transition conference. All exit portfolios included the transition plan, completed assessments, a résumé, employment application, educational records, a calendar with dates, times, and locations of follow-up appointments within the community, and vocational certifications when applicable. Each record contained a copy of the youth's birth certificate, Social Security card, and State of Florida issued identification card.

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

The program has a written policy and procedures addressing the exit conference. A review of three closed case management records found an exit conference was conducted within fourteen days prior to each youth's release date. Reviewed documentation confirmed the youth's juvenile probation officer (JPO) was notified of each youth's release prior to the program conducting an exit conference. The exit conference was documented including dates and signatures of all participants. The program staff noted participants attending by telephone on the signature line, when applicable. The date of admission and release coincided with the dates entered in the Department's Juvenile Justice Information System (JJIS). Reviewed documentation supported the case manager, parent/guardian, education staff, JPO, youth, and other applicable parties participated in the exit conference.

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

The program has a written policy and procedures outlining the guidelines for the creation and review of safety plans for all youth. Each plan shall identify warning signs, baseline behaviors, crisis recognition, jointly developed coping strategies, intervention strategies preferred by the youth, and debriefing preferences. Each initial plan shall be developed by the multi-disciplinary team, prepared with the youth, parent/guardian, and clinical staff within fourteen days of admission. The plan will incorporate any recommendations from previous or current clinical assessments and be updated every thirty days. Three youth safety plans were reviewed. Each contained the required elements and incorporated recommendations from previous or current clinical assessments. Three of the reviewed youth records documented the initial plans were completed within fourteen days of the youth's admission, as required. All three youth records reflected the safety plans were updated every thirty days. Two of three youth interviewed youth stated they were involved in the development of their safety plan and one youth stated they were not sure what the safety plan was. Three interviewed staff knew where the youth safety plans are located. The program maintains a safety plan on each youth and is securely located in each living cottage which is easily accessible to staff.

Standard 3: Mental Health and Substance Abuse Services

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

The program has a full-time State of Florida licensed mental health counselor (LMHC) who serves as the designated mental health clinician authority (DMHCA) and as the clinical director. The DMHCA is supervised by the campus-wide director of treatment services. The DMHCA's license is clear and active in the State of Florida with an expiration date of March 31, 2021. The DMHCA is scheduled to be on-site Monday through Friday from approximately 9:00 a.m. to 5:30 p.m. The program does not maintain a sign-in log for the DMHCA since they are a full-time employee. 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 six non-licensed master's-level therapists and one non-licensed PhD-level therapist. The DMHCA supervises one mental health file clerk, 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 seven non-licensed therapists. A review of the DMHCA position description indicated they provide oversight of the mental health and substance abuse clinical staff and provide at least one hour of on-site, face-to-face supervision to each of the seven non-licensed therapists weekly. An interview with the DMHCA indicated they serve as the mental health and substance abuse authority and is responsible for ensuring compliance with overlay requirements, which include Mental Health Overlay Services (MHOS), substance abuse treatment overlay services (SAOS), behavior modification, cognitive behavioral therapy, individual and group services, assessments, and diagnostic services. The DMHCA is responsible for ensuring youth receive evidenced-based group therapy from qualified and supervised mental health and substance abuse clinicians, receive the required primary Standardized Program Evaluation Protocol (SPEP) services, and supplemental specialty services addressing each youth's unique clinical needs. Additional responsibilities 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 indicated they have direct, daily communication with the clinical staff. All clinical and case management staff have the DMHCA's cellular telephone number and the DMHCA is available for consultation twenty-four hours a day, seven days a week. The program conducts daily management meetings in which the DMHCA attends and provides updates regarding the youth and also participates in weekly meetings with the psychiatrist to discuss each youth receiving services. A review of the DMHCA's position description validates the services provided and serving as the program's mental health and substance abuse authority.

3.02 Licensed Mental Health and Substance Abuse Clinical Staff (Critical)	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. The contract requires a licensed therapist to serve as the campus-wide director of treatment services for five campus-wide programs. Both licensed therapists are licensed mental health counselors (LMHC) and each 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. The director of treatment services is responsible for monitoring group fidelity as it relates to standardized protocols, coordinate training agreements with doctoral and master's degree programs, validate supervision of doctoral students, interns, and staff, and provide on-the-job training for all new clinical staff. The director of treatment services monitors the fidelity of psychiatric services campus-wide.

The program is licensed through the Department of Children and Families (DCF) in accordance with Florida Statute, Chapter 397, to provide substance abuse services for outpatient treatment with an expiration date of April 7, 2021. The program 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. An interview with the DMHCA verified both the psychiatrist and DMHCA are on-call for emergencies and consultation twenty-four hours a day, seven days a week. 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. The program also maintains an independent contractor agreement with a State of Florida licensed psychologist to provide services on an as-needed basis. Staff interviews and reviewed documentation supported the psychologist completes assessments, intelligence quotient (IQ) tests, provide consultation of youth who may be experiencing crisis-related situations, and communicate with the director of treatment services. An interview with the campus-wide assistant facility administrator and DMHCA indicated the program did not utilize the psychologist's services in the last twelve months.

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

The program has six master's-level non-licensed therapists and one doctoral-level non-licensed therapist. The program's non-licensed therapist caseload assignments are based on youth dormitories. At the time of the annual compliance review, three of the six dormitories were open, as the population was down to nine youth. Five youth were identified as receiving mental health overlay services (MHOS) and four youth were receiving substance abuse treatment overlay

services (SAOS). A review of caseload assignments reflected each was below sixteen, as contractually required. One of the seven non-licensed therapists is a State of Florida certified addiction professional (CAP) and is an internationally certified alcohol and drug counselor (ICADC). One therapist is a doctoral candidate, one with a doctoral-level degree, two are registered mental health counselor interns, and two are master's-level therapists. The program also has a contracted board-certified behavior analyst (CBA). Youth identified with exhibiting self-destructive or violent behavior such as self-mutualization or explosive rage, receive behavior therapy/behavior modification and analysis provided by the part-time CBA. The CBA's State of Florida certification expires on December 31, 2020. The program utilizes a part-time CBA to provide services to youth in the program and is on-site on Monday's and Wednesday's each week. Services provided include conducting functional behavioral assessments and developing behavioral plans. The youth are referred through program staff and the school teachers. The CBA maintains monthly data sheets on each youth to document the progress of each youth and provide weekly 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's therapists provide mental health and substance abuse treatment under the direct supervision of both licensed mental health counselors (LMHC).

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 designated mental health clinician authority (DMHCA) and clinical director are responsible for providing clinical supervision to the non-licensed clinical staff. Reviewed Clinical Supervision Logs validated the DMHCA conducted the weekly face-to-face supervision with each non-licensed therapist. The reviewed documentation found the clinical supervision logs included a review of case history, caseload directions, review of fidelity checks, clinical service instructions, documented strengths, findings, trends, and/or problem areas, situational concerns, and training. Reviewed direct supervision logs included all information, as outlined on the Department's Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log form. A review of the training records for the non-licensed staff validated two of the seven completed the required twenty-hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. Training documentation included the administration of five Assessments of Suicide Risk or Crisis Assessments conducted on-site in the physical presence of a licensed mental health professional and was documented on the Department's Non-Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk form. The program was unable to provide the applicable training for five master's-level non-licensed therapists. Reviewed mental health records and documented practice supported the applicable ASRs and Crisis Assessments were completed by the two trained non-licensed therapists and approved by the licensed mental health counselor.

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

The program maintains a written comprehensive plan for mental health and substance abuse services to establish the coordination of mental health and substance abuse services for all youth. The program is a non-secure risk residential program designed to service low and

moderate-risk males between the ages of thirteen and eighteen years of age. Mental health and substance abuse treatment is provided on-site through the provision of either mental health overlay services (MHOS) or substance abuse treatment overlay services (SAOS). As a key component of the initial intake process, the mental health and substance abuse intake screening consists of the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) screening being conducted on the day of admission.

A review of three mental health and substance abuse records indicated the program administered a MAYSI-2 screening on the day of admission. All three reviewed MAYSI-2 screenings were completed by the program's file clerk. A review of training records indicated the file clerk completed the required MAYSI-2 training. Each reviewed MAYSI-2 reflected the screening was completed in full in the Department's Juvenile Justice Information System (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. Although each MAYSI-2 resulted in each youth requiring a referral for further evaluation, the program's practice is to conduct further evaluation on each youth admitted regardless of the MAYSI-2 results; therefore, no additional referrals are generated during the intake process.

There were no instances where a staff member believed the youth 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 program's campus-wide facility administrator (FA) and campus-wide assistant facility administrator reported upon intake the program completes the MAYSI-2 and ASR to address any suicide risk a youth may have. The FA also reported if the youth verbalizes or exhibits any suicide gestures or ideations while in the program an ASR is completed.

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

The program maintains a written plan for mental health and substance abuse services to establish the coordination of mental health and substance abuse services for all youth. The plan outlines the process by which all youth, regardless of identified needs, are referred for the completion of a Comprehensive Mental Health and Substance Abuse Bio-Psychosocial Evaluation. The non-licensed therapist is responsible for completion of the evaluation, make recommendations, and to provide a provisional diagnosis. The program's licensed clinical staff is then responsible for reviewing each Comprehensive Mental Health and Substance Abuse Bio-Psychosocial Evaluation and 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 also supported the program assesses each youth utilizing the Department's Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB), American Society of Addiction Medicine (ASAM), Adolescent Psychopathology Scale™ – Short Form (APS-SF), Massachusetts Youth Screening Instrument – Second Version (MAYSI-2), Reynolds Adolescent Depression Scale - Second Edition (RADS-2), Assessment of Suicide Risk (ASR), Adolescent Substance Abuse Subtle Screening Inventory (SASSI-A2), Trauma Symptom Checklist for Young Children™(TSCC), and the Trauma Symptom Inventory™(TSI). Each reviewed record contained an evaluation completed within thirty days of admission by a non-licensed therapist. Reviewed practice supported the licensed clinical therapist reviewed and signed the evaluation within the required ten calendar days. 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. Each reviewed record contained a signed Youth Consent for Substance Abuse, Youth Consent for Release of Substance Abuse Treatment Records, and Consent for Urine Collection and Analysis.

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

The program maintains a written policy and procedures to ensure all mental health and substance abuse treatment services are available to 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. Reviewed documentation supported each youth was assigned to a treatment team comprised of representatives from the program's administration, living unit representative, education, medical, mental health and substance abuse therapists, in addition to the youth and parent/guardian. 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 and individual therapy sessions. Family therapy sessions were provided to two of the

three youth, as one youth in the custody of the Department of Children and Families Foster Care. 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 group facilitators and non-licensed therapists facilitate mental health and substance abuse groups. Three youth were interviewed regarding participation in groups at the program. Each youth reported participating in mental health and/or substance abuse groups daily, individual. Three program staff were interviewed regarding mental health and substance abuse groups at the program. Each interviewed staff reported the clinical therapists facilitate groups. An interview with the campus-wide facility administrator and the designated mental health clinician authority confirmed the program offers Mental Health Overlay Services and Substance Abuse Treatment Overlay Services.

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

The program maintains a written policy and procedures outlining a comprehensive plan for mental health and substance abuse (MHSA) services. The MHSA treatment services are provided through the provision of mental health overlay services (MHOS). All MHSA treatment services conducted at the program are provided by or under the direct supervision of the licensed mental health counselor (LMHC) who serves the program's designated mental health clinician authority (DMHCA). Youth determined to have a mental health and/or substance abuse Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, shall have an initial and 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 non-licensed therapist, case manager, living unit representative, facility administrator LMHC, and the youth. Two of the three reviewed plans were signed by the LMHC within ten days, as required. One was signed three days late. All three reviewed youth mental health and substance abuse records were applicable for the youth being admitted on prescribed psychotropic medication. Each Initial MHSA Treatment Plan documented the frequency of medication management and details regarding the prescribed medication. All three reviewed youth mental health and substance abuse records contained a completed Individualized Mental

Health and Substance Abuse Treatment Plan which was developed within thirty days of each youth's admission. Each completed individualized plan was documented on the program's form containing all the elements of the Department's Individualized Mental Health/Substance Abuse Treatment Plan form and outlined prescribed services including individual, group, and family therapy.

Each reviewed plan was signed by the non-licensed therapist creating the plan. Two of the three reviewed plans documented signatures of all treatment team members who participated in the development of the plan. One plan did not contain the living unit representative. All three completed plans documented the signature by the LMHC within ten days of completion, as required. None of the reviewed plans documented the parent/guardian participated in plan development. Each plan included provisions for psychiatric services and after the initial psychiatric evaluation, two youth remained on psychotropic medications. 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.

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's practice is to obtain the parent/guardian signature upon release and to send the discharge summary to the JPO by mail. Reviewed documentation supported this practice for each of the three reviewed records.

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

A review of the program's contract, clinical program description, and interview with the campus-wide facility administrator (FA) indicated the program provides on-site mental health and substance abuse (MHSA) services through the provision of mental health overlay services (MHOS) and substance abuse treatment overlay services (SAOS). 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 mental health counselor (LMHC) who serves as the program's designated mental health clinician authority (DMHCA) or provided by one of the seven non-licensed therapists working under the direct supervision of the DMHCA.

Each youth is assessed upon admission for MHSA utilizing the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) and the Department's Assessment of Suicide Risk (ASR). The program has forty-eight MHOS slots for youth diagnosed with mild to moderate mental health disorders, who may have a co-occurring substance abuse diagnosis. The program has thirty-two SAOS slots for youth diagnosed with substance abuse related disorders.

At the time of the annual compliance review, the program had five MHOS youth and four SAOS 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 Strategies for Anger Management, Anger Management for Substance Abuse and Mental Health Clients, Skillstreaming the Adolescent, Young Men's Work, 24:7 Fathering Handbook, and Thinking, Feeling, Behaving. MHOS includes The Teen Relationship, Passport Program, Living in Balance, Pathways to Self-Discovery and Change, and Toward No Drugs. The program's contract outlines SAOS provided includes Cannabis Youth Treatment (CYT) Services, Living in Balance, Pathways to Self-Discovery and Change, Anger Management for Substance Abuse and Mental Health Clients, and Strategies for Anger Management. SAOS includes Skillstreaming the Adolescent, The Teen Relationship, Young Men's Work, and 24:7 Father Handbook.

The program indicated CYT services has not been conducted for approximately three years. The program's response was the last qualified therapist resigned and the program did not have enough youth to conduct an effective group therapy session. The program's contract requires the utilization of a certified behavior analyst (CBA). The program utilizes a contracted part-time board-certified behavior analyst (CBA). Youth identified with exhibiting self-destructive or violent behavior such as self-mutualization or explosive rage, receive behavior therapy/behavior modification and analysis provided by the part-time CBA. The CBA's State of Florida certification expires on December 31, 2020. The 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, and the program currently uses the services of the regional psychologist, when necessary.

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

3.09 Psychiatric Services (Critical)	**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 provided since the last annual compliance review. A review of the back-up psychiatrist's license showed it was a clear and active MD licensure in the State of Florida with an expiration date of January 31, 2021. A review of 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 non-licensed mental health therapists.

An interview with the DMHCA confirmed this practice. 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 individualized mental health and substance abuse records indicated two youth were admitted on prescribed psychotropic medications. However, the program's practice is to complete a psychiatric initial diagnostic interview completed within seven days of admission on all youth. Each diagnostic interview documented youth 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. Subsequent to admission, two youth admitted on prescribed psychotropic medications remained on the medications. Each youth was 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 the role of providing initial psychiatric evaluations for every youth entering the program, providing medication management for all youth on psychotropic medications, and meeting with the clinical treatment team members and the DMHCA every week to review youth in the program.

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

The program maintains a written suicide prevention plan. The suicide prevention plan was last updated and approved by the designated mental health clinician authority (DMHCA) on January 10, 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 campus-wide 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 reviews the circumstances surrounding the event, procedures relevant to the incident, relevant training received by involved staff, pertinent medical and mental health services involving the youth, possible precipitating factors, and any recommendations for changes in policy, training, physical plant, medical, or mental health services.

The program maintains eight complete suicide response kits located in each of the six cottages, the cafeteria, and in medical services. 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 youth 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. Each reviewed ASR determined the youth were not at risk of suicide and were placed on standard supervision.

According to interviews with the campus-wide assistant facility administrator (AFA) and the designated mental health clinician authority (DMHCA), the program had one youth applicable for placement on precautionary observation (PO) within the last twelve months. The youth was placed on PO due to expressing suicidal ideations to staff. A review of the applicable ASR found

the form was completed by a trained non-licensed therapist and was signed by the licensed mental health counselor the following morning. The youth was referred and assessed on the same day determined to be at risk and was placed and maintained on 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 completion of a mental status examination and transitioned to standard supervision.

Each transition to a lower supervision level documented a discussion between the DMHCA and the campus-wide facility administrator (FA). 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 none were applicable for placement on PO while at the program. According to interviews with the campus-wide assistant facility administrator (AFA) and the designated mental health clinician authority (DMHCA), the program had one applicable youth placed on precautionary observation (PO) within the last twelve months. The youth was placed on PO due to expressing suicidal ideations to staff. The one applicable youth record was reviewed for PO and Suicide Precaution Observation (SPO) Logs. The program's 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)	Satisfactory Compliance
All staff who work with youth shall be trained to recognize verbal and behavioral cues indicating suicide risk, suicide prevention, and implementation of suicide precautions.	

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 this 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 is exceeding the required quarterly drill on each shift. A review of drills for the past twelve months showed the program completed monthly drills on each shift. Three interviewed staff indicated drills are conducted monthly. Six of the completed drills included the use of life saving measures.

Each reviewed emergency drill clearly documented a description of the incident, synopsis of response, deficiencies identified, corrective action, and staff members involved. The suicide drills conducted since the last annual compliance review were reviewed and reflected forty-three of the forty-six applicable staff who have direct contact with youth participated in at least one semi-annual mock drill. The three missing staff were one part-time youth care worker, one full-time youth care worker, and one part-time therapist. The program's practice is to review all suicide drills during morning management meetings, which occur Monday through Friday, at all shift briefings with oncoming staff, and during monthly all staff meetings. By reviewing the drill scenarios at these meetings, staff are updated with the necessary information on how staff responded to an incident of suicide attempt or serious self-injury.

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

The program 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 program's designated mental health clinician authority on August 4, 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 no instances requiring the completion of a Crisis Assessment. An interview with the campus-wide assistant facility administrator (AFA) and the designated mental health clinician authority (DMHCA) indicated the program had two applicable youth requiring a Crisis Assessment in the last twelve months. A review of both 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. Both Crisis Assessments were completed by a trained master's level non-licensed mental health therapist working under the direct supervision of the designated mental health clinician authority (DMHCA). Each Crisis Assessment was completed in full and was reviewed and signed by the DMHCA the same day. Reviewed documentation showed in each instance the youth posed a safety or security risk to harm self or others and were subsequently placed on precautionary observation. Each reviewed record also documented the completion of a mental status examination prior to transitioning the youth to standard supervision.

3.16 Emergency Mental Health and Substance Abuse Services (Critical)	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 designated mental health clinician authority (DMHCA) on January 10, 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 campus-wide facility administrator (FA) 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 Horizons of the Treasure Coast and Okeechobee in Fort Pierce, Florida. The program utilizes the emergency services through Raulerson Medical Center in Okeechobee, Florida for substance abuse Marchman Act. The program's policy states all program staff have the right to immediately contact 9-1-1 and have access to rescue tools in

case of an emergency. Three interviewed staff indicated all program staff have the ability to call 9-1-1 in the event of an emergency.

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

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

Standard 4: Health Services

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

The program has a written policy and procedures which requires a contracted health 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 holds an unrestricted clear and active license with an expiration date of March 31, 2022. The DHA is contracted to be on-site at a minimum of two hours weekly with no more than nine days passed between site visits. A review of 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 coverage in place for scheduled absences, emergency services, and vacations. The backup MD has an active license to practice in the State of Florida with an expiring on January 31, 2021.

The program does not utilize an advanced practice registered nurse (APRN) or physician's assistant. 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 showed the DHA provides oversite for all healthcare provided at the program. During an interview, the DHA reported he is responsible for completing comprehensive physical assessments (CPA) on all newly admitted youth within seven days of each youth's admission, assessment, and renewal of medication for chronic conditions and health complaints which need to be address by a physician. The DHA reported reviewing labs, progress notes, acute complaints, referrals to specialists as needed, review of all specialty visits and recommendations, and reviewing/signing healthcare policies and procedures and nursing protocols.

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 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 (FOP) on September 23, 2019. The psychiatric FOPs were each signed by the psychiatrist on December 19, 2019. The facility administrator (FA) signed on July 1, 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 occur between annual compliance reviews. The facility operating procedures and protocols are reviewed annually. The

program's health services administrator (HSA) reported 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 Authority for Evaluation and Treatment (AET) for all youth admitted into the program. Three youth Individual Healthcare Records (IHCR) were reviewed for an AET. One youth's record contained a copy of the AET. The AET did not have the word "Copy" stamped on the document maintained within the record. One applicable IHCR had a parent/guardian signature along with a witness signature. When applicable, the IHCR included a copy of a completed parental notification behind the AET. The program utilizes a separate form for youth eighteen years of age or older providing consent for release of specific information, as noted on the Release of Information Authorization for Youth Eighteen Years of Age and Older form and to whom the information can be released and shared. Two of the three IHCRs were applicable for youth eighteen years of age or older. Documentation supported both youth signed a Release of Information Authorization Form for Youth Eighteen Years of Age or Older. None of the reviewed IHCRs were applicable for a court order filed in the record due to the youth being in the care of the Florida Department of Children and Families (DCF). An interview with the program's health services administrator (HSA) found if the youth do not have an AET, the health care staff will work together with both the case manager and juvenile probation officer (JPO) in obtaining a new and/or current AET.

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

The program has a written policy and procedures ensuring the parent/guardian is informed of significant changes in the youth's condition and obtains consent of new medications or treatment prescribed. A review of three youth Individual Healthcare Records (IHCR) validated each maintained documented parental/guardian notification. Two 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 reflected two had significant changes to existing medications. Two youth required off-site emergency care and parent/guardian notification was made by telephone and, subsequently, in writing.

A review of documented practice supported written notification was sent to the parent/guardian regardless of telephone notifications. Two youth were taken off-site for outside medical care and reviewed documentation supported parental notification and consent was attempted and/or obtained. 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. 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 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. A review of three youth Individual Healthcare Records (IHCR) validated each youth received an admission screening utilizing the Department's Facility Entry Physical Health Screening (FEPHS) form. All admission screenings were completed by a registered nurse on the date of the youth's admission to the program. One youth had one change in custody and a review of documentation supported a new FEPHS re-screening form was completed by the registered nurse (RN) upon the youth's return to the program. An interview with the health services administrator (HSA) 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 all youth are oriented on the general process of healthcare delivery services at the program. 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. Three youth Individual Healthcare Records (IHCR) were reviewed for healthcare orientation. Each applicable record reflected youth received a healthcare services orientation on the day of the youth's admission to the program. 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. A signed and dated receipt of healthcare orientation was observed in all three records reviewed. In addition to the admission health orientation, youth received health education throughout their stay documented in the healthcare record. A review of the Health Education form 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 ensure the designated health authority (DHA) is notified when youth admitted to the program require emergency care or routine notification. The program's practice is to notify the DHA of the admission of any youth with a chronic medical condition, psychotropic medication, or medical concern. The DHA is notified by telephone, text message, or verbally, if on-site, of all admissions. Three youth Individual Healthcare Records (IHCR) were reviewed. Each of the IHCRs reflected telephonic notification of the (DHA) of the youth's admission into the program. None of the youth presented with a condition requiring an emergency response. All records reflected notification documented in the youth's chronological progress notes. 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 ensuring each youth admitted shall receive and/or shall have a completed Health-Related History (HRH) completed prior to a Comprehensive Physical Assessment (CPA) and prior to any participation in sports, exercise, or any other strenuous activity. Three youth Individual Healthcare Records (IHCR) reflected a new HRH was completed by a registered nurse (RN) on the day of admission for each youth. 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 HRHs were completed prior to the CPA. An interview with the program's health service administrator (HSA) 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 admitted shall receive and/or shall have on record a current Comprehensive Physical Assessment (CPA) and Health-Related History (HRH) no later than seven calendar days of admission into the program. A review of three youth Individual Healthcare Records (IHCR) validated the program utilizes the Department's CPA form. All CPAs were completed by the DHA within seven days of the youth's admission. All sections of the CPA were completed in full utilizing "O" with no applicable "X" markings. None of the reviewed CPAs had completed sections for numbers nineteen through twenty-two, twenty-five, and twenty-six; however, the DHA documented "Deferred, age inappropriate." The youth did not refuse any portion of the examination 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 documentation found the results of the TSTs 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 indicated youth will not be placed into the general population until healthcare needs identified are deemed not to 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 health service administrator (HSA) reported the CPA form is completed within seven days by the DHA and each youth is screened at admission.

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 (STI) 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 (STI) and human immunodeficiency virus (HIV). The designated health authority (DHA) shall then decide, based on the screening tool and medical evaluation, to order testing for STIs. A review of three youth Individual Healthcare Records (IHCR) 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. 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. An interview with the program's health service administrator (HSA) reported youth are screened for STIs and offered testing at the time of admission. 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, referral for medical treatment as indicated, education, and prevention counseling. The program utilizes a site-specific HIV Risk Assessment and a referral for testing is based on the assessment results. A review of three youth IHCRs validated each youth was provided the opportunity to receive counseling, testing, and treatment for HIV. One youth consented and two did not; therefore, two additional applicable IHCRs were reviewed. Reviewed IHCRs validated when youth received pre-counseling, testing, and post-counseling, 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/AIDS 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 regarding sick call requests. There are approved treatment protocols appropriate to the level of the provider conducting sick call. Sick

call care is provided by licensed medical staff, pursuant to the staff's 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 practice is to have youth complete a Sick Call Request utilizing the Sick Call Request form and submitting the forms in the wall-mounted locked boxes located in designated areas in the program. The program's practice is to check the boxes randomly throughout the day.

Sick call is provided Monday through Friday from 7:00 a.m. to 7:30 a.m. and 5:30 p.m. to 6:00 p.m. Saturday and Sunday's Sick Call is scheduled from 7:30 a.m. to 8:30 a.m. and 12:00 p.m. to 12:50 p.m. The program also provides a Non-Healthcare Medical and Emergency Protocol Guide for staff to utilize when nursing staff are not on-site. The DHA is on-call seven days a week, twenty-four hours a day for consultation. The program also provides a Non-Healthcare Medical and Emergency Protocol Guide for staff to utilize when nursing staff are not on-site. 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's date of February 28, 2022 and February 28, 2021. Emergency dental care services shall be provided by the contracted/licensed dentist and/or the youth will be transported to the emergency room.

A review of three youth Individual Healthcare Records (IHCR) found two applicable youth completed a Sick Call Request form at least once during their stay; therefore, one additional applicable IHCR was reviewed. Reviewed documentation found 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 for two of the applicable youth's IHCR. One youth's Sick Call Request form and Sick Call Index form could not be found according to the program's health service administrator (HSA). However, the youth's sick call request was documented on the program's Sick Call Referral Log. There were no applicable youth who presented a similar sick call complaint three or more times within a two-week period. Two sick call incidents were documented on the Sick Call Index and the completed forms were filed electronically in the program's electronic medical record as well as the healthcare record. All sick call incidents were documented on the Sick Call Referral Log.

The program does not utilize restricted housing. When a licensed healthcare staff is not on-site, all Sick Call Request forms shall be turned into the supervisor for review. When a licensed healthcare staff is not on-site, all Sick Call Request forms shall be turned into the 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 determine if the sick call requires immediate attention. The designated health authority (DHA) and the HSA are on-call and available for consultation to determine if the sick call requires immediate attention and/or for instructions. 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; observation of the program's sick call process could not be conducted. Three interviewed staff indicated nursing staff reviews and conducts sick call. One interviewed youth indicated they can see the nurse immediately and two youth reported within one day of submitting a sick. Two interviewed youth indicated they are allowed to see a dentist immediately. One youth reported not seeing a dentist.

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, in response to unexpected illnesses, accidents, or conditions requiring immediate attention or an immediate professional assessment to determine the 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 person must have a follow-up evaluation by a licensed healthcare professional the next time this person is on-site, or sooner, if indicated. The healthcare staff then documents the follow-up evaluation on a nursing chronological note. A review of three youth Individual Healthcare Records (IHCR) 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 care incidents by date, name of youth, Department identification number, injury and/or emergency, treatment rendered, registered nurse initials, and whether the youth was referred to the designated health authority (DHA) on the log.

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 the kits are fully stocked and do not have any issues. The AED provides audio instructions on step-by-step procedures. The AED located in the gymnasium batteries expire in April 2021 and were last changed on April 13, 2020. The AED pads expire in October 2021 and were last changed April 13, 2020. The AED located in the maintenance area has batteries which expire in March 2021 and were last changed on April 13, 2020. The AED pads expire in December 31, 2021 and were last changed in October 2020. The AED located in the administration has batteries which expire in April 2021 and were last changed in April 2017. The AED pads expire on December 31, 2021. The date the pads were last changed could not be determined. The AED located in the medical area has batteries which expire on September 30, 2023 and were last changed on September 2, 2019. The AED pads expire on July 31, 2021. The date the pads were last changed could not be determined. The program conducts medical drills monthly on each shift. The program conducts announced and unannounced 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. A review of three staff training records supported each maintained a current certification in first aid and cardiopulmonary resuscitation (CPR). Training records also supported supervisory staff were trained in assisting youth in self-administration of the epinephrine auto-injector. The registered nurses each maintained current certifications in CPR/AED and basic first aid. 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 the program's AEDs, first aid kits, and suicide response kit could not be conducted. The program reported emergency telephone numbers were located in each office and the medical clinic accessible to staff but inaccessible to youth. Three interviewed 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 for the provisions of off-site emergency and non-emergency referrals for medical care and treatment. 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. Evaluations conducted off-site shall be recorded on the Department's Summary of Off-Site Care form. A review of three youth Individual Healthcare Records (IHCR) found two youth required off-site care and/or emergency care; therefore, one additional applicable IHCR was reviewed. Reviewed documentation supported the parent/guardian was 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 reviewed 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 program's health service administrator (HSA) 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. Two youth were identified upon admission into the program. All youth were classified with a medical grade of two through five. All youth were taking prescribed medication on an ongoing basis and there was one youth currently undergoing treatment for physical health condition which included a body mass index greater than thirty.

The program maintains a youth roster of youth requiring periodic evaluations identifying the youth's name, date of admission, whether youth was admitted with prescribed medication, chronic condition, date of last visit, and next visit date. Reviewed records supported each youth received periodic evaluations, as required. 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. Both youth IHCRs documented updating of the Department's Problem List as changes occurred.

At the time of the annual compliance review, the program did not have any youth taking anti-TB medication. The designated health authority (DHA) reported youth with chronic conditions are evaluated every sixty days and as needed. The DHA also indicated writing orders for youth to follow-up for chronic clinic within sixty days to ensure youth are being evaluated in accordance to policy. An interview with the health service administrator (HSA) also confirmed this practice.

The DHA also confirmed weekly meetings between the administration staff and medical staff to discuss the care and conditions of youth at the program.

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 which outlines the process of how medications are to be received, stored, inventoried, and administered in a safe and effective manner. 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) form 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 two youth were admitted into the program on prescribed medication; therefore, one additional applicable record was reviewed.

A review of nursing Chronological/Notification Progress Notes confirmed the designated health authority (DHA) and the psychiatrist were notified by telephone of each youth's admission providing a history, obtaining admission orders, and to continue the prescribed medications. The registered nurse (RN) completed the DHA Notification of Admission form documenting current medications, applicable chronic conditions, allergies, and medical grade. Documentation showed the DHA or psychiatrist resumed the prescribed medication for each youth. Reviewed Medication Administration Records (MAR) validated the continuation of medications. There were no instances when a youth's medication could not be verified and had to be returned to the youth's parent/guardian. The RN completed the Prescription Medication Verification Checklist and Medication Receipt, Transfer, and Disposition form when youth are admitted with current prescribed medications ensuring all medications have a current and valid order and are given pursuant to a current prescription.

All three reviewed applicable youth IHCRs reflected the prescribed medication was continued, discontinued, changed, or a new medication was ordered. In each instance, the practitioner's order clearly documented the medication and dosage. 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. The youth's MAR and/or Individual Controlled Medication Inventory Record is updated after each administration and shift-to-shift inventories of controlled medications are conducted by conducted by registered nurses (RNs). All three reviewed MARs supported the youth received the medications, as prescribed. Each youth's MAR clearly documented medication start and stop dates. The program's RN initialed the MAR for each administered medication entry. 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. Nursing staff documented side effect monitoring on each MAR daily each time medication was administered. Medications listed on the Authority for Evaluation and Treatment (AET) form for the trained non-licensed staff to utilize when nursing staff are not on-site. The trained non-licensed staff are permitted to assist youth with over-the-counter (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.

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 medication administration could not be conducted. 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 procedures outline all controlled substances are to be maintained in the securely locked box within the securely locked medication cart located in the medical clinic. In compliance with the CDC guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site; therefore, storage of controlled substances and other medication could not be observed. The program maintains one refrigerator in the medical clinic for the storage of medication and nursing staff reported the temperature is monitored daily. Three youth were interviewed and reported medication is administered by the nurse. Three staff were interviewed and all three confirmed the nurse provides youth with medication.

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.

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, medication inventory was unable to be observed. All medications were securely stored in the medical clinic inaccessible to youth. 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 substance with a shift-to-shift inventory conducted by two registered nurses. Syringes and sharps are counted through a perpetual inventory and are verified weekly. The program contracts with a pharmacy and a State of Florida licensed consultant pharmacist. The consultant pharmacist license expires December 31, 2020. The consultant picks up all expired medication, unused medication, disposal of narcotics, and other controlled substances at the end of the month for proper disposal. Reviewed documentation supported the consultant pharmacist conducted monthly on-site inspections and maintained a consultant pharmacist inspection log and consultant pharmacist monthly inspection report.

All disposed medications are documented on the Consultant Pharmacist Monthly Inspection form and on the applicable Controlled Medication Inventory Record in the disposition of remaining doses box. 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

report's not having any discrepancies within the last six months. The program also maintains a 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.

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 August 17, 2018, designated health authority (DHA) on October 21, 2019, and corporate 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 a contracted provider. 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 facility administrator (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 heath 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 four RNs, and one health service administrator (HSA). The program reported having one 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 expecting 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 leisure activity in the cottage day room, and movement from the dormitory to medication pass in the cafeteria. Prior to any movement, staff informed master control, by way of two-way radio, of the starting location, the number of youth moved, and the group's destination.

During the observations, staff were actively supervising youth and 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 indicated the program was in compliance with the required ratio. The program has implemented a system of primary and secondary hold days for each staff to ensure the program operates within the required staff to youth 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 staff were formally interviewed and 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 able to correctly identify the number of youth under their supervision without having to count heads. 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 training records for in-service training indicated all staff completed training on the

BMS. The program had no staff applicable for completion of pre-service training since the last annual compliance review. A review of training documentation verified the educational staff were trained in the implementation of the BMS on April 20, 2018 by the program's clinical director. The program's youth handbook includes an explanation of the BMS. A review of three youth case management records indicated each youth received an orientation to the program which included training on the program's BMS, and an explanation of youth expectations, responsibilities, and consequences. Observations of the youth cottages indicated a BMS tracking sheet was posted to document those youth who earned daily and weekly incentives. Observations made during leisure time and during youth movements 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.

An interview with the facility administrator (FA) indicated youth receive an informal and formal treatment team meeting each month. Youth who require one, receive a special treatment team for program violations. The BMS is implemented during school hours by the direct care staff; in addition, the program's teachers completed training in the BMS. Three staff were interviewed and each correctly explained the program's BMS, knew what type of rewards the program provided as a part of the BMS, and stated nothing can be taken away from youth as a consequence. Three youth were interviewed and described the process for receiving consequences. The 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, while one youth who had been in the program for three months stated he did not know how the BMS levels worked.

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, deny basic rights, or services, promote the use of group punishment, allow youth to punish other youth, or include disciplinary confinement. The program's policy requires immediate processing of negative behavior with the youth. The program has a process during weekly treatment team meetings for staff to explain to the youth the reason for any imposed sanctions. Youth are given an opportunity during this process to explain their behavior. A special treatment team meeting is held when youth whose behavior requires immediate intervention. The program does not utilize room restriction for major infractions.

A review of three staff position descriptions indicated BMS implementation is addressed as a part of the staff daily functions. An interview with the facility administrator (FA) indicated the BMS is monitored to ensure all staff with 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 as needed and appropriate, during monthly All Staff meetings. Three youth were interviewed, and all stated youth are not allowed to punish other youth. Two youth indicated staff are consistent in the use of rewards and one reported he did not know about the use of rewards and could not remember the last time he was rewarded. Three staff were interviewed and asked how supervisors provide feedback regarding the implementation of the BMS. One staff stated feedback is given during staff meetings, while another staff indicated written comments could be received as feedback. The third interviewed staff stated supervisors do not 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 their 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 six cottages which are named Adams, Carver, Johnson, Koger, Marshall, and Robinson, with each containing camera surveillance. The program has fifty-two recording video cameras from which video recordings are maintained for at least thirty days. An interview with the campus-wide facility administrator indicated only forty-four cameras were functional during the week of the annual compliance review. While eight cameras located in Johnson Cottage were operational for viewing live video only, the video recording's ability for the eight cameras was non-functional since August 3, 2020. Staff interviews indicated the program maintains video camera recording footage for at least thirty days. According to the facility administrator (FA), Marshall and Johnson cottages are currently not in use. A review was conducted of ten Ten-Minute Check Logs from five randomly selected dates and times, along with the corresponding video footage recordings, indicated checks were consistently conducted, as documented on the Ten-Minute Check Logs. Three staff were interviewed, and one indicated room checks are conducted every ten-minutes, and two staff stated every seven minutes, when youth are in their sleeping quarters for non-punishment reasons.

5.05 Census, Counts, and Tracking	Satisfactory Compliance

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

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

The program shall maintain a chronological record of events as they occur, or, if an event disrupts the safety and security of the program, as soon as is 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 whereabouts of youth at all times. The program tracks daily census information to include the daily count, new admissions, releases, youth temporarily away from the program, transfers, and direct discharges. Youth are accounted for at all times by a physical count and both scheduled and informal head counts are requested by master control. A review of the facility logbooks for the previous six months was found to have documented youth counts at the beginning of each shift, after outdoor activities, and movements to/from school, groups, and medication pass. Documentation in the logbooks included reconciliation of counts and recorded youth temporarily away from the program.

The program maintains an approved escape response plan to ensure appropriate levels of supervision is maintained to provide adequate safety and security which is necessary to prevent escapes. The plan was approved by the facility administrator (FA) on January 7, 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 moved and the destination. An informal interview with three staff was conducted. Each staff knew how many youth they were supervising without performing a count and indicated when the count is not reconciled, master control is contacted, and all movement stops until the count is corrected. Three staff were interviewed and explained when youth counts are conducted and what happens when there is a discrepancy, including emergency counts.

5.06 Logbook Entries and Shift Report Review	Satisfactory Compliance

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

The program 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 facility tours by supervisors. Each entry is to be made in ink with no erasures or white-out.

The campus-wide facility administrator stated in an interview the program does not maintain living unit logbooks. A review of logbooks from the previous six months indicated errors were not consistently struck through with a single line and were not consistently initialed by the staff correcting the error. Overwriting was observed to change the time of logbook entries staff/youth names, the number of youth in a movement, and the name of the cottage from which youth were moved to. 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 sign the shift report to acknowledge the information has been shared. A review of 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 facility. The program utilizes a Daily Key Log to track keys. The log indicates the name of staff and what type of key they are assigned according to their position. Program keys are maintained in the master control office within a locked key box which has limited access. Keys are bound on tamper-resistant color-coded rings which include a brass colored tag with a tracking number and the initials of staff positions. Medical staff keys are maintained in a separate locked key box to ensure only appropriate staff are issued medical keys. Upon arrival at the facility, staff gain access to the program by way of master control. Staff are to submit personal keys in exchange for a program key. Staff sign the key log, acknowledging receipt of the keys. Personal keys are to be placed in the key box next to the corresponding staff's name. Observations of key assignment and reconciling of keys verified this practice. Damaged keys are turned over to maintenance staff to have the key replaced.

The program has a list of staff who are assigned permanent keys. Permanent keys are issued, and staff sign an acknowledgment form indicating receipt of the key identification number and the number of keys issued. Master control staff complete a daily inventory of program keys. A review of key inventory documentation for the previous six months confirmed this practice. A random check of three staff indicated none of the staff had personal keys on their person. An interview with the master control operator indicated if keys are reported lost, all program movement is stopped, and a search is conducted. If the keys are not found within two hours, a call to the Department's Central Communications Center (CCC) is made. A review of CCC incident reports since the last annual compliance review verified there was one incident were

program keys were lost and not recovered; the CCC was contacted, as required. The locks were rekeyed within twenty-four hours, as required, by the program's policy, and the responsible staff received coaching and retraining on key control and security. Three staff were interviewed and were able to explain the program's key control process including how keys are assigned, reconciled, as well as the processes for missing or lost keys, and damaged keys.

5.08 Contraband Procedure	Satisfactory Compliance
The program's policy must address illegal contraband and prohibited items. *A program shall delineate items and materials considered contraband when found in the possession of youth, the list must include: sharps, escape paraphernalia, tobacco products, electronic or vaporless cigarettes, non-facility issued electronic equipment or devices, metals, personal non-facility issued cellular devices, unauthorized currency or coin(s), and non-facility issued keys. The program shall provide youth with the list of contraband items and materials and inform the youth of the consequences if found with contraband. The program shall establish a system to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, facility grounds, and its staff/youth.* *The program shall document the confiscation of any illegal contraband and the manner of disposition. The program shall keep a copy of the documentation in the case file. If a confiscated item is not illegal, the program director or designee has the discretion to discard the item, return it to its original owner, mail it to the youth's home, or return it to the youth upon release. In all instances involving confiscation of illegal contraband, the program shall turn the item over to local law enforcement and a criminal report filed.*	

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

A review of daily search reports for the previous six months validated this practice. All incoming and outgoing correspondence is searched to control the introduction of contraband into the program and to detect information which could present a threat to the security of safety of the program. The program's perimeter security is checked on each shift. A review of the program logbooks for the previous six months indicated perimeter searches were conducted and documented in the logbook. A review of the Department's Central Communications Center (CCC) reports for the past six months indicated there was no illegal contraband confiscated. Three staff were interviewed and stated youth searches are conducted anytime a youth is moved from one area to the next. An interview with the facility administrator (FA) indicated if there is any illegal contraband found, an incident report is completed, as well as a search form, to indicate where the contraband was found. The FA is notified and, if applicable, the CCC will be informed of the findings. Contraband is quickly removed from the campus 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 visitation. Searches are conducted by a staff of the same gender as the youth searched. Parents/guardians are notified of searches during visitation by way of the parent/guardian intake letter which is sent at the time of the youth's admission. Youth are searched after school, transports, groups, outdoor recreation, meals and at each movement. Youth who are a new admission, re-admission, returning from visitation, returning from off campus, suspected of contraband, or are a security risk are searched prior to returning to the general population. Observations of searches conducted during the week of the annual compliance review, indicated searches were conducted by a same gender staff, conducted in a manor not to degrade the youth, and based on the Protective Action Response (PAR) training manual. Three youth were interviewed and indicated searches are conducted when returning from off campus, after outdoor activities, when items are missing, after visitation, after meals, and after work detail. Three staff were interviewed and 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 it had an installed safety screen and doors which could not be opened from inside the passenger area. The observed vehicle was equipped with a fully-charged fire extinguisher, a seatbelt cutter, window punch, and operable seatbelts for each passenger. The vehicles first aid kit was stored in master control to be checked out when using the vehicle. Annual vehicle inspections are conducted by the program's in-house mechanic, who is automotive service excellence (ASE) certified until June 30, 2022 to conduct auto maintenance, breaks, and light repairs. Reviewed documentation for both vehicles indicated the vehicle which was previously sold passed an annual safety inspection on April 27, 2020 and the remaining van was due for annual inspection the week following the annual compliance review by 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 secure.

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

The program maintains a written policy and procedures for the safe and secure transportation of youth. Staff are not permitted to leave a youth unattended in a vehicle and youth are not permitted to drive the program or staff vehicles. Observations of a transport was not possible during the week of the annual compliance review. Interviews were conducted with three staff all of whom 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 ratio 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 staff holding an eligible driver's license which is to be updated monthly and signed by the facility administrator (FA). The program provided the Approved Drivers List dated May 4, 2020, and advised May was the last month the required list was completed. No explanation was provided as to why the monthly license check and approved list was not completed in June or July 2020. The campus-wide facility administrator advised during the annual compliance review the program would conduct a check of staff driver's licenses immediately.

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 who is responsible for conducting the audits, procedures to implement corrective actions for deficiencies, and an internal system to verify deficiencies are corrected. The program's policy calls for the weekly safety and security audits to be conducted by the physical plant manager or designee and documented on the Department's Facility Security Audit and Safety Inspection form. However, there was no documentation to indicate weekly inspections were conducted for two of the twenty-six weeks reviewed, with the weeks of May 10-16, 2020 and May 31-June 6, 2020 omitted. The program's practice was to have the unit manager complete the weekly inspections. 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. 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 review of the program's logbooks verified this practice.

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

The program maintains a written policy and procedures addressing the proper control and management of tools used within the facility. The policy encompasses the storage and inventory of tools, as well as class type. Tools are maintained in the carpenter's shop and the mechanic shop which are located outside of the program's secured fenced perimeter and inaccessible to youth. Tools are stored on shadow boards, in locked cabinets, with a list of the contained tools posted on the outside of each cabinet. Additional tools are maintained in the maintenance truck's bed-mounted tool chests organized with wooden tool cut-outs for each stored tool. 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 tools 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 and mops, are stored in each living cottage in a designated locked closet with an inventory list posted on the interior side 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 staff were interviewed and stated youth are allowed to use scrub brushes, mops, and brooms.

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 were completed and identified whether the youth was eligible to handle tools. Observations of a secured storage closet confirmed it contained a broom, mop, mop bucket, toilet plunger, and dust pan. 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) where youth utilize Class A tools. Three staff were interviewed and 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	Limited 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 or electronic devises 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. The contraband guidelines which are signed by each contractor, did not prohibit smart watches, as required by Department guidelines relating to contraband in residential programs. When a contractor arrives on campus, the workers are to sign-in on the log, are provided a visitor's contraband list outlining unauthorized items, and review and sign the contractor guidelines. A list of tools the contractor requires to complete the project is inventoried. If any unauthorized items are needed by the contractor while in the program, approval must be obtained by the facility administrator (FA) or designee. An interview with the physical plant manager indicated youth are not allowed in the vicinity of the work area while work is completed. A maintenance staff is assigned to the work area to ensure the work is completed, all tools are accounted for, and to ensure no items which may be identified as contraband are present. A review of three invoices for contractor services rendered at the program in July 2020 revealed the contracted workers did not sign-in or sign-out of the facility related to 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 once a month on each shift. Drills are to be conducted on a random basis under varied conditions and include all staff, youth, and visitors located on the premises of the facility. Program staff document drills on Facility Drill forms which include the beginning and ending time of the drill, the nature of the drill, the participants, a brief scenario description, and the findings/recommendations. Reviewed documentation of drills confirmed the program completed drills in accordance with the COOP, The program completed COOP drills each month on each shift relating to safety and/or evacuation with scenarios involving a hurricane, attempted escape, power outages, riot, bomb threat, lightning in the area, and a terrorist threat.

An interview with the facility administrator (FA) confirmed fire drills are completed once a month on each shift, while COOP drills are completed quarterly. Reviewed documentation reflected the program's practice is to complete fire and COOP drills monthly on each shift with the exception of missing one fire drill in March 2020 on the 6:00p.m. to 6:00 a.m. 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. Three youth were interviewed, and all indicated they have been instructed on what to do in the case of a fire.

5.17 Disaster and Continuity of Operations Planning	Satisfactory Compliance
The program shall have a coordinated disaster plan and Continuity of Operations Plan (COOP) or one comprehensive plan incorporating both. The plan(s) shall provide for the basic care and custody of youth in the event of an emergency or disaster and continuity of the aforementioned, while ensuring the safety of staff, youth and the public. The plan shall be submitted to the regional director, or designee, for approval and signature. *A residential commitment program shall establish and maintain critical identifying information and a current photograph which are easily accessible to verify a youth's identity, as needed, during his or her stay in the program.*	

The program maintains a written Emergency Disaster Preparedness and Continuity of Operations Plan (COOP) which identifies a coordinated disaster plan. The plan provides for a continuity of mission essential functions across a varied range of potential emergency situations. A review of the COOP validated the plan was submitted and approved by the Department on March 4, 2020. Further review of the COOP indicated alternative housing plans were included should the program be required to vacate due to an emergency or disaster. The program maintains the required critical identifying information for each youth in administrative hard-copy records which are accessible and mobile in the event of an emergency. 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 weather drills, major disturbance drills, bomb threat drills, hostage situation drills, flooding drills, escape drills, fire drills, suicide drills, and medical drills at the program within the last twelve months.

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

The program maintains a written policy and procedures to address the control of hazardous materials. These items are stored in locked metal cabinets within a secure building outside the secure fenced perimeter of the program and are inaccessible to the youth in the program. A binder of Safety Data Sheets (SDS) is located with the chemical items and includes a photograph of each item. The program's physical plant manager maintains a list of materials, an authorized staff list for access to chemicals posted on the outside of the door, and a permanent log to display the signing in/out of chemicals. The program records the daily use of chemicals on a daily chemical usage log including the initials of the authorized staff using each chemical. All of the chemicals are inventoried once a week by the program's physical plant worker. The storage area was neat and well-organized. Chemicals used to clean the living cottages are stored in a program central location with limited access. When a cleaning chemical is needed, an authorized staff supplies the chemical to the living cottage.

An inventory sheet is maintained and documents the daily use. The program previously reported all areas are disinfected daily during the COVID-19 pandemic. The program's chemical inventory logs for February, March, and May 2020 included an all-purpose cleaner as the only chemical stored, while the logs for April, June, and July 2020 included the all-purpose cleaner and a disinfectant. The logs indicated quantities of disinfectant decreased during the month, indicating the disinfectant was used; however, the Class B Tool & Chemical Control Logs for all months from February through July document did not indicate a disinfectant was ever signed

out. The program's inventory on April 30, 2020 documented a quantity of six all-purpose cleaners and two disinfectants; however, the inventory for the next day, May 1, 2020, indicates zero all-purpose cleaners and no disinfectant included on the log at all. The program's inventories did not indicate the number of bottles of chemicals which were signed-out or signed back in. The inventory did not document when bottles of chemicals were emptied during use and not returned to the inventory. The facility administrator (FA) stated it was a staff documentation error of identifying the primary cleaning product, the program will address the error with additional training

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. Youth care workers, nursing staff, case management staff, clinical staff, and administrative staff are authorized to use chemicals but may not draw chemicals from the inventory. Authorized staff maintain control over all flammable, poisonous, toxic items off-site and must be secured when not in immediate hands of staff. When needed, authorized staff will obtain a supply of chemicals used to clean the living cottages from the supply closet. A chemical sign-out log is maintained within the closet. Youth are not allowed to possess flammable, poisonous, toxic, or caustic items. When necessary, staff are to spray the chemical and youth will wipe it up. Youth are not permitted to clean any chemical spills, handle, or dispose of any person's biohazardous human 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, and toxic materials. An interview with the physical plant manager indicated the

program disposes of unused chemicals during the county's Amnesty Day which is a day set bi-annually by Okeechobee County Waste Management for the disposal of 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 their admission to the program, outlines visitation, telephone calls, and mail correspondence. The program encourages visitation from the parents/guardians by sending a welcome letter and parent handbook upon the youth's admission, notifying the days and time of visitation, who is allowed to visit, and the corresponding rules of visitation. A list of authorized visitors and correspondence is maintained in each youth's case management records and updated as needed. Youth are permitted weekly telephone calls. Youth are permitted to visit with the parent/guardian, grandparents, siblings, and step-parents unless prohibited by a court order. The program's policy also details procedures for visitation including when a person is denied visitation or correspondence with a youth.

A review of three youth case management records verified each record contained an approved correspondence, visitation, and telephone log. 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; however, an interview with the assistant superintendent confirmed video conferencing is available. Youth are provided writing materials, and a self-addressed stamped envelope to send letters to approved family members. Youth have unimpeded access with the courts, attorneys, assigned juvenile probation officer (JPO), and/or Department of Children and Families case worker. Observations of the living cottages indicated the visitation and telephone schedules were visibly posted. Three youth were interviewed, and each indicated they are given the opportunity to communicate with family members by mail, telephone, and/ or visitation.

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

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

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

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

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

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