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): February 18-21, 2020

Promoting Continuous Improvement and Accountability
In Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Christine Calvert-Joyner, Office of Program Accountability, Lead Reviewer (Standard 3)
Nicos Antonakos, Office of Program Accountability, Regional Monitor (Standard 5)
Teves Bush, Office of Program Accountability, Regional Monitor (Standard 5)
Rosa Flores, Office of Program Accountability, Regional Monitor (Standard 2)
Tonya Gittens, Office of Program Accountability, Regional Monitor (Interviews)
Peter Keelan, Office of Education, Education Coordinator, South Region (Standard 2)
Shakela Minns, Office of Program Accountability, Regional Monitor (Standard 4)
Marissa Stress, Office of Program Accountability, Regional Monitor (Standard 1)

Program Name: Okeechobee Youth Treatment Center
Provider Name: TrueCore Behavioral Solutions, LLC
Location: Okeechobee County / Circuit 19
Review Date(s): February 18-21, 2020

MQI Program Code: 1325
Contract Number: 10188
Number of Beds: 80
Lead Reviewer Code: 163

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
3.01 Designated Mental Health Clinician Authority or Clinical Coordinator	3.15 Crisis Assessments *
3.02 Licensed Mental Health and Substance Abuse Clinical Staff *	5.26 Safety Planning Process for Youth
3.03 Non-Licensed Mental Health and Substance Abuse Clinical Staff	
3.07 Treatment and Discharge Planning *	
5.04 Ten Minute Checks *	
5.13 Tool Inventory and Mangement	

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	Non-Applicable
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

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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	Limited
3.02	Licensed Mental Health and Substance Abuse Clinical Staff *	Limited
3.03	Non-Licensed Mental Health and Substance Abuse Clinical Staff	Limited
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 *	Limited
3.08	Specialized Treatment Services*	Satisfactory
3.09	Psychiatric Services *	Satisfactory
3.10	Suicide Prevention Plan *	Satisfactory
3.11	Suicide Prevention Services *	Satisfactory
3.12	Suicide Precaution Observation Logs *	Satisfactory
3.13	Suicide Prevention Training *	Satisfactory
3.14	Mental Health Crisis Intervention Services *	Satisfactory
3.15	Crisis Assessments *	Failed
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

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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 *	Limited
5.05	Census, Counts, and Tracking	Satisfactory
5.06	Logbook Entries and Shift Report Review	Satisfactory
5.07	Key Control*	Satisfactory
5.08	Contraband Procedure	Satisfactory
5.09	Searches and Full Body Visual Searches	Satisfactory
5.10	Vehicals and Maintenance	Satisfactory
5.11	Transportation of Youth	Satisfactory
5.12	Weekly Safety and Security Audit	Satisfactory
5.13	Tool Inventory and Mangement	Limited
5.14	Youth Tool Handling and Supervision	Satisfactory
5.15	Outside Contractors	Satisfactory
5.16	Fire, Safety, and Evacuation Drills	Satisfactory
5.17	Disaster and Continuity of Operations Planning (COOP)	Satisfactory
5.18	Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.19	Youth 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
5.26	Safety Planning Process for Youth	Failed

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Program Overview

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 treatment through Mental Health Overlay Services (MHOS) and Substance Abuse Overlay Services (SAOS). Additionally, the program fosters each youth by providing Thinking for a Change (T4C) 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, 24:7 Fathering Handbook, Thinking Feeling Behaving, Teen Relationships, The Passport Program, Living in Balance, Pathways to Self-Discovery and Change, and Towards No Drugs. An interview with the campus-wide superintendent reported the program administration is comprised of a campus-wide superintendent, campus-wide assistant superintendent, facility administrator, cottage managers, shift supervisors, a campus-wide health services administrator, a director of treatment services, a director of case management, a designated mental health clinician authority (DMHCA), campus-wide regional compliance managers, a regional director, regional mental health and medical staff, one campus-wide physical plant manager, and one campus-wide human resource manager. Case management services are provided by a director of case management, two transitional service managers, five case managers, one group facilitator, and a file clerk. Mental health staff at the program include a campus-wide director of treatment services, a DMHCA, a recreation therapist, seven non-licensed therapists, one group facilitator, and a file clerk. Additionally, the program contracts with a psychologist, a 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 three registered nurses (RNs), 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 forty-three operating security cameras. All the cameras were operational during the annual compliance review week. The digital video recorder (DVR) has a recording capacity and storage for a maximum of thirty days. At the time of the annual compliance review, the program had twenty-four vacancies which included one director of treatment services, two case managers, and twenty-one youth care worker I positions.

Strengths and Innovative Approaches

- Program youth participate in church outings at Believers Fellowship Church located in Okeechobee where the residents attend bible study and church on a weekly basis. This outreach affords youth the opportunity to enrich their spiritual life and develop positive relationships as they prepare to re-enter mainstream society. Four youth are selected weekly to attend. This event was placed on hold for the past couple of months due to health issues of a coordinating church member.

- The program has a partnership with the Treasure Coast Food Bank where youth can volunteer and give back to the community by preparing food baskets for distribution to the residents of Okeechobee County. This activity allows the youth to understand the importance of building healthy communities and lending a helping hand to those in need. This event was conducted three times in 2019. The program is currently waiting for new dates to continue the event.

- The program has partnered with the Florida Conservation Corps and Florida State Parks in the annual park clean up and preservation in the Okeechobee area. At this event, the youth have a chance to fellowship with the local Mayor and Sherriff of Okeechobee in the effort to maintain the local national parks. On September 28, 2019, the program participated in an event locally in Okeechobee.

- The program has partnered with Kyros Ministries to provide mentorship to twenty youth. This is a six-month program where twenty volunteers provide mentorship to the youth on a weekly basis. These volunteers provide six to eight hours of mentorship monthly.

- On December 1, 2019, the program partnered with Our Village Okeechobee, which is a non-profit organization which provides health and education services to the Okeechobee community. Youth were able assist with holiday decorating.

- Youth in the program have opportunities to participate around campus assisting in jobs such as painting, waxing floors, and general area beautification. These tasks are outside of the normal assigned chores and help promote higher level of teamwork among the youth and care for the area in which they live in. In November 2019, several youth volunteered to help clean up and paint the school area and laid mulch around the program. Program youth are also beginning to create art work mural projects in the cottages.

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 fourteen newly hired staff and one contracted staff since the last annual compliance review. There were two volunteers and/or mentors applicable for an initial background screening. Reviewed documentation supported the fourteen newly hired staff, one contracted staff, and two volunteers and/or mentors received background screenings completed by the Department's Background Screening Unit (BSU)/Clearinghouse prior to each individual's date of hire and/or contact with youth or access to confidential information. None of the newly hired staff required 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 was reviewed. Each newly hired staff, contracted staff, and volunteer was added to the Clearinghouse roster, and none were applicable for breaks in service. Each direct care staff is required to complete a pre-employment assessment and receive a passing score. The program had ten direct care staff who required a pre-employment assessment since the last annual compliance review. Reviewed documentation found a pre-employment assessment was completed by the ten newly hired direct care staff and a copy of the passing score was maintained in each staff's personnel record. The Annual 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 their original date of hire. Rescreening documentation must be submitted to the Department's Background Screening Unit (BSU)/Clearinghouse at least ten days prior to the staff's five-year anniversary date. The program maintains a staff roster which is reviewed routinely by the program's human resource manager to determine when a five-year rescreening is required. The tracking of contracted staff

rescreening's is completed by the program's corporate office. Five-year rescreening's 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 two staff and four contracted staff were applicable for a five-year background screening. Reviewed documentation found two staff background screenings were submitted late to the Department's Background Screening Unit (BSU) which resulted in one screening completed eighty-two days late and one screening completed forty days late. Five of the seven re-screenings were completed and submitted to the Department's BSU prior to their anniversary date. Reviewed documentation supported there were no volunteers or mentors applicable for a five-year 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 unhindered access to reporting alleged abuse to the Florida Abuse Hotline. The policy outlines the reporting procedures for staff to follow when a youth request to make an abuse call. Additionally, the program maintains a staff handbook which outlines the program's code of conduct. All staff are required to sign and acknowledge receipt of the staff handbook and code of conduct, which outlines the grievance policies and their understanding of the program's code of conduct. A review of seven staff records found each contained documentation of acknowledgement, receipt, and review of the program's code of conduct. Observations conducted during the annual compliance review found postings of the Florida Abuse Hotline and the Department's Central Communications Center (CCC) throughout the facility. Each cottage has a telephone which allows the youth to have direct access to the Florida Abuse Hotline. Observations during the physical plant tour found the telephone was currently working in each cottage. 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, which has a

direct access to the Florida Abuse Hotline. The youth can be taken directly to the administration building or the case manager's office to place the call. If a youth wishes to make a CCC call, they 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 also 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 program completed a Trauma Responsive and Caring Environment (TRACE) assessment on May 22, 2019 and is scheduled to complete another one in March 2020. Seven staff were interviewed, in which each staff stated youth have unrestricted access to the Florida Abuse Hotline and Department's CCC. Each interviewed staff was able to describe in detail the program's abuse and CCC reporting process. Each interviewed staff denied ever observing a co-worker use profanity, threats, or intimidation when speaking with a youth. Seven youth were interviewed, and each youth reported they are aware of the abuse reporting process. Each youth reported never being denied access to contacting the Florida Abuse Hotline or the Department's CCC. Each youth reported they always feel safe in the program and have never been denied any basic rights. Six of the seven interviewed youth described the staff to be respectful and reported they never heard staff make threats towards a youth. One youth reported sometimes staff are not respectful if youth start cursing at staff first. Three of the seven interviewed youth reported never hearing staff use curse words. Three youth reported hearing staff use curse words occasionally and one youth reported hearing staff use curse words often. A review of all incidents since the last annual compliance review found there were five incidents which involved complaints of abuse against staff; however, each incident was closed and unsubstantiated for abuse. The Florida Abuse Hotline and the Department's CCC was notified, as required, for each reviewed incident. One of the five incidents reviewed was substantiated for violation of rule and policy. The facility administrator (FA) and the program's compliance manager reported if an allegation is made against staff, the staff is immediately removed from youth contact and an internal investigation is started. Corrective action may include oral warnings, written disciplinary actions, suspension, and up to termination. The program also follows all recommendations of the Department's investigation.

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 (FA) confirmed this practice. A review of all incidents since the last annual compliance review found five incidents which involved a complaint against staff for physical 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 were removed from youth contact as appropriate. Each reviewed report was found to be unsubstantiated for abuse. However, one of the reviewed incidents was substantiated for violation of policy on two staff members.

Documentation confirmed written reprimands were given to both staff involved in the incident 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 timeframe. 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-eight reportable incidents within the last six months, of which five were reviewed. Documentation confirmed two of the five incidents were reported to the CCC outside the mandatory two-hour timeframe ranging from four to fifty-six minutes late. Three of the five incidents were reported to the CCC within the mandatory two-hour timeframe. The program maintains monthly logbooks for recording reports to the CCC. Four of the five incidents reviewed were documented in the monthly logbooks, and one was not. A review of internal incidents for the past six months showed there were no incidents which should have been reported to the CCC and were not. An informal interview was conducted with the program's facility administrator (FA). The program's FA stated if a youth believes they have been abused or neglected, they are given unrestricted access to the Florida Abuse Hotline and/or the CCC for youth eighteen years old and over. If the youth refuses to make an abuse call, the staff is responsible for making the call as they are mandated reporters. The program has experienced an increase in the number of reportable incidents to the CCC in comparison to the last annual compliance review. An informal interview with the program's compliance manager reported the increase is due to the influx of youth and anonymous calls.

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/supervisory staff, post-PAR interview, 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 December 21, 2018. The program had five PAR reports completed within the last six months in 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 timeframe by all required parties. Reviewed documentation showed two of the five records documented a post-PAR interview conducted within thirty minutes of the incident. Three records

showed documentation of a post-PAR interview conducted five to fifteen minutes past the thirty-minute required timeframe. A review of the PAR incident reports and written comments by the FA and/or designee within seventy-two hours of the incident, was found in each PAR report. None of the reviewed reports required a Mechanical Restraint Supervision Log to be completed. None of the reviewed PAR reports alleged any injuries or required a PAR 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. None of the reports reviewed mandated a report to the Department's Central Communications Center (CCC), and there was no documentation to support any involved youth made a report to the Florida Abuse Hotline. The program maintains a PAR binder which contains all PAR reports and PAR monthly summary reports, which are submitted to the Department monthly. The program's PAR rate has increased since the last annual compliance review. The program's PAR rate during the annual compliance review period was 2.19 which is below the statewide Residential PAR rate of 2.41. The program's compliance manager stated all staff are trained to always use verbal interventions as the primary method to handle difficult situations with youth. A review of seven pre-service and seven in-service staff training records found each staff received PAR training approved by the Department's Office of Staff Development and Training.

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 January 10, 2019 and approved on January 16, 2019. Pre-service training is provided through a combination of instructor-led classes, web-based courses, and on-the-job training. All floor staff inclusive of supervisory staff are considered direct care staff and are counted in the staff-to-youth ratio. Seven staff records were reviewed for pre-service training. All reviewed records found each of the seven reviewed staff completed the certification process within 180 days of hire. Required trainings included Protective Action Response (PAR), first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), professionalism and ethics, suicide prevention, emergency procedures, child abuse reporting, Prison Rape Elimination Act (PREA), and active shooter training prior to having any contact with youth. All seven staff training records reviewed showed documentation to support each staff exceeded the required 120 hours of pre-service training. Documentation showed all training was delivered by qualified trainers and documented in the Department's Learning Management System (SkillPro). A review of the program's contract found staff are additionally required to complete training in staff stress, gender responsiveness, post-traumatic stress disorder, behavior of children, and risk factors training. All seven staff training records reviewed found documentation to support each of the additional training requirements were completed.

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 January 10, 2019 and approved on January 16, 2019. Seven staff records were reviewed for in-service training. Three of the seven records were supervisory staff. Each reviewed staff training record documented the staff exceeded the twenty-four hours of in-service training requirements. Each staff had current certifications in first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), and Protective Action Response (PAR). Each staff also completed training in professionalism and ethics, standards of conduct, active shooter, as well as six hours of suicide prevention training. Three supervisor records were reviewed for completion of eight hours of management and supervisory training inclusive of management, leadership, personal accountability, staff relations, communications skills, and fiscal. Reviewed documentation supported each supervisor exceeded the required eight hours of supervisory training. All trainings were conducted by certified trainers and documented in the Department's Learning Management System (SkillPro). 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.

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

The program maintains a written policy and procedures outlining the grievance process. Staff must adhere to a formal and informal grievance process. Youth are oriented to the grievance process during admission into the program. The program maintains a written plan for all pre-service training which includes the program's grievance process and procedures. Seven pre-service training records were reviewed for grievance training. Each reviewed training record contained documentation to validate each staff member was trained on the grievance process. The program's grievance process outlines an informal, formal, and appeal phase. The program uses "Let's Talk" forms prior to filing a formal grievance. "Let's Talk" forms allow youth to voice objections and informally file an issue or complaint prior to filing a formal grievance. All informal grievances must be responded to within forty-eight hours. Observations during the physical plant tour during the annual compliance review found "Let's Talk" forms and grievance forms were available to youth in the cottages and common areas. The program maintains a centralized binder of "Let's Talk" and grievance forms for at least twelve months. An informal interview with the facility administrator (FA) confirmed the program's grievance policy and procedures. There were two formal grievances filed and sixty-four "Let's Talk" forms submitted by youth in the last twelve months. A review of the two grievances revealed each grievance was

resolved at the formal level and within the required seventy-two-hour timeframe. Five “Let’s Talk” forms were reviewed of the sample size of seven. Each reviewed “Let’s Talk” form confirmed each form was resolved at the informal level and within the required forty-eight-hour timeframe. Each grievance and “Let’s Talk” form showed documentation of youth participation, supervisory oversight, and final outcomes. None of the reviewed grievances required an appeal. Documentation revealed the grievance forms were consistently filled out completely. Seven staff interviews were conducted in which each staff reported they were aware of the grievance process and forms placed throughout the program. Seven youth were interviewed in which five youth stated they were aware of the grievance process and knew where the grievance forms were located, if needed. Two youth reported never submitting a grievance. Six of the seven youth reported being able to ask for assistance in completing a grievance form if needed and the remaining youth reported never submitting a grievance.

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

The program maintains a written policy and procedures ensuring youth are provided delinquency interventions through evidence-based principles. A review of the program’s contract and an interview with the program’s compliance manager confirmed the program utilizes Impact of Crime (IOC) and Thinking for a Change (T4C) as the delinquency intervention programs. A review of the program’s activity schedule identified IOC and T4C are each scheduled for one hour, twice a week, along with other structured activities. The program has six trained IOC facilitators and one T4C facilitator. Delinquency intervention groups are facilitated by case managers or youth care workers (YCWs). A review of records for staff who facilitated the groups found the appropriate trainings in each applicable intervention were completed and each staff had the applicable educational background for the group practices. An informal interview with the program’s compliance manager confirmed the program considers staff’s intervention training, education, and work experience to determine which staff deliver the delinquency intervention services. A review of the group sign-in sheets validated T4C and IOC groups were held, as required, with minimal interference. A review of seven youth records and group sign-in sheets confirmed three of the seven youth received IOC delinquency service interventions, and the intervention service goals were included as part of their individualized performance plans. The remaining four youth were scheduled to begin IOC groups February 24, 2020. Additionally, four of the seven youth were also receiving T4C delinquency service interventions, and the intervention service goals were included as part of their individualized performance plans.

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

The program maintains a written policy and procedures ensuring youth receive life and social skills training. The program’s policy ensures the youth receive life and social skills training to include decision making, communication, interpersonal relationships and interaction, non-violent conflict resolution, anger management, critical thinking, and problem solving. A review of the

program's contract and an interview with the program's facility administrator (FA) confirmed the program identified SkillStreaming the Adolescent and Independent Living Skills as the primary life and social skills curricula. A review of the program's activity schedule and documentation of group sign-in sheets confirmed youth received these services and participate in groups. A review of the staff who facilitate the groups validated they were trained to deliver the applicable curricula. An interview with the program's compliance manager and FA confirmed the program considers staff's intervention training, education, and work experience to determine which staff deliver the life and social skills groups to the youth. An informal interview with the clinical director confirmed youth are provided opportunities to learn decision making, communication, coping, and problem-solving skills. Seven youth were interviewed, and each youth reported participating in groups and learning new coping skills, impulse control, and how not to blame others. Reviewed group activities included worksheets and role-play activities.

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

The program maintains a written policy and procedures ensuring youth are provided activities or instruction to increase youth awareness and empathy for crime victims and survivors. A review of the program's contract identified the Impact of Crime (IOC) curriculum and community service projects as the restorative justice programming. The IOC curriculum includes victim impact, personal accountability, consequences of actions, introduction to harm, managing conflict, effects of crime, and the road to reparation. A review of the program's activity schedule confirmed IOC groups are scheduled for one hour, twice a week. A review of group sign-in sheets validated groups were held according to the dates on the activity schedule. A review of staff training records confirmed staff facilitators of IOC completed IOC training prior to facilitating groups. Documentation of sign-in sheets and records confirmed the program utilizes guest speakers to share personal stories to teach youth about victim impact and personal accountability. An interview with the program's facility administrator (FA) was conducted. The FA reported youth participate in IOC and community service projects as a part of the program's restorative justice practice. Youth are also encouraged to participate in campus cleanup projects. A review of seven youth records and IOC sign-in sheets confirmed each youth was participating in restorative justice programming as outlined in their individual performance plan.

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

The program maintains a written policy and procedures outlining youth participation in gender-specific programming. The program provides delinquency interventions and treatment services which are gender-specific and focus on preparing youth to live responsibly in the community upon release. A review of the provider's contract identified the program utilizes the Young Men's Work and 24:7 Dad Fatherhood Handbook for gender-specific programming. The Young Men's Work group is a group for males ages fourteen to nineteen. The group is designed to teach young men to work together to solve problems without violence. The 24:7 Dad Fatherhood 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 Fatherhood Handbook are each scheduled once a week for one hour. A review of group sign-in sheets and handouts confirmed gender-specific programming is being delivered according to the program's group schedule. An interview with the clinical director and facility administrator (FA) confirmed each youth participates in gender-specific groups while at the program. Seven randomly selected youth were interviewed, and each youth confirmed participation in gender-specific groups.

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

The program has written policy and procedures ensuring alerts are entered in the Department's Juvenile Justice Information System (JJIS) and maintained in the program's internal alert system. Critical and special alerts are reviewed, updated, and responded to appropriately. An informal interview with the facility administrator (FA) confirmed alerts are entered into JJIS. The FA also confirmed alerts are entered and verified by medical, mental health, case management, substance abuse, and administration staff. Each day administration and shift supervisors review JJIS alert reports and internal alerts in the morning management meeting and during each shift debriefing meeting. Medical alerts are updated and sent to staff daily. Reviewed documentation confirmed the program's internal alerts are reviewed daily during shift briefings by supervisory staff. Any new or changed alert is also discussed in the youth classification and treatment team meeting. A hard copy of the alerts is always maintained with the shift supervisor. The program's internal alerts are also maintained in the program's shift logbook daily, on each shift. The program has an alert board in master control, which identifies each youth's special alerts, escape risk, mental health alerts, and/or gang affiliation. The alert board has each youth's picture, arranged by living unit, and the alert associated with the youth. A review of the alert board found the alert board to be maintained and updated. A current alert list is also maintained in master control and accessible to all staff. A review of seven youth records for case management, medical, mental health, and substance abuse alerts found documentation reflecting each record was applicable for an alert. Each record had documentation which supported the appropriate alert was entered into JJIS and the program's internal alert system. A review of each record found evidence supporting thirty-three of the thirty-four alerts were entered in the program's daily shift logbook. One mental health alert was not documented in the program's daily shift logbook. Six of the seven youth records reviewed were applicable for alerts removed or updated. The six applicable records showed documentation supporting the appropriate designee closed the alert in JJIS and in the program's internal alert system. Documentation reviewed found one mental health alert for one youth for the period of December 14 through December 16, 2019 was created and removed on

February 11, 2020. An interview with the FA confirmed only a licensed mental health staff may remove or downgrade a mental health alert, only a licensed medical staff may remove or downgrade a medical alert, and only facility administration may remove or downgrade a security alert. Seven staff were interviewed regarding the program's alert process and each interviewed staff member was aware of the alert board located in master control.

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

The program maintains a written policy and procedures ensuring the maintenance, creation, and storage of individual healthcare, mental health, substance abuse, and case management records for each youth. The program maintains individual, color coded, hardbound binders for case management, healthcare, and mental health and substance abuse records. Observations of the records found each was marked "confidential" and secured in file cabinets in assigned offices not accessible to youth when not being used. Observations of the records showed each record had the required documentation on the spine and the front of the binder, to include the youth's name, date of birth, county of residence, date of admission, committing offense, and the Department's identification number (DJJID). Reviewed records showed the most recent information was placed in chronological order. Documents were organized into required sections and information was separated into designated sections with tabs for legal, demographic, case management with treatment plan and interventions, correspondence, and a miscellaneous tab.

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

The program maintains a written policy and procedures ensuring youth have the opportunity to provide constructive feedback. The program maintains a youth advisory board comprised of youth enrolled in the program, giving the youth the opportunity to have verbal contact with the program's administration regarding program operational issues, complaints, and/or suggestions. The youth advisory board meets at least once a month under the supervision of the facility administrator (FA) or designee and various staff as available. The FA confirmed this practice. A review of the youth advisory board meeting binder confirmed meetings are held at least once a month. 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 positive and negative issues which may arise. Furthermore, program administration conducts quarterly surveys with randomly selected youth to obtain feedback and satisfaction regarding the program. The results of the interviews are sent to the corporate office for review and then utilized to provide changes to the program if needed. Seven youth were interviewed, of which each stated they were allowed to provide feedback and input, if desired. An informal interview was conducted with the program's compliance manager, who confirmed youth surveys are given to youth throughout their stay in the program, at a minimum of once a quarter.

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

The program maintains a policy and procedures ensuring the program has a community advisory board which meets quarterly. The program has an advisory board serving seven programs located in Okeechobee County. Each program's advisory board was combined to have one for all programs due to a limited amount of people living in the rural community and the number of boards the local representatives join. 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 at least quarterly. There was clear documentation to support the program made attempts to schedule meeting dates and work around community advisory board member's schedules by the program's facility administrator (FA) mailing a letter, thirty days in advance of the scheduled meeting to increase attendance. Reviewed community advisory board agendas and meeting minutes documented the program provides the board members with information regarding program updates, community updates, and giving back to the community. The next advisory board meeting is scheduled for March 3, 2020. A telephone interview conducted with a current board member confirmed the board member's involvement with the community advisory board. An interview with the FA confirmed community advisory meetings are held quarterly. Board members provide suggestions to the program to improve community partnerships and provide donations for youth.

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

The program maintains a written policy and procedures for ensuring the program's planning, adequate staffing, staff appreciation, and recognition. The program conducts 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. A review of the monthly staff meeting agendas showed documentation addressing topics inclusive of training, performance guidelines, communication with staff and youth, staff dress code, safety and security, staff recognition, proper logbook documentation, policies and procedures, and youth supervision. 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 gift cards to staff as incentives for performance and leadership. The program also has a staff of the month program and offers referral bonuses to staff, along with tuition assistance. The program reviews the Department's Comprehensive Accountability Report (CAR) with staff during staff meetings and utilizes the CAR for strategic planning. The program conducts quarterly surveys with staff and youth. The results of the surveys are incorporated into the program's planning process and recommendations for the program. The program also utilizes "Let's Talk" forms as an informal

process to provide suggestions to the program. The program provides parent/guardian surveys to each parent/guardian who attend visitation quarterly. Seven staff were interviewed, and each staff reported staff meetings are held monthly. Topics which are discussed in staff meetings include policies and procedures, youth supervision, training, dress code, staff recognition, and staff assignments. Three of the seven of the interviewed staff reported being briefed on annual reports and/or youth or parent/guardian survey results. One interviewed staff reported communication is very good at the program, one staff said it is good, two staff reported it is fair, two staff reported it is poor, and one reported it is very poor. Two of the seven interviewed staff reported staff can provide feedback during monthly staff or supervisor meetings. Four interviewed staff reported there is no real ability to provide feedback and/or nothing changes if you do. One interviewed staff reported concerns of retaliation if providing feedback. An informal interview with the facility administrator (FA) was conducted. The FA stated the program has been working to reduce staff turnover since the last annual compliance review by working to increase morale through the TrueCore Way program and staff recognition programs. The program has also been actively recruiting staff through job fairs, online advertising, and other recruitment tools with the help of the program's corporate team. The FA confirmed staff meetings are held monthly and suggestions, recommendations, training, policies and procedures, and long-term planning are just some of the topics which are discussed.

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 also 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. Seven staff records were reviewed, and each included the specific job description. Five of the seven reviewed records contained the applicable performance evaluation completed within the required timeframes. One ninety-day performance evaluation was completed eighty-seven days late and one ninety-day performance evaluation was completed forty-four days 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 director of treatment services. The program's director of treatment services, a key position, has been vacant since December 6, 2019. Seven randomly selected staff were interviewed. Five staff reported they receive an evaluation annually and two reported they just received an initial ninety-day evaluation.

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

The program maintains a written policy and procedures ensuring the active participation in a variety of structured recreation and leisure activities. Youth shall have the opportunity to make

choices, assume meaningful roles, including team memberships, and leadership roles, and give input into the roles and operation of the residential community. A review of the program's 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 for the contract. A review of the program's activity schedule found recreational time is scheduled from 3:00 p.m. to 4:00 p.m. daily. Observations during the annual compliance review found the program adhering to the scheduled time on the daily activity schedule. 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 in ranging from basketball to core workouts. 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. A review of seven youth records found each contained a completed individual wellness plan. The program has a formal process in place which allows youth to provide constructive input and feedback to the program. The youth's advisory board meets monthly to provide suggestions and recommendations on recreation and leisure activities. "Let's Talk" forms are also utilized to bring concerns or issues to the attention of staff. Surveys are given to youth quarterly, as well. Seven randomly selected staff were interviewed. Each interviewed staff reported all program 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, and/or general exercise and indoor activities are inclusive of cards, dominoes, and board games. Interviews completed with seven randomly selected youth revealed youth participate in football, basketball, kickball, cards, and board game activities. Each interviewed youth reported receiving varying degrees of mental and physical exertion throughout the day.

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 the admission. Seven youth records were reviewed, and each contained documentation of the program notifying each parent/guardian by telephone, within twenty-four hours, of the youth's admission. Each reviewed record reflected all pertinent court officers were notified of the youth's admission to the program, in writing, within forty-eight hours of entering the program.

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. This orientation also details the services provided to youth. Seven youth case management records were reviewed, and each record documented evidence of the youth participating in the program's orientation. 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 also 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, the introduction and description of the Prison Rape Elimination Act, and how to report sexual misconduct. The documentation also revealed the orientation also 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 youth participation in the orientation process and the receipt of an orientation packet as well as a copy of the program's Youth Handbook. The program did not conduct any admissions during the week of the annual compliance review; therefore, observations of an orientation was not possible. Seven 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. Seven case management records were reviewed, and one was applicable for written consent of youth over the age of eighteen before providing or discussing information with the parent/guardian. Two additional records were requested and reviewed for a sample size of three. Each youth record contained consent forms signed by the youth allowing the program to share with the parent/guardian any information related to the youth's physical or mental health screening, assessment, or treatment.

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. These procedures and policies include a classification system which promotes overall safety and security for both youth as well as for the program. This includes the establishment or creation of an effective delivery system of treatment services which is solely based upon the needs of each youths' individual needs and risk factors. This policy also addresses when reassessment is warranted based upon changes in the youth's supervision status, new and updated alerts, relevant information available to the youth's treatment team, as well as any behavioral concerns. Seven 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 also included the identification of suicidal, mental, behavioral, medical, or security risks. During the initial intake process for each admitted youth, the policy also states a risk assessment is completed and updated every month to ensure there are not any presenting problems in regard to youth or program safety and security. The classification process takes into consideration a review of alerts entered into the Department's Juvenile Justice Information System (JJIS). In the reviewed youth records, only one new alert needed to be entered into JJIS. The alert was entered as required. Six of the seven reviewed records were applicable for youth displaying a history of violence, all seven displayed criminal behavior, six of the seven displayed sexual aggression or a vulnerability to victimization, one was identified a suicide risk, three were identified as a medical risk, one was identified as an escape risk, and one was identified as a security risk. A review of seven youth records for reassessments showed each youth had an increase in their individual privileges or freedom of movement, and an increase of work privileges or activities involving the use of tools or

instruments which may be used as potential weapons or means of escape. Two youth reassessments showed youth participate in off-campus activities. 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 seven 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. The policy includes the immediate notification to the local law enforcement agency upon the youth's admission to the program. Seven reviewed youth case management records showed three were applicable for gang identification. Each of the three records contained a law enforcement notification sent by electronic mail to the local law enforcement gang liaison, as well as to the program's educational provider. A review of the Department's Juvenile Justice Information System indicated each youth's juvenile probation officer was notified by the program of the youth's suspected gang member classification and an alert was entered for all three youth.

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

The program maintains 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 and drug use resistance. The program's gang prevention and intervention curriculum used is Gang Resistance and Drug Education (GRADE). The GRADE curriculum identifies causes for gang and drug use, methods to separate from such anti-social behavior, and methods to avoid further involvement in said behaviors. The contents of this curriculum include various lessons and assigned reflective essays for youth. The program maintains sign-in sheets documenting youth participation in the intervention activities. Seven youth records were reviewed and three were applicable for either active or past gang involvement or affiliation. Each of the three applicable youth have participated or were currently participating in the anti-gang program. Each record contained performance plans which included goals and objectives relating directly to the curriculum 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) to be completed within thirty days of admission. Seven 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. The initial RAY was maintained in each youth's case management record and completed in the Department's Juvenile Justice Information System. Each of the seven records were applicable for a RAY Reassessment. All seven RAY Reassessments were completed within ninety days of the initial assessment.

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 youth admission into the program. Seven reviewed case management records contained a completed YNAS. All reviewed records documented the YNAS was completed within thirty days of the youth's admission. All records indicated the YNAS was documented in the Department's Juvenile Justice Information System as required.

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 Individual Performance Plan (IPP) developed within the initial thirty days of each youth's admission. A review of seven youth case management records revealed all records contained an IPP created within thirty days of the youth's admission. All seven youth records documented the youth's plan was

developed with participation of the treatment leader, youth, parent/guardian, medical representative, administrative representative, living unit representative, mental health representative, and education staff. Each reviewed IPP contained all the required elements, such as the youth's individualized goals, top three criminogenic needs, youth and staff responsibilities, delinquency interventions, court sanctions, target completion dates, and goals for transition. Each of the seven reviewed IPPs outlined staff and youth responsibilities to accomplish the goals. All seven 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) or the Department of Children and Families (DCF). Seven youth were interviewed, and six of the seven youth indicated participating in the development of the IPP and one indicated not knowing what an IPP was. Four of the seven indicated they were provided a copy of their IPP and three indicated they did not receive a copy.

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). Seven reviewed youth case management records found performance plan revisions for five of the seven records. Two records were not applicable for a revision. Revisions were made to three of the youth's Individual Performance Plans (IPPs) due to failure to progress towards goal completion. Two IPPs were updated due to rendered transition services. A review of three closed case management records indicated, 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. Seven open youth case management records were reviewed, and each was applicable for the completion of a ninety-day summary. Summaries included reports on mental health, education, performance plan goal progress, staff and peer interactions, significant events, the youth's level of motivation to change, as well as anti-social and pro-social behaviors. All seven youth were provided the opportunity to review the performance plan and add comments. Three closed applicable case management records were reviewed, and each contained a release summary which was sent to the committing court within the required timeframe. Each of the three closed records reflected the required signatures of the youth, treatment team leader, the staff member preparing the summary, and the facility

administrator or designee. Each of the three closed records showed copies of the summary sent to the committing court, juvenile probation officer (JPO), and parent/guardian within the ten-day requirement. Three closed youth case management records were reviewed and revealed each youth's performance summary was completed every ninety days or less. All three records showed a summary with justification for release sent with a Pre-Release Notification (PRN) to the supervising JPO. None of the records contained an objection by the court or was 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 their participation in the intervention and treatment team meetings for the purpose of developing the Individual Performance Plans (IPPs). Seven case management records were reviewed. Each youth case management record contained documentation the parent/guardian participated in the development of the IPP and treatment team meetings and/or contained documentation of attempts made by telephone contact and/or mail to involve the parent/guardian in the case management process. If unable to attend, the program gives the parent/guardian the opportunity to participate by telephone or provide written input prior to the meeting. During the annual compliance review, a treatment team meeting was not observed due to the program having the treatment team meetings scheduled for the following week. In lieu of a treatment team meeting, an exit conference was observed, and all pertinent members participated. The youth are allowed weekly telephone calls and the parents/guardians are encouraged to call the conference line during treatment team meetings every month. All seven interviewed youth confirmed their parents/guardians are involved in their case management, treatment team, and treatment plan process.

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 to address 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, youth, representatives of program administration, the youth's living unit representative, clinical/medical staff, education staff, the youth's assigned juvenile probation officer (JPO), the parent/guardian or Florida Department of Children and Families (DCF) case worker, and when applicable the program's gang prevention specialist. Formal treatment teams are held for each youth at least once every thirty days and informal treatment teams are held on a biweekly basis. Seven youth case management records were reviewed and contained supporting documentation of each youth treatment team meeting comprised with signatures of each required member in attendance. Reviewed documentation confirmed the parent/guardian and JPO participation was noted by telephone and/or if an attempted contact was made. There was one youth record applicable for a thirty-day treatment team meeting involving the DCF representative and documentation supported the case worker's participation. The program's practice is to send an invitation, in advance, to the DCF representative. During the annual compliance review, a treatment team

meeting was not observed due to the program treatment team meetings scheduled the week after 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). Seven youth case management records were reviewed. Each had separate academic, mental health and/or substance abuse, and wellness plans which were incorporated into the IPP. Each case management record 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 incorporation of the IPP with the DCF plan. There were no applicable youth receiving services from the Agency for Persons with Disabilities (APD) during the annual compliance review period.

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. Seven case management records were reviewed. Each of the seven youth records documented formal treatment team reviews were conducted at least once every thirty days. Informal meetings were held with each youth biweekly to review youth performance, including progress on the individual performance plan goals. The performance plan 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. In the event the youth's assigned JPO, parent/guardian, or other pertinent parties were unable to participate in person, they were invited to participate by telephone or could provide written input. During the annual compliance review, a treatment team meeting was not observed due to the program having the treatment team meetings scheduled for the following week. In lieu of a treatment team meeting, an exit conference was observed and all pertinent members participated. Seven 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 their 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, useful interpersonal skills, as well as valuable decision-making skills. These skills are both age and intellect appropriate. The career education component allows students to investigate possible career choices which would be aligned to the individual's skill set and intellectual ability. Course work includes, but is not limited to, completing job applications, creating résumés, and participating in mock interviews. This 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 were enrolled and participated in a vocational employability course. Each reviewed record contained résumés, job applications, as well as mock interview participation forms. Documentation supported each assigned juvenile probation officer and parent/guardian was aware of the plan. An interview with the school principal and facility administrator indicated youth are provided with a career interest survey upon admission to determine possible appropriate career choices.

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

The program'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 are attending school during the times indicated on the activity schedule. According to the school principal, educational staff attend and/or submit written input during formal treatment team meetings, transition conferences, and the exit conference for each youth. A review of seven active and three closed case management records documented youth received credit for participation in educational services. Seven interviewed youth reported there are minimal interruptions during educational instruction.

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

The program has a policy and procedures in place regarding educational transition plans. 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 based upon the youth's specific goals for post release from the program. Each plan identified key personnel related to the transitional activities to include the youth, the youth's parent/guardian, the program's

educational representative, a certified school counselor and registrar from the school district the youth is returning to, and applicable post-release staff. Each reviewed transition plan also included an exit portfolio, which contained industry certifications, a schedule of post release appointments, Career Source locations, and additional information related to the youth's transition plan goals. A review of three records for a social security card, a State of Florida issued identification card, and birth certificate found only two contained all required documents. The program provided clear documentation supporting attempts to obtain assistance in obtaining these items in the remaining record. The record clearly documented the parent/guardian's refusal to assist. The applicable record did contain necessary applications to obtain a social security card and a State-issued identification card. Upon release from the program each youth is provided a copy of their education transition plan.

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. Reviewed documentation validated a transition conference was held at least sixty days prior to the targeted release date. Three closed youth case management records were reviewed. The program sent written notification to all required participants including the parent/guardian, the youth's juvenile probation officer (JPO), educational staff, and other pertinent parties. The youth, treatment team leader, clinical, medical, and education staff participated in the transition conference as evidenced by the signatures on the transition plan. The JPO and parent/guardian participated by telephone. Each youth's JPO, parent/guardian, education staff and any other pertinent parties were invited to provide written input if they were unable to participate in person. Three closed youth case management records were reviewed, and each identified the target completion dates and the individuals responsible for completion of the transition goals. Three of the three closed youth records confirmed the youth participated in a Community Re-Entry Team (CRT) meeting prior to their 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. Three closed records were reviewed for the completion of exit portfolios. All records contained documentation the exit portfolio was discussed and started during 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 any applicable vocational certifications. Two of the three youth records contained a copy of the youth's birth certificate, social security card, and State of Florida issued identification card. One of the three youth case management records did not contain a copy of the youth's birth certificate, social security card, or a State of Florida issued identification card; however, attempts to obtain were documented in the case notebook. Upon release from the program, each youth is provided a copy of their exit portfolio.

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 the 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 the admission and release coincide with the dates entered in the Department's Juvenile Justice Information System (JJIS). The reviewed documentation supported the case manager, parent/guardian, youth, education staff, JPO, and other applicable parties participated in the exit conference. All three youth had a plan for continuation of education and/or employment and instructions for their post-release supervision. The date of admission and the date of release documented in each record correlated with the information in the Department's JJIS. Each reviewed record also contained correspondence to the parent/guardian and JPO, which confirmed the youth's release date and transportation arrangements for the youth's return to the community.

Standard 3: Mental Health and Substance Abuse Services

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

The program's contract outlines the position requirements of the designated mental health clinician authority (DMHCA) to be accountable for ensuring appropriate coordination, implementation and oversight of mental health and substance abuse services in the program. The DMHCA position is outlined to be on-site forty hours each week, on-call twenty-four hours each day, and responsible for providing weekly face-to-face clinical supervision to the program's seven master's-level non-licensed therapists. A review of staffing for the DMHCA position for the past six months did not clearly show the DMHCA is on-site weekly as contractually required. For the past 180 days, the role of the DMHCA was vacant for 110 days. During the vacancy the duties were assumed by the director of treatment services for seventy-one days. For thirty-nine days, the duties were assumed by the regional director of treatment services whom was also assuming the duties of the previous campus-wide director of treatment services. There was no clear documentation to support the actual time devoted to DMHCA role for both coverage periods. Additionally, the program utilized the services of alternate licensed clinicians located at a program on the same campus under the shared contract number to provide clinical supervision for several weeks and attested those individuals were not assuming the role of the DMHCA. The program has an operating capacity of eighty youth and does not utilize a clinical coordinator. The DMHCA position was filled on February 17, 2020. The new DMHCA is currently attending new hire orientation. The newly hired DMHCA is a licensed mental health counselor (LMHC). The reviewed license showed it was clear and active in the State of Florida with an expiration date of March 31, 2021.

3.02 Licensed Mental Health and Substance Abuse Clinical Staff (Critical)	Limited 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 and one campus-wide director of treatment services. The campus-wide director of treatment services position is a key licensed clinical staff position. The director of treatment services is responsible for mental health oversight of five program's located on the property under the shared contract number. At the time of the annual compliance review, the position was vacant for seventy-four days. A potential candidate has been offered the position with an anticipated start date of April 6, 2020. The program's regional director of clinical services has been assuming the duties of the director of treatment services position in addition to other duties

throughout the south region. The contracted position is outlined to be on-site forty hours each week. The program did not have any clear documentation to support the actual time devoted to the director of treatment services role since the position became vacant on December 6, 2019. The regional clinical director is a licensed clinical social worker (LCSW). The reviewed license showed it was clear and active in the State of Florida with an expiration date of March 31, 2021. 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, 2020.

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

The program has one full time bachelor's-level group facilitator, and seven master's-level non-licensed therapists. Two therapists recently began employment with the program and were not providing clinical services. The program's master's-level non-licensed therapist's caseload assignments are based on youth dormitories. A review of caseload assignments reflected each was below sixteen as contractually required. The program's therapists and group facilitator offer mental health and substance abuse treatment. 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, 2020. The program's designated mental health clinician authority and/or the campus-wide director of treatment services are responsible for providing clinical supervision to the non-licensed clinical staff; however, these positions were vacant for periods during the annual compliance review period. The program is situated on a large campus comprised of three additional programs and clinical staff have been receiving clinical supervision and treatment planning assistance from clinical directors on the same campus under a shared contract number. 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 completion of the required twenty-hours and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. Training documentation included the administration of five Assessments of Suicide Risk or crisis assessments conducted on-site in the physical presence of a licensed mental health professional and was documented on the Department's Non-Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk form. Clinical supervision was applicable for one group facilitator and five non-licensed therapists. Reviewed clinical supervision for the six clinical staff for the past six months showed none received weekly clinical supervision for all weeks where services were provided. The first staff was missing six weeks of supervision, the second was missing five weeks of supervision, the remaining four therapists were missing four weeks of supervision each.

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 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 pre-screen process by which a youth's individualized history is reviewed and an admission screening is completed. A review of seven individualized mental health and substance abuse records showed the program administered a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) screening on the day of admission. Each reviewed record documented a review of available information to include the commitment packet, reports, and records of existing documentation of mental health or substance abuse problems on the program's document review form. A review of seven individualized mental health and substance abuse records reflected each MAYSI-2 screening was completed on the day of admission by the program's file clerk. A review of training records indicated the file clerk had completed the required MAYSI-2 training. Each of the seven reviewed MAYSI-2s reflected the screening was completed on the Department's Juvenile Justice Information System (JJIS) as required. 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 in the seven reviewed records. Four of the seven reviewed records indicated the need for further assessment based on screening results and the need for further assessment was clearly checked on each form. The program's practice is to refer all newly admitted youth for a biopsychosocial comprehensive evaluation and an Assessment of Suicide Risk (ASR) regardless of MAYSI-2 screening results; therefore, the program does not utilize a separate mental health referral form. The program's facility administrator (FA) 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 are referred to a mental health service provider for the completion of a Comprehensive Mental Health and Substance Abuse Evaluation. The program policy is to complete a new Comprehensive Mental Health and Substance Abuse Evaluation regardless of identified needs for each new admission. The master's-level non-licensed therapist is responsible for completion of the evaluation, 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 Evaluation and indicating a statement of concurrence or provision of alternative treatment recommendations based upon the findings of the review. The program also completed the Reynolds Adolescent Depression

Scale - Second Edition, Adolescent Psychopathology Scale™ Short Form, Trauma Symptom Checklist for Young Children™, Trauma Symptom Inventory™, Substance Abuse Subtle Screening Inventory, and Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) assessments upon admission and throughout treatment as indicated by the therapist. A review of seven individualized mental health and substance abuse records showed each was applicable for a new Comprehensive Mental Health and Substance Abuse Evaluation. Each of the seven reviewed records contained an evaluation completed within thirty days of admission as required. Each of the reviewed records documented the non-licensed staff completed the evaluation, and five of the evaluations were signed by the licensed staff within ten calendar days as required. One evaluation was signed five days late and the second evaluation was signed six days late. Each of the seven completed Comprehensive Mental Health and Substance Abuse Evaluations documented identifying information, relevant background information, behavioral observations, mental status examinations, interview procedures administered, discussion of findings, diagnostic impressions, recommendations, and contained substance abuse/use specific information, including patterns of use, impact of use, and risk factors of continued use. Six of the seven completed evaluations documented accurate original referral reasons indicated on the Massachusetts Youth Screening Instrument - Second Version (MAYSI-2) and one documented incorrect information. The program is licensed under Florida Statute, Chapter 397, and certified through the Department of Children and Families (DCF) to provide substance abuse services for adolescents with an expiration date of April 7, 2020. Each of the seven reviewed records contained a signed consent obtained for substance abuse services and urinalysis dated the day of admission.

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 plan for mental health and substance abuse services to establish the coordination of mental health and substance abuse services for all youth. Services are available to youth at the program who are determined to meet clinical criteria. The program's plan for mental health and substance abuse services indicated all youth are prescribed treatment based on their individualized identified needs, and at a minimum, all youth shall receive monthly individual therapy sessions, monthly family sessions, and daily clinical group services. The delivery of services at the program also include supportive counseling, and substance abuse treatment and education groups to include prevention, intervention, relapse prevention, and the twelve-step model. Each newly admitted youth is assigned to a multidisciplinary intervention and treatment team within the admission intake and classification process. A review of seven youth mental health and substance abuse records documented each youth was assigned to a treatment team upon arrival to the program. Each youth record contained an admission card and an Initial Mental Health and Substance Abuse Treatment Plan created the day of arrival. Reviewed documentation supported each youth was assigned to a treatment team comprised of representatives from administration, education, medical, mental health, and substance abuse departments, in addition to the youth and parent/guardian. Each youth's mental health and substance abuse treatment is prescribed by an Individualized Mental Health and Substance Abuse Treatment Plan. The primary therapist develops the youth's

treatment plan based on identified needs, and treatment is provided by staff trained to perform the services provided. The program is licensed under Florida Statute, Chapter 397, and certified through the Department of Children and Families (DCF) to provide substance abuse services for adolescents. The program's group facilitators and master's-level therapists facilitate mental health and substance abuse groups. Six of the seven reviewed records contained an Authority for Evaluation and Treatment (AET) form. One youth record reflected the youth was under the care of DCF upon admission and also turned eighteen while in the program. The applicable record contained both a copy of a court order and the AET for Youth Eighteen or Older form. Each of the reviewed seven youth records contained, a Substance Abuse Treatment Consent form and a Urinalysis Consent form dated the day of admission. Each of the seven reviewed mental health and substance abuse treatment records contained notes which included all elements of the Department's Counseling/Therapy Progress Note form. Weekly progress notes are maintained by an assigned counselor for each youth. Each reviewed weekly progress note form contained youth identifying information, date of services, start and end time of services, type of service, number of participants, curriculum, clinical interventions, youth response, summary of overall progress in treatment for the week, goals addressed during the week, summary of significant events, summary of family involvement, and the primary counselor's signature. A review of prescribed services for seven youth for a six-month period showed youth received services, as prescribed, by their corresponding treatment plans. The program's contract outlines four mental health groups and five substance abuse groups to be provided to youth at the program. A review of case notes, sign-in sheets, and group schedules for the past six months supported mental health and substance abuse groups were scheduled and provided as required. All clinical groups are facilitated by the program's trained master's-level mental health staff. Reviewed sign-in sheets reflected mental health groups had no more than ten youth and substance abuse groups had no more than fifteen youth as required. Seven youth were interviewed regarding group therapy participation in the program. Five youth reported participating in restorative justice or gender-specific groups. Two youth reported they did not participate in groups or receive any specialized therapy; however, six youth reported engaging in role play activities during group sessions. Seven program staff were interviewed regarding which staff facilitate mental health and/or substance abuse groups at the program. All seven staff reported direct care staff do not facilitate groups and groups are led by the therapists.

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

The program maintains a written plan for mental health and substance abuse services to establish the coordination of mental health and substance abuse treatment services and planning. A review of seven youth mental health and substance abuse records showed each contained an Initial Mental Health Substance Abuse Treatment Plan documenting development on the day of admission. Each Initial Treatment Plan was documented on the program's form and contained all elements outlined in the Department's Initial Mental Health/Substance Abuse

Treatment Plan form. Each of the reviewed seven youth records contained, a Substance Abuse Treatment Consent form and a Urinalysis Consent form dated the day of admission. Each reviewed initial plan included signatures of the master's-level non-licensed therapist, treatment team members who participated in the development of the plan, and the youth. Each plan was signed by a licensed clinician within ten days, as required. Three of the seven reviewed records were applicable for the youth being prescribed psychotropic medication. Each of the three applicable records documented the frequency of medication management and details regarding the prescribed medication. The program practice is to refer all youth for an initial psychiatric evaluation, which was also documented on each of the seven reviewed records. A review of seven youth records found six contained a completed Individualized Mental Health and Substance Abuse Treatment Plan which was developed within thirty days of the youth's admission. One record contained a plan which was completed two days late. Each 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 individualized plan was completed and signed by the clinical staff person creating the plan. Each plan documented signature of all treatment team members who participated in the development of the plan. Five of the seven plans documented signature by the licensed staff within ten days of completion as required. One plan documented signature by the licensed staff five days late, and the second was thirteen days late. Each of the seven completed plans included provisions for psychiatric services. A review of seven youth records showed each was applicable for Individualized Treatment Plan reviews to be completed every thirty days. The program documented reviews on the program's form containing all elements of the Department's Individualized Mental Health/ Substance Abuse Treatment Plan Review form. One record documented each plan was signed by a licensed clinician within ten days as required. Six of the seven reviewed records documented late signatures and/or late completion. A review of the first youth record showed three treatment plan reviews were signed between three and seventy-three days late by the licensed clinician. The second reviewed record contained, five treatment plan reviews signed between two and 119 days late by the licensed clinician, and one review was not signed by the licensed clinician. The third youth record showed two treatment plan reviews signed between five and fifteen days late by the licensed clinician. The fourth reviewed record contained three reviews signed between three and fifty-nine days late by the licensed clinician, one unsigned by the therapist who completed the review, and one review which was completed twenty-six days late. The fifth record showed two reviews signed between four and six days late by the licensed clinician. The sixth reviewed record contained two reviews signed between five and six days late by the licensed clinician. The sixth record also contained one review signed by the youth and the assigned therapist in December 2019 and all remaining team members on or after February 16, 2020. Three closed records were reviewed for the completion of a Mental Health and Substance Abuse Discharge Summary. Each record contained a summary documented on the program's form containing all elements in the Department's Mental Health/ Substance Abuse Treatment Discharge Summary form. None of the three reviewed discharge summaries were applicable for a youth released on suicide precautions. Each reviewed discharge summary documented services needed for daily maintenance of positive improvement in behavioral, emotional, and social skills made by the youth during treatment. Each reviewed discharge summary documented the beginning and ending diagnoses with the presenting symptoms to support the diagnostic criteria. Each reviewed discharge summary documented a discussion of the plan and recommendations with the youth's juvenile probation officer (JPO) and applicable parent/guardian during the exit conference as required. The program practice is to obtain the parent/guardian signature upon release and to send the discharge summary to the JPO by mail. Reviewed documentation supported this practice for each of the three reviewed records.

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

The program provides Mental Health Overlay Services (MHOS) and Substance Abuse Treatment Overlay Services (SAOS). The program has forty-eight MHOS slots for youth diagnosed with mild to moderate mental health disorders, who may have a co-occurring substance abuse diagnosis. The program has thirty-two SAOS slots for youth diagnosed with substance abuse related disorders. The program provides the youth with group therapy services seven days a week. The program also provides each youth with monthly individualized therapy and family therapy, as prescribed by each youth's Individualized Treatment Plan. The program's contract requires the program to have a licensed psychologist available to provide services as needed, and the program currently uses the services of the regional psychologist when necessary. The program's contract also requires, and the program utilizes the services of a certified behavioral analyst (CBA) when necessary. An interview with the program's lead therapist indicated the program offers SAOS and MHOS. 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, 2020. The program completes a monthly American Society of Addiction Medicine (ASAM) level one continued stay document for all youth with a substance abuse diagnosis. The program also carries an active outpatient and residential treatment accreditation through the Commission on Accreditation of Rehabilitation Facilities (CARF). An interview with the facility administrator reported the program provides MHOS services through daily therapeutic groups along with individual therapy and family therapy once each month.

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 contract with a licensed psychiatrist who is board certified in psychiatry, as well as child and adolescent psychiatry, to provide services to the youth at the program. A review of the license showed the program's psychiatrist is a medical doctor (MD). The reviewed license was found to be clear and active in the State of Florida with an expiration date of January 31, 2021. The program does not utilize an advanced practice registered nurse (APRN). A review of the program's contract revealed the psychiatrist is to be on-site weekly, in addition to on-call for emergencies and consultation twenty-four hours a day, seven days a week. The psychiatrist has a back-up psychiatrist to provide coverage while on vacation or leave; however, no back-up coverage was needed or provided in the past six months. The program's practice is to complete a new psychiatric evaluation on all admitted youth within fourteen days of admission. A review of seven youth mental health and substance abuse records showed each youth received an initial diagnostic psychiatric interview within fourteen days of admission. Three of the seven reviewed records were applicable for a youth admitted on prescribed psychotropic medications. Each reviewed initial psychiatric interview documented the

youth's medical, mental health, and substance abuse history, mental status examination, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) documented diagnosis, and treatment recommendations. All reviewed records documented the initial diagnostic psychiatric interview on the Department's Clinical Psychotropic Progress Note (CPPN) form, and each contained page number three of the CPPN. Each youth was continued on prescribed medications and the explanation of the need for psychotropic medication related to the youth's diagnosis, target symptoms, initial treatment goals, potential side effects, as well as risks and benefits of taking the medication was clearly documented. Each of the three youth records applicable for the prescription of psychotropic medications supported the youth was seen a minimum of every thirty days as required. Reviewed documentation supported there were no standing orders for psychotropic medications and there were no emergency treatment orders for psychotropic medications. Reviewed documentation supported the psychiatrist participated in weekly treatment team meetings and weekly on-site visits. The psychiatrist reported the role of providing initial psychiatric evaluations for every youth entering the program, providing medication management for all youth on psychotropic medications, and meeting with treatment team members every week to review youth concerns at 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 policy and procedure and an attached suicide prevention plan. The policy was signed by the facility administrator on August 17, 2018 and again on January 7, 2019. The suicide prevention plan was last updated and approved by the previous campus-wide director of treatment services on September 4, 2018, the psychiatrist on August 31, 2018, the previous designated mental health clinician authority on June 3, 2019, and the south region director of mental health services on January 10, 2020. The plan outlines all required elements to include 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.

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 policy and procedures to establish a method in which suicide prevention services shall be provided to all youth. The program also maintains an attached suicide prevention plan. The prevention plan outlines provisions for screening, staff observation, assessment, documentation, levels of supervision, and staff training. The program's practice is to complete an Assessment of Suicide Risk (ASR) on the day of admission, regardless of intake

screening results. The program maintains eight complete suicide response kits located in master control, medical, the school area, and each of the five cottages. Observations during the annual compliance review confirmed each kit contained the knife-for-life, wire cutters, and needle nose pliers. The program's practice is to conduct and ASR for all youth on the day of admission. A review of seven youth mental health and substance abuse records found each youth was screened upon admission utilizing the program's form and containing all elements included in the Department's ASR form. Five of the seven reviewed completed ASRs determined the youth were not at risk of suicide and were placed on standard supervision. The remaining two records documented the youth was placed on suicide precautions. Each record documented the authorization of precautionary observation (PO) status, the completion of a Suicide Precautions Observation Log, and support services provided by the program's mental health staff. The two applicable records documented the completion of a Follow-up ASR completed the day after the ASR was completed. Each Follow-up ASR was completed on the program's form and contained all elements on the Department's Follow-up Assessment of Suicide Risk form. Both Follow-up ASRs clearly documented the time, date, and results of a conference held with the facility administrator and the licensed mental health staff prior to stepping the youth to close supervision. The two reviewed records documented telephone contact with the youth's juvenile probation officer (JPO) and parent/guardian regarding the youth's potential suicide risk. One reviewed Follow-up ASR was completed by a licensed clinician and the rest were completed by the master's-level non-licensed lead therapist. A review of the master's-level non-licensed lead therapist's training showed completion of the required twenty hours of ASR training under the direct supervision of a licensed professional. Both records documented the lowering of supervision following the completion of the Follow-up ASR and the subsequent completion of a mental status examination prior to stepping the youth from close to standard supervision. A review of the Department's Juvenile Justice Information System (JJIS) documented alerts were initiated and removed as required. A review of the program's shift reports and logbooks documented one of the two applicable updates regarding youth on precautionary observation status was completed. One youth's placement and removal of suicide risk was not documented within the program's logbook. The program does not utilize secure observation. The program utilizes New Horizons of the Treasure Coast and Okeechobee in Fort Pierce, Florida for crisis stabilization (Baker Act) and Raulerson Hospital in Okeechobee, Florida for Marchman Act. Seven staff were interviewed regarding the location of the program's suicide response kits. Staff reported kits are available in the youth dormitories, master control, and the medical office. Seven staff were interviewed regarding direct care staff responsibilities when a youth expresses suicidal thoughts. All seven staff reported they are responsible for notifying mental health staff, searching the youth room for sharp objects, maintain constant sight and sound of the youth, and document supervision. Four staff also reported they would call for a program supervisor.

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 policy and procedures to establish a method in which suicide prevention services shall be provided to all youth. The program also maintains an attached suicide prevention plan. The prevention plan outlines provisions for staff observation and documentation. A review of seven individualized mental health and substance abuse records showed three were applicable for placement on precautionary observation (PO) while at the

program. Each of the three reviewed records contained a completed Department Suicide Precaution Observation Log form. All three reviewed logs contained real time supervision notes maintained by the direct care staff. Each supervision log documented observations within thirty-minute intervals as required. One of the reviewed records was applicable for a youth displaying warning behaviors while on PO and the mental health staff was contacted as required. Each reviewed PO log documented signature of the shift supervisor, in addition to identifying safe housing requirements. Two of the three records documented the daily review and signature of the program's clinical staff and one documented review and signature by the mental health staff eleven days later. Three youth previously placed on suicide precautions were interviewed during the annual compliance review. Each of the three youth reported never being left alone while on PO status.

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 to establish a method in which suicide prevention services shall be provided to all youth. The program also maintains an attached suicide prevention plan. The prevention plan outlines provisions for staff training and the completion of mock suicide drills. The policy dictates all staff who work with youth must receive six hours of annual training on suicide prevention and implementation of suicide precautions, in addition to participation in mock suicide and emergency drills. A review of seven in-service training records and seven pre-service training records showed each staff completed all required training. A review of the program's mock suicide drills confirmed the program is completing two quarterly drills on each shift. A review of drills for the past twelve months showed the program has completed six mock drills. Seven of the completed mock drills included the use of life saving measures. Each reviewed emergency drill documented a description of the incident, synopsis of response, deficiencies identified, corrective action, and staff members involved. The mock suicide drills conducted since the last annual compliance review were reviewed and reflected at least fifty-percent of all direct care staff personally participated in mock drills at least semi-annually. The program practice is to review all mock suicide drills during morning management meetings, which occur Monday through Friday, at all shift briefings with oncoming staff, and during monthly all staff meetings. An interview with the facility administrator reported the program provides training and/or mock drills for staff monthly, which includes emergency response to suicide attempts or self-inflicted 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 policy and procedure and an attached Crisis Intervention Plan. The policy was signed by the facility administrator on August 17, 2018 and again on January 7, 2019. The plan was last updated and approved by the previous campus-wide director of treatment services on September 4, 2018, the psychiatrist on August 31, 2018, the previous designated mental health clinician authority on June 3, 2019, and the south region director of

mental health services on January 10, 2020. The plan detailed all required crisis intervention procedures to include notification and alert system, means of referrals, including youth self-referral, communication, supervision, documentation, and review process.

3.15 Crisis Assessments (Critical)	Failed 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 policy and procedures to establish a method in which crisis intervention services shall be provided to all youth. The program also maintains a written crisis intervention plan, which includes provisions for the completion of Crisis Assessments. A review of seven youth mental health and substance abuse records found one instance requiring the completion of a Crisis Assessment. An interview with the program's lead therapist and regional director of mental health services reported there was only one additional Crisis Assessment completed at the program since the last annual compliance review. A review of the two applicable assessments showed one was completed within the appropriate timeframes, contained all required documentation, and upon completion the youth was deemed appropriate for standard supervision. A review of the second Crisis Assessment showed the referral for Crisis Assessment needed on December 13, 2019 was not created or submitted. The youth was identified to be in crisis on the evening of December 13, 2019 and the Crisis Assessment was completed on December 14, 2019 at 4:45 p.m. The youth was placed on precautionary observation (PO) after the assessment time with no increased supervision prior to the assessment. The licensed staff did not sign the Crisis Assessment until February 10, 2020. The incorrect follow up assessment was completed the next day. A Follow Up Assessment of Suicide Risk (ASR) was completed on December 15, 2019 where a follow up Crisis Assessment was needed. The Follow Up ASR was not signed by the licensed staff until December 23, 2019. The mental health observation log maintained on December 14, 2019 documented only one of the three shift supervisor signatures and the mental health staff documented review on December 18, 2019. The mental health staff review was documented after the youth was placed on standard supervision. Additionally, the mental health supervision alert for the youth which was applicable for December 14 through 16, 2019 was entered and closed in the Department's Juvenile Justice Information System (JJIS) on February 11, 2020.

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 policy and procedure and an attached Emergency Mental Health and Substance Abuse Services Plan. The policy was signed by the facility administrator

on August 17, 2018 and again on January 7, 2019. The plan was last revised and approved by the previous campus-wide director of treatment services on September 4, 2018, the psychiatrist on August 31, 2018, the previous designated mental health clinician authority on June 3, 2019, and the south region director of mental health services 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 facility administrator 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 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. Seven interviewed staff acknowledged the ability for all program staff to call 9-1-1 in the event of an emergency.

3.17 Baker and Marchman Acts (Critical)	**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 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 maintains a contract with a State of Florida board-certified licensed medical doctor to serve as the designated health authority (DHA). The DHA is a licensed osteopathic physician (DO) who holds an unrestricted clear and active license with an expiration date of March 31, 2020. The program has had two DHAs, one medical doctor (MD), and one backup DO provide services on two occasions since the last annual compliance review. A review of the two DHA's, the one back up DO, and the one backup MD's licenses confirmed each license was clear and active in the State of Florida. The program currently also has a cooperative working agreement with a licensed medical doctor (MD) as a back-up to provide service in the event the current DHA is on scheduled leave, emergency services, and vacations. 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. The DHA is scheduled to be on-site weekly for a minimum of two hours. Reviewed attendance logs for the last six months validated the DHA was on-site weekly, as required, with no exceptions. An interview with the DHA confirmed performing Comprehensive Physical Assessments (CPAs) within seven days of each youth's admission, conducting periodic evaluations within sixty days for youth with chronic conditions, ordering and reviewing labs, ordering medications, sick calls, follow-ups 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 maintains Facility Operating Procedures (FOPs) for all health-related procedures and protocols utilized. The program's designated health authority (DHA) conducts an annual review of all health-related policies, procedures, and protocols. Reviewed protocols, policies, and procedures validated they were reviewed, updated, and approved by the two previous DHA's, the osteopathic physician (OD), the medical doctor (MD), and current DHA signed all healthcare policies and procedures. One DHA signed on June 10, 2019, another signed on August 22, 2019. The current DHA signed on October 21, 2019. The facility administrator signed on July 9, 2019. The psychiatric FOPs were each signed by the psychiatrist on August 11, 2018. 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. The program maintains a nursing protocol manual developed and approved by the previous DHA on August 22, 2019. The current DHA signed all nursing protocols on September 16, 2019. A review of the FOPs cover page documented signatures of all medical staff. However, a review of the updated cover page for eighteen FOPs requiring review was missing one medical staff and the HSA signatures. The HSA signed the updated policy cover page during the week of the annual compliance review.

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 Department's Authority for Evaluation and Treatment (AET) form. At the time of the annual compliance review, the program had one youth in the shared custody of the Department of Children and Families (DCF) who had turned eighteen years of age since the last annual compliance review. The record contained court orders to administer medical treatment and a signed program Release of Information for Youth Over Eighteen Authorization form. The other six reviewed healthcare records supported no youth had an original AET; however, the word "Copy" was legibly stamped on a copy maintained within the record. Each AET was valid until the youth's eighteenth birthday. Each reviewed record contained completed parental notifications behind the AET in the Individual Healthcare Record (IHCR). During an interview with the health service administrator regarding the acquisition of AETs, it was reported the case manager is made aware of any needed AETs. The case manager is then responsible for contacting the youth's assigned juvenile probation officer (JPO) and obtain a new one or a copy of the current AET if one is available. If the youth is in DCF custody and parental rights have been terminated relating to medical decisions, then the program staff would contact the DCF case manager to obtain a court order.

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 to inform the parent/guardian of significant changes in the youth's condition and obtain consent when new medications and treatments are prescribed. Seven Individual Healthcare Records (IHCRs) found one youth was 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. Three of the seven youth were applicable for significant changes to existing medication and/or chronic conditions, not consented for on the current Authority for Evaluation and Treatment (AET) form. None of the reviewed IHCRs found a parent/guardian consented for vaccination/immunizations were needed. Three 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. Each applicable record contained documentation of the program obtaining 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. A review of seven youth records validated each contained a printed Florida Certification of Immunization record pulled from the Florida Shots website. Reviewed documentation supported the registered nursing staff and the designated health authority reviewed the certificate of immunization within the first seven days of admission into the program. There were no applicable youth whereby a parent/guardian did not consent to a vaccination for medical reasons or submitted a Religious Exemption Immunization form. The health service administrator reported if a parent/guardian exempts from immunization for religious reasons, the parent/guardian shall complete the Religious Exemption Immunizations form provided from the health department and mail back to the program.

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 regarding healthcare screening for each youth upon admission into the program. The program's practice is to complete a rescreening and complete the Department's Facility Entry Physical Health Screening (FEPHS) form anytime a youth is admitted into the program or each time the physical custody of the youth changes with subsequent return or readmission to the program. A review of seven youth Individual Healthcare Records (IHCRs) validated each youth received an admission screening utilizing the Department's FEPHS form. Six youth admission screenings were completed by a registered nurse on the date of the youth's admission to the program. One youth's admission screening was completed by the health service administrator on the date of admission. One of the seven youth was applicable for a change in custody. Reviewed documentation confirmed a new FEPHS was completed by a registered nurse upon re-admission. An interview with the health services administrator (HSA) confirmed the program's practice. The interviewed HSA also reported the nurse notifies the designated health authority (DHA) immediately by telephone to make them aware of the youth with serious or chronic conditions and obtain consent to continue current medications if indicated. Reviewed documentation confirmed this practice.

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

The program has a written policy and procedures to ensure each youth admitted into the program receives a healthcare orientation. A review of seven youth Individual Healthcare Records (IHCRs) validated each youth receive orientation on the required healthcare topics; how to access sick call, what constitutes an emergency, how medication is administered, the right to refuse care, and notifying staff of all allergies, chest pain, and/or extreme shortness of breath. The orientation includes what to do in the case of a sexual assault and the non-disciplinary role provided by medical staff. All youth were orientated within twenty-four hours of admission. Youth and nursing staff signed the health education packet acknowledging the training was conducted and the youth reviewed and understood the information. A review of the posted healthcare contacts confirmed the list was accurate with the healthcare staff information.

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

The program has a written policy and procedures to notify the designated health authority (DHA), by telephone or verbally, of all youth admitted into the program identified with chronic health conditions or youth in need of emergency care. Seven youth Individual Healthcare Records (IHCRs) were reviewed. Three applicable youth IHCRs found the DHA and, when applicable, the psychiatrist was notified of a youth's admission into the program. Each contact was made by telephone and was documented on the program's DHA and Psychiatrist

Notification of Admission form, as well as on the Admission Chronological Progress Note. None of the youth presented a condition requiring an emergency response.

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

The program has a written policy and procedures to address the completion of the Health-Related History (HRH) form prior to the completion of the Comprehensive Physical Assessment (CPA) upon each youth's admission to the program. A review of seven youth Individual Healthcare Records (IHCRs) found a new HRH form was completed within seven days of the youth's admission. All seven completed HRH forms were completed by a registered nurse and reviewed by the designated health authority (DHA). Reviewed documentation supported the HRH form was completed on the day of admission. An interview with the program's health service administrator (HSA) confirmed this practice. Reviewed documentation supported the HRH was completed before or at the same time as the CPA.

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 the completion of the Department's standardized Comprehensive Physical Assessment (CPA) form for all youth admitted into the program. A review of seven youth Individual Healthcare Records (IHCRs) validated the program utilizes the Department's standardized CPA form. All CPAs were completed within seven days of the youth's admission by the designated health authority (DHA) and/or the designee. Each of the seven reviewed CPAs had documentation of an "O" for each completed portion. Each reviewed record did not contain an "X" on portions of the form requiring comment. All reviewed CPAs did not complete sections numbers nineteen through twenty-two, twenty-five, and twenty-six and the DHA documented "Deferred, age inappropriate". None of the youth refused any portion of the examination. Each CPA documented the youth's medical grade and visual acuity test results. All seven youth IHCRs included documentation to support a Tuberculin Skin Test (TST) was completed within the last year and the results was recorded on the CPA and Infectious and Communicable Disease (ICD) form. The youth were assessed prior to placement in the general population. None of the youth required further testing or procedures. Reviewed documentation validated the Department's Problem List was updated for each youth throughout their stay, when applicable. During an interview, the health service administrator confirmed the CPA form is completed within seven days by the DHA and each youth is screened for tuberculosis 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 (STIs) and HIV risk factors.	

The program has a written policy and procedures ensuring all youth admitted shall be clinically screened and medically evaluated for sexually transmitted infections (STIs) and human immunodeficiency virus (HIV). Seven youth Individual Healthcare Records (IHCRs) were reviewed and documentation supported each youth was screened for STI upon admission. Each

youth was referred to the designated health authority (DHA) for further evaluation. Testing was ordered and performed for each youth within twenty-four hours. Test results were filed in the lab section of the IHCR and the screening results were documented on the Department's Infectious and Communicable Disease (ICD) form. There were no applicable youth who were out of the Department's custody for over thirty days and/or required a rescreening due to symptoms present. A review of seven youth IHCR found each youth was offered the opportunity to receive counseling and testing for HIV. Four youth consented to receive counseling and testing. Each youth signed the Department's HIV Antibody Test Youth Consent form. Three youth indicated they did not consent on the Department's HIV Antibody Test Youth Consent form. All applicable youth received pre-counseling, testing, and post-counseling services. The program's DHA is authorized to provide pre-counseling, testing, and post-counseling. Reviewed IHCRs validated when youth receive pre-counseling, testing, and post-counseling, the youth's Health Education Record was updated. The results were placed in a sealed envelope marked 'Confidential' with the youth 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 receive testing. Seven youth were interviewed and indicated they can request a HIV test while in the program.

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 ensuring all youth shall be able to make Sick Call requests and have their complaints treated appropriately through the Sick Call system. During a tour of the program, the annual compliance review team observed Sick Call Request forms posted within the cottages. The program's practice is to have youth complete a Sick Call Request utilizing the Sick Call Request form and submitting them 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. The program conducts Sick Call 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. Sick call care is provided by licensed healthcare professionals, pursuant to their scope of practice and according to protocols approved by the designated health authority (DHA). The program also provides a Non-Healthcare Medical and Emergency Protocol Guide for staff to utilize when nursing staff are not on-site. The program currently has all shift supervisors trained on the Sick Call Process. The DHA is on-call seven days a week, twenty-four hours a day for consultation. All staff have access to call 9-1-1 if they feel a youth requires emergency care. Seven youth Individual Healthcare Records (IHCRs) were reviewed and reflected each youth completed a Sick Call Request form at least once during their stay. Documentation confirmed the registered nurse (RN) conducted all sick calls reviewed. Sick call treatment and services provided are documented on the Sick Call Request form and maintained in each youth's IHCR. There were no applicable youth who presented a similar Sick Call complaint three or more times within a two-week period. All sick calls were documented on the Department's Sick Call Index and on the Sick Call Referral Log. The program does not utilize restricted housing. An observation of one sick call encounter indicated the youth are assessed in the medical clinic by the RN. The youth provided verbal consent for the regional monitor to observe the Sick Call Process. The youth was seen in a private area within the medical clinic on an exam table. The direct care staff

stood by the door inside the clinic during the assessment. Seven interviewed staff indicated the nursing staff conduct Sick Call. One interviewed youth indicated they can see the nurse immediately and four youth reported within one day of submitting a Sick Call Request. Two youth indicated they are seen within three days of submitting a Sick Call Request.

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 has a written policy and procedures ensuring there is a written plan to provide twenty-four-hour emergency medical, mental health, and dental care to youth, as needed. The program maintains four automated external defibrillator (AED), twelve first aid kits, and eight suicide response kits containing a knife-for-life, wire cutters, and needle nose pliers. The AED were observed in the administration, maintenance, gymnasium, and the case management offices. The AED provides audio instructions on step-by-step procedures. The health service administrator (HSA) demonstrated the AEDs and validated each AED was working properly. The suicide kits were located on all cottages, the kitchen, and the case management office. The first aid kits and suicide response kits are checked weekly and the AED is checked monthly by nursing staff. During the annual compliance review, three first aid kits were inspected, and each contained the required items. Episodic care is provided by the nurse and documented in the progress chronological notes and tracked on the Episodic Care Log. 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 seven youth Individual Healthcare Records (IHCRs) found five applicable youth requiring 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/or emergency care incidents by date, name of youth, Department identification number, injury/emergency, treatment rendered, registered nurse initials, and whether the youth was referred to the designated health authority (DHA) on the log. An interview with the HSA confirmed this practice. 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 seven staff training records supported each maintained a current certification in first aid and cardiopulmonary resuscitation (CPR). In addition, all nursing staff maintained current certifications in CPR. Training records also supported supervisory staff were trained in assisting youth in self-administration of the epinephrine auto-injector. Seven interviewed youth indicated they can see a doctor and/or dentist if needed. Four interviewed staff indicated they are personally allowed to call 9-1-1 if a youth has a medical emergency. Three staff indicated they are required to notify master control and master control staff will contact 9-1-1.

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 to provide timely referrals, coordination, and documentation of medical services to off-site health care providers for youth with emergent or non-emergent needs. The Summary of Off-Site Care form is utilized for youth requiring off-site medical or emergency care, and the completed form is filed in the youth's Individual Healthcare

Record (IHCR). Once the youth returns to the program the registered nursing staff reviews all notes and orders and notifies the designated health authority (DHA). The DHA then signs and dates all off-site care documentation during the next on-site visit. A review of seven IHCRs reflected three youth were applicable for receipt of off-site care. Parental notification was documented when applicable. The Summary of Off-Site Care form was completed for each applicable youth and was filed in the IHCR. Reviewed documentation supported the DHA reviewed each completed Off-Site Care form and applicable discharge paperwork as evidenced by the DHA signature and date. All three applicable youth required follow-up care and there was evidence the referrals were tracked, and the youth received the appropriate care as needed. An informal interview with the health service administrator indicated the registered nurse tracks follow-up testing, referrals, and appointments.

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 chronic illnesses receive regularly scheduled evaluations with the required follow-up. A review of seven youth Individual Healthcare Records (IHCRs) indicated three youth were admitted with an identified chronic condition as documented on the Facility Entry Physical Health Screening form. All three youth were classified with a medical grade two to five. There were two youth undergoing treatment for a 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. One youth IHCR found there was indication of a missed periodic evaluation for the month of December 2019. The health service administrator (HSA) provided documentation of the youth's evaluation; however, the document did not notate if the youth was seen for a periodic evaluation. All on-site evaluations were maintained in the IHCR chronological progress notes and treatment orders were clearly written. All three IHCRs documented updating of the Department's Problem List as changes occurred. The designated health authority (DHA) reported youth with chronic conditions are evaluated every sixty days and as needed. An interview with the HSA also confirmed the practice.

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 seven youth Individual Healthcare Records (IHCRs) indicated one youth was admitted into the program on prescribed medication. The program provided two additional youth IHCRs for review. Each applicable IHCR included a

designated health authority (DHA) Notification of Admission form, which documented current prescribed medication and verbal notification by telephone to continue medication was also received on the day of admission. Documentation showed the DHA or psychiatrist resumed the prescribed medication for each youth. There were no instances when a youth's medication could not be verified and had to be returned to the youth's parent/guardian. Reviewed documentation supported all medications had a current, valid order, and were given pursuant to a current practitioner's order. Reviewed Medication Administration Records (MARs) validated the practice. Each reviewed MAR documented the youth's name, Department identification number, date of birth, youth allergies, precautions, side effects, medical grade, and an attached copy of a current picture of the youth. All three youth were taking prescribed medications upon admission and the initial MAR matched the medication listed. The youth's MAR and/or Individual Controlled Medication Inventory Record is updated after each administration. 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 registered nurses (RNs) 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. Observations during the annual compliance review found the medication cart was clean and well organized and all medications were securely stored in the medical clinic inaccessible to youth. All controlled medications were stored in a separate, secure box located in a locked medication cart. Oral medications were not stored with injectable or topical medications. The program maintains a locked refrigerator for medications requiring refrigeration. Observations of medication administration confirmed the nursing staff maintained the Six Rights of Medication Delivery/Administration. The youth approached the nurse and the nurse then prepared the medication by removing it from a blister pack and placing in a small medication cup and handed the medication to the youth with a small cup of water to self-administer. The nurse and the direct care staff both swabbed the youth's mouth and had the youth cough to ensure the medication was swallowed. Seven interviewed staff indicated nursing staff administer medication, three staff also reported the shift supervisors also administer medication. Six interviewed youth reported the nurse administers medication and one youth reported not taking 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 regarding requirements for the storage and inventory of medications and sharps ensuring all medication is inaccessible to youth at the program. Observations during the annual compliance review week found all medications were securely stored in the medical clinic inaccessible to youth. All non-controlled medications were stored in a separate, secure, locked medication cart and a small amount of over-the-counter medications were placed in a black tackle box on the wall of the clinic. The program securely stored sharps and syringes separate from medications. Three over-the-counter (OTC) medications were reviewed and inventories were accurate. Three sharps were reviewed and inventories were accurate. Three youth prescribed with narcotic or controlled medications found the inventories were accurate. The program practice is to store the controlled medications in a locked box located in the locked medication cart. Oral medications were not stored with injectable or topical medications. The medications are in blister packs documenting the number of pills in each prescription order. The program contracts with 1st Choice Pharmacy and a State of Florida licensed consultant pharmacist. The program's pharmacy license issued through the

Department of Health, Division of Quality Assurance, expires on February 28, 2021. The consultant pharmacist's license expires December 31, 2020. The program's process for the disposal of medication is for all medications to be disposed in the physical presence of the consultant pharmacist utilizing the Rx Destroyer Pharmaceutical Disposal System. 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. A review of the program's counts from the past six months found no discrepancies. Perpetual inventories with running balances are maintained on all controlled substances with a shift-to-shift inventory conducted by two registered nurses (RNs). Sharps are counted through a perpetual inventory and are verified weekly. During an informal interview, the health service administrator was able to explain the reporting criteria and procedures for inventory discrepancies in its entirety.

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 exposure control and infection control ensuring staff, youth, volunteers, and visitors are not exposed to infectious and communicable diseases. The infection control plan includes prevention, containment, treatment, and reporting requirements related to infectious diseases, as outlined in the Occupational Safety and Health Administration (OSHA) federal regulations and guidelines. The plan was reviewed and approved by the facility administrator (FA) on July 9, 2019, the previous designated health authority (DHA) on June 10, 2019, the corporate medical doctor (MD) on August 22, 2019, and the current DHA on October 21, 2019. The infection control procedures include common, infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, and tuberculosis. In addition, the plan includes Hepatitis A, B, C, and human immunodeficiency virus (HIV) infectious diseases caused by blood-borne pathogens. The plan outline outbreaks in pediculosis and/or scabies, outbreaks or epidemics caused by other infectious agents, food-borne illnesses, bio-terrorist's agents, chemical exposures, Methicillin-Resistant Staphylococcus Aureus (MRSA), and other emerging antibiotic-resistant micro-organisms. The program maintains procedures for staff to adhere to universal precautions, and the program provides staff with the opportunity for Hepatitis B immunizations and access to protective equipment. The program reports there were no incidents involving a contagious disease requiring the quarantining or hospitalization of at least ten percent of the total population of youth or staff or six individuals, which ever number is less. The program's plan has a comprehensive process for needle stick post-exposure evaluation. In the event of an incident, the FA has a process in place to establish a separate file containing all documents for youth and staff who have experienced a facility or occupational exposure. There were no documented instances of staff having experienced a facility or occupational exposure

since the last annual compliance review. 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

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 has a written policy and procedures to ensure youth are supervised and the appropriate staff to youth ratio is maintained. The program promotes safety and security by maintaining active supervision of youth to include interacting positively with youth, engaging youth in a full schedule of constructive activities, closely observe behavior of youth and change inappropriate behavior, and consistently apply the program's positive performance system. The program conducts formal and informal head counts throughout the day. A review of the program logbooks for the past six months verified head counts and movements are conducted and documented by master control. Observation of staff supervision for four days during the annual compliance review week included movement from classroom to cafeteria, from classroom to living cottages, and from classroom to classroom. During the observations, staff were actively supervising youth and strategically situated to visibly see youth and respond to any emergency. According to the program's contract, staff to youth ratio of one to eight during awake hours was observed and were in compliance. Prior to any movement, staff informed master control, by way of two-way radio, of the count. Once the count is confirmed, youth are moved to the designated area. An informal interview with direct care staff indicated all knew how many youth under their supervision without counting and knew what to do when the count cannot be reconciled. Seven staff were formally interviewed and were able to explain when youth counts are conducted and what happens when there is a discrepancy, including emergency counts.

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 has a written policy and procedures addressing the implementation and training of the program's behavioral management system (BMS) which has not changed since the last annual compliance review. The program has a clearly written BMS which is a multi-level system designed to enhance the youth treatment, increase healthy, pro-social behavior using reinforcing and decreasing unhealthy behaviors through natural consequences. A review of seven staff training records for pre-service training and seven for in-service training indicated one staff was not trained on the BMS for pre-service training and three staff were not trained on the BMS for in-service training. A review of training documentation verified teachers were trained in the implementation of the BMS on April 20, 2018. A review of the Youth Handbook indicated the BMS is included. A review of seven youth records indicated each received an orientation informing the youth of the BMS to include youth expectations, responsibilities, and consequences. Observation of the youth cottages indicated the BMS is posted to reflect youth

who have earned daily and weekly incentives. Observation, during school and lunch, of staff interaction with youth indicated staff adhered to the BMS, addressing a ratio of four to one positive to negative consequences when redirecting the youth, as indicated in the program's policy. An interview with the facility administrator indicated youth receive an informal and formal treatment team meeting each month. Youth, who require one, receive a special treatment team for program violations. Seven staff were interviewed and 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. Seven youth were interviewed and were informed of the consequences used in the program and described the process for receiving consequences. Seven youth were interviewed and six were able to explain the difference between the levels, how to move from one level to the next, and about the rewards used in the program's BMS. One youth stated they did not know the BMS procedures.

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

The program has a written policy and procedures to ensure staff are provided feedback regarding the implementation of the behavioral management system (BMS). 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 has a process during weekly treatment team meetings for staff to explain to the youth the reason for any imposed sanctions. Youth are also given an opportunity during this process to explain their behavior. A special treatment team meeting is held when those youth whose behavior require immediate intervention is required. The program does not utilize room restriction for major infractions. A random review of seven staff program descriptions indicated BMS implementation is addressed as a part of the staff daily functions. An interview with the facility administrator indicated the BMS is monitored to ensure all staff having direct contact with youth, have access to a Youth Handbook which describes the positive performance system, program rules and the progressive disciplinary system for the youth. The Youth Handbook is updated as necessary when changes or modifications are made to the system. Staff having direct contact with youth are trained in the implementation of the positive performance system, to include the principles who serve as the basis for the positive performance system complete pre-service training. On-going training is provided related to the positive performance system as needed and appropriate, during monthly all staff meetings. Seven youth were interviewed and were able to explain the difference between the levels, how to move from one level to the next, and about the rewards used in the program. Seven interviewed youth stated youth are not allowed to punish other youth. Five were able to explain how staff are consistent in the use of rewards and two reported they did not know. Seven staff were interviewed and asked how supervisors give feedback regarding the implementation of the BMS. Six staff stated feedback is given during briefings and staff meetings. One staff stated

supervisors do not give feedback. Seven youth were interviewed on how they rate the BMS. Two stated very good, two stated good, two stated fair, and one stated poor.

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

The program has a written policy and procedures in place for ten-minute checks when youth are in their room for sleeping or for non-punishment reasons. The program has a total of seventy-two recording video cameras with each being operable and capable of recording thirty-days of video footage. Staff are required to check each occupied room every ten-minutes when youth are in their sleeping quarters. Staff are not allowed in a youth's room; however, they are to ensure skin, or a body part is seen to confirm the youth's presence. Staff will document the actual time of the room check and initial on the Ten-Minute Check Log sheets verifying who completed the room check. If a youth is not in their room, an "X" is marked in the box. Supervisors are required to conduct three room checks and visibly see flesh of each youth in their room. Supervisors then document, in red ink, on the Ten-Minute Log sheets to include the time of the check and initials. The living units consist of six cottages which are named Adams, Carver, Johnson, Koger, Marshall, and Robinson, with each containing camera surveillance. According to the facility administrator (FA), Marshall cottage is currently not in use. A review of ten Ten-Minute Check Logs from ten different days, along with the corresponding video footage from each occupied living cottage, indicated checks were not consistently conducted as documented on the Ten-Minute Check Logs. A review of ten-minute checks for Robinson cottage from 4:00 a.m. to 5:00 a.m. on February 3, 2020 indicated staff completed a check at 4:15 a.m. and did not complete the next check until 4:30 a.m.; however, the staff documented a check was conducted at 4:21 a.m. A review of ten-minute checks for Johnson cottage from 4:00 a.m. to 5:00 a.m. on February 11, 2020 indicated staff competed a check at 4:15 a.m. and did not complete the next check until 4:27 a.m.; however, the staff documented a check was completed at 4:21 a.m. Both incidents were called into the Department's Central Communications Center by the FA. Seven staff were interviewed, and four indicated room checks are conducted every ten-minutes, two stated every seven minutes, and one stated every five 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 has a written policy and procedures to track youth daily census. The program tracks daily census information to include the daily count, new admissions, releases, youth temporarily away from the program, transfers, and direct discharges. Youth are accounted for at all times by a physical count and random head counts when requested by master control. Random review of the facility logbooks for the past six months contained documentation of youth counts at the beginning of each shift, after outdoor activities, and movement from school and groups. Documentation in the logbooks also included youth temporarily away from the program, missed counts, emergency counts, and reconciliation of the count. The program maintains an approved escape response plan 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. A review of the Department's Central Communications Center (CCC) reports indicated the program had an attempted escape since the last annual compliance review. A review of the CCC report coupled with the logbook entry indicated the program initiated the escape plan and conducted an emergency count. Observation of youth count during the annual compliance review week indicated prior to any youth movement, staff contact master control using a two-way radio to communicate the number of youth being moved and to what location. An informal interview with five 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. Seven staff were interviewed and were able to explain 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 has a written policy and procedures for logbook documentation. Master control maintains a permanently bound logbook with sequentially numbered pages. The master control

operator documents 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, and supervisors are able to leave special instructions pertaining to supervision of youth. Each entry is made in ink with no erasures or white-out. A review of logbooks for the past six months indicated errors are not consistently struck threw with a single line and are not initialed by the staff correcting the error. Supervisors conduct staff briefings prior to the beginning of each shift, and it is documented on the daily shift report. Incoming staff are briefed on the previous shift and sign the shift report to acknowledge information has been shared. A review of the program's shift reports indicated information is shared with incoming staff prior to the beginning of the shift. An informal interview with four staff verified 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 has a written policy and procedures for assignment, inventory, tracking, and storage of program keys. The program has a Daily Key Log to track keys. The log indicates the name of staff and what type of key they are to be assigned according to their position. Program keys are maintained in mater control in a locked key box with limited access. Keys are bound on a tamper resistant color-coded ring which includes a brass colored tag with the initials of staff positions and a tracking number. Medical staff keys are maintained in a separate locked key box to ensure the appropriate staff are issued the correct keys. When staff arrive to work, they gain access to the program by way of master control. Staff will submit their personal keys and receive a program key. Staff would sign the key log acknowledging receipt of the keys. Personal keys are placed in the key box next to the corresponding staff's name. Observation 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 also has a list of staff who are assigned permanent keys. Permanent keys are issued, and staff sign an acknowledgment form indicating a key identification number and the number of keys issued. Master control staff complete a daily inventory of program keys. A random review of key inventory documentation for the past six months verified this practice. A random check of three staff indicated none had personal keys on their person. An interview with the master control operator indicated if keys are lost, all program movement is stopped, and a search is conducted. If the keys have not been found within two hours, a call to the Department's Central Communications Center (CCC) is made. A review of CCC incident reports since the last annual compliance review verified there were two separate incidents were program keys were lost or missing. In each instance, the CCC was contacted as required. Seven staff were interviewed and were able to explain the program's key control process including how keys are assigned, reconciled, the process for missing or lost keys, damaged keys, and restricted keys.

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 has a written policy and procedures which identifies a list of unauthorized and illegal contraband and how it is to be disposed. Youth are notified through the program's Youth Handbook of unauthorized and prohibited contraband and the consequences of possessing contraband. Each parent/guardian is also provided a Parent Handbook which explains what is considered unauthorized and prohibited contraband. Visitors are also notified of unauthorized and prohibited contraband during visitation. A review of the program's policy, Youth Handbook, Parent Handbook, and visitor contraband list verified a list of unauthorized items are indicated. The program conducts search of rooms on each of the two shifts and document on a contraband report of any contraband found. The staff would list the contraband found by the youth's name, indicate if it is contraband or unauthorized contraband, and how it was discarded. A random review of daily search reports for the past six months verified this practice. The program also conducts perimeter checks on each shift. A review of the program logbooks for the past six months indicated perimeter searches are 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. Seven 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 has a written policy and procedures to ensure searches and full body visual searches are conducted according to Florida Administrative Code. Youth are searched at the time of admission, after off campus activity, and visitation. Searches are conducted by two staff of the same gender as the youth searched and are conducted in a private area. 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, transport, group, outdoor recreation, and meals. Youth who are a new admission, re-admission, returning from visitation, returning from off campus, suspected of contraband, or a security risk are searched prior to returning to the general population. Observation of searches was conducted of after school, after vocational classes, after meals, after group, and during transport indicated searches are 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 and reflect trauma informed practices. Seven youth were interviewed and indicated searches are conducted when returning from off campus, after outdoor activities, when items are missing, after visitation, after meals, and after work detail. Seven 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 has a written policy and procedures to ensure vehicles used to transport youth are properly maintained. The program has two operable vans to transport youth. Inspection of both vehicles verified each had a safety screen and doors which could not be open from inside the passenger area. Each vehicle received an annual safety inspection. Both observed vehicles are equipped with an up-to-date fire extinguisher and first aid kit, a seatbelt cutter, window punch, and operable seatbelts for each passenger. An informal interview with transportation staff indicated all passengers wear seatbelts. The youth are secured first by the staff and then staff are secured. Observations of a transport verified this practice. The program's practice is when program vehicles and personal vehicles are not occupied, they remain secured. Observations of both program vehicles and twenty-two personal vehicles verified they were secured. 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 verified each vehicle received an annual safety inspection. Seven staff were interviewed on the type of communication devices are provided to staff during transport. Six staff stated a cellular telephone is provided, of which one staff commented is old and does not work. When the interview results were shared with the facility administrator (FA) during the review, the FA reported all phones are checked and are functional. One staff reported not conducting transports. Seven interviewed staff stated staff are not allowed to use their personal vehicles to transport youth.

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 has a written policy and procedures to ensure the safe secure transportation of youth and staff. The program has two operable vehicles to transport youth. Inspection of both vehicles verified each had an up-to-date fire extinguisher, first aid kit, seatbelt cutter and window

punch. First aid kits remain in the mater control area until ready for use. Staff are not permitted to leave a youth unattended in a vehicle and youth are not permitted to drive the program or staff vehicles. The program maintains a list of staff who have an eligible driver's license which is updated monthly and signed by the facility administrator. The program also provides a ratio of one staff to five youth during transport. Transporters are provided a fully charged cellular telephone to communicate during emergency situations. Observation of a transport verified the ratio of staff to youth was in compliance, the youth were supervised and not attached to any part of the vehicle, and the youth and staff utilized seatbelts. Seven staff were interviewed on the type of communication devices provided to staff during transport. Six staff stated a cellular telephone is provided, of which one staff commented is old and does not work. When the interview results were shared with the facility administrator (FA) during the review, the FA reported all phones are checked and are functional. One staff reported not conducting transports. Seven interviewed staff stated staff are not allowed to use their personal vehicles to transport youth.

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

The program has 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. Weekly safety and security audits are conducted by the facility administrator (FA) or designee and documented on the safety and security audit inspection form. Deficiencies are addressed on the form and a work order is submitted to the appropriate staff for corrections. Deficiencies are also discussed during the morning managers meeting. A review of safety and security audits for the past six months indicated there were two separate incidents which identified deficiencies. Youth bathrooms for each of the five youth-living cottage were identified on July 2, 2019 of having mold. The other deficiency identified on July 1, 2019 identified the hallway storage closet in Koger cottage was unable to be secured. A work order was submitted on July 24, 2019 for both deficiencies. The mildew deficiency was corrected on July 26, 2019; however, the mildew deficiency continued to be identified for six months even though the deficiency was corrected. The hallway storage door in cottage deficiency was corrected on July 26, 2019; however, the deficiency continued to be identified for two months even though it was corrected. Supervisors also conduct perimeter checks and are documented in the program's logbook. Checks are conducted on each shift. A random review of the program's logbooks verified this practice. An interview with the FA indicated deficiencies are noted by staff or walk-throughs conducted by supervisors, cottage managers, or the FA. Work orders are then written and approved by the FA and then given to maintenance. During daily morning management meetings, maintenance reviews the work order tracker and discuss which ones have been completed and which ones are still outstanding.

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

The program has a written policy and procedures for tool management. The policy addresses storing and inventory of tools as well as class type. The program maintenance tools are kept in the carpenter's shop located off-site and a daily tool inventory is kept on each tool when the shop is in use. Tools are organized on a shadow board in a locked cabinet with a list of each

tool located on the outside. All tools are classified as Class A list tools by the program. Mechanic tools are kept locked in the mechanic shop inaccessible to youth. Each tool is labeled and inventoried daily. An inventory of each tool is listed on the outside of the storage cabinet. Review of the inventory list for both carpenter and mechanic tools verified there were no missing tools. Observation of areas for carpenter and mechanic tools indicates the area was clean and neat. An interview with maintenance staff confirms youth are not allowed to utilize tools. Kitchen tools and knives are stored in a locked cabinet inside the kitchen with limited access to kitchen staff. Each tool is numbered for easy identification. A review of the daily inventory logs for the past six months indicated kitchen tools are inventoried three times a day. Class B tools are stored in each living cottage in a designated locked closet. An inventory list is posted on the inside of the door indicating the tools and how many are stored. A review of the inventory verified the tools were listed and each accounted for. The Home Builders Institute (HBI) provides carpentry vocational instructions to the youth who are eligible. The HBI tools are maintained in two secured cabinets accessible only by the HBI instructor. An inventory list is maintained to include sign-in and sign-out sheets. A review of the tool inventory verified each tool is marked with a number, identified on the inventory list, and inventoried daily. The Okeechobee County School District has mechanic tools which were used for the diesel mechanic vocational course. The program ended on August 2018 and the tools have not been used by the youth or staff since. Observation of the mechanic tools indicated an inventory list is maintained which includes a corresponding number for each tool. An observation of the tools indicated they are not marked for easy identification. Some tools are identified with engraved numbers and some are not. A cross-reference of the tools using the inventory list and comparing it to the engraved number on the tool indicated it was not the same number identified on the inventory list. A review of the inventory sheets for the past six months indicated the tools were inventoried monthly except for the months of October and November 2019. During the annual compliance review week, the tools were removed from the program and stored in the maintenance shed, located outside the secure area of the program. Seven 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 has a written policy and procedures in place for youth tool handling and supervision. The program provides a ratio of one staff to five youth. A storage closet, which includes a broom, mop, mop bucket, plunger and dust pan, is designated for each of the living cottages. 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 seven youth case management records verified risk assessments are completed and identify if a youth is eligible to handle tools. A review of seven staff in-service training records indicated each were trained in the use of tools. The program also has a vocational program operated by the Home Builders Institute (HBI) were youth utilize Class A tools. A review of seven youth enrolled in the vocational program indicated each had an up-to-date risk assessment indicating they are eligible to handle tools. Seven staff were interviewed and stated youth are allowed to use scrub brushes, mops, and brooms. Seven youth were interviewed and each stated they are allowed to use mops and brooms. In addition to the mops and brooms, one youth in the Home Builders Institute (HBI) program stated he can use a screw driver and a hammer.

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

The program has a written policy and procedures establishing guidelines for outside contractors prior to beginning any work in the program. When a contractor arrives on campus, they sign the contractors sign-in log, are provided a visitor's contraband list outlining unauthorized items, and review and sign the contractor guidelines. A tool 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 is obtained by the facility administrator (FA) or designee. A review of the contractor's sign-in sheet, contractor's guidelines coupled with the corresponding work invoices verified the contractors provided the service on the same date. An interview with the physical plant manager indicated while work is completed, youth are not allowed in the vicinity of the work area. A maintenance staff is assigned to the work area to ensure the work is completed and all tools are accounted for. The work area is inspected for utilization.

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's Continuity of Operations Plan (COOP) which addresses fire, safety, and evacuation emergency drill are to be conducted monthly, at random times, and under varied conditions. Drills are documented on the program's drill form which identifies the type of drill, date and time of the drill, participants involved, a brief scenario, and supervisor recommendations. A review of program drills conducted since the last annual compliance review verified drills were performed on both shifts and included all staff on duty. The forms also included debriefing recommendations and feedback on how the drills were performed. Observation of the program during the annual compliance review indicated egress plans are posted throughout the program and in each living cottage. Observation of fire extinguishers indicated they were up-to date and the location of each extinguisher was identified on the egress plans. An interview with the facility administrator (FA) indicated COOP and fire drills are conducted monthly. Seven youth were interviewed, and six indicated they have been instructed on what to do in the case of an emergency. One youth stated he was not instructed. Seven youth were interviewed on how often drills are conducted. One youth stated once a month, one stated weekly, one did not know, one stated not very much, one stated he has not been involved in a fire drill since admitted in the program, and one stated he has been in the program for eight months and only been involved in one drill.

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 has a Continuity of Operations Plan (COOP) which identifies a coordinated disaster plan. The plan provides for a continuity of mission essential functions across a wide range of potential emergency situations. A review of the COOP verified the plan was submitted and approved by the Department on May 17, 2019. Further review of the COOP indicated alternative housing plans if the program must be vacated due to an emergency or disaster. The program maintains the required critical identifying information for each youth in an administrative hard-copy records which is easily accessible and mobile in the event of an emergency. An interview with the facility administrator (FA) indicated a copy of the COOP is in master control, the administration building and the medical office. Seven 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.

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

The program has a written policy and procedures for the storage and inventory of flammable, poisonous and toxic materials. Toxics are stored off-site in the locked maintenance shed. A list of staff who are authorized to use chemicals are posted on the outside of the storage door. All caustic materials are stored according to type and use. A Safety Data Sheet (SDS) binder is kept inside the storage area with a picture of each material and a number corresponding to the SDS for each chemical. A random selection of chemicals verified the number on the chemical matched the number on the appropriate SDS. A perpetual chemical inventory list is maintained and checked daily. A review of the inventory list for the past six months verified this practice. The program also has a chemical daily usage log used to track all toxics when in use by authorized staff. The form identifies the chemical number, description, amount used, amount remaining, date chemical is used, and initial of staff using the chemical. Observation of the storage area indicated it is clearly marked hazardous chemicals, items were neatly stored on metal shelving, and the storage was securely locked. Flammable items are stored in a metal cabinet clearly marked as flammable items. Chemicals used to clean the living cottages are stored in a central location with limited access. When a chemical is needed, an authorized staff supplies the chemical to the living cottage. An inventory sheet is maintained and documents the daily use. Observations of the chemical storage closet verified the stored chemicals matched the inventory list.

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 has a written policy and procedures to ensure youth do not handle poisonous, flammable, and toxic items and materials. Authorized staff maintain control over all flammable, poisonous, toxic items off-site with limited access. When needed, authorized staff will obtain a supply of chemicals used to clean the living cottages from the supply closet. A sign out chemical log is maintained within the closet. A review of the logs verified staff sign out chemicals when in use. Youth are not allowed to possess flammable, poisonous, toxic and caustic items. When necessary, staff will spray the chemical and youth will wipe it up. Youth are not permitted to clean any chemical spills, handle, or dispose of any person's biohazardous human waist. Seven youth were interviewed and asked if they handle any chemicals. Six youth stated they do not handle chemicals. One stated they handle paint for art work. The program maintains a schedule for garbage removal, pest control, and program maintenance. Visual inspections are conducted weekly by the facility administrator (FA). Deficiencies are documented on a work order to have the issue resolved. Once the issue has been corrected, the date of correction is indicated on the work order. A review of random work orders verified this practice.

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 has a written policy and procedures to ensure all flammable, toxic, caustic, and poisonous items are disposed appropriately. All unused hazardous materials are kept in the locked storage shed located off campus and are disposed of according to the Safety Data Sheet (SDS). The program has a list of staff who are authorized to dispose of unused flammable, poisonous, toxic materials. An interview with the physical plant manager indicated the program disposes of unused chemicals during Amnesty Day which is a day set bi-annually by Okeechobee County Waste Management for the disposal of such materials. Signed documentation from the county is received indicating 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 KRK Enterprise Pumping and Plumbing Service.

Reviewed invoicing verified the grease trap was last serviced on January 9, 2020. All chemical spills are reported to master control and the shift supervisor immediately. An evacuation of the affected area is conducted and a determination by the facility administrator (FA) whether to contact outside assistance to contain the spill is made. Staff and youth are not allowed to return to the affected area until it has been deemed safe by a qualified professional. An informal interview with the FA 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 has a written policy and procedures ensuring youth have visitation and communication with family members to re-establish family and community relationships. Youth are informed of visitation upon admission during the orientation process. Each youth is provided a Youth Handbook which outlines visitation, telephone calls, and mail correspondence. The

program encourages visitation from the parents/guardians by forwarding 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 the youth's case management records and updated as needed. Youth are permitted five approved individuals for telephone calls to include parent/guardian, grandparents, siblings, aunts/uncles, cousins, mother of the youth's child, and juvenile probation officer when applicable. Youth are permitted a ten-minute telephone call and can exceed beyond the length at times. Youth are permitted to visit with the parent/guardian, grandparents, siblings, and step-parents unless prohibited by a court order. Further review of the program's policy indicates procedures when a person is denied visitation or correspondence with a youth. A review of seven youth case management records verified each record contained an approved correspondence, visitation, and telephone log. Visitation is held in the cafeteria on Saturdays from 1:00 p.m. to 4:00 p.m. Special visitations are also provided for those parent/guardians who are unable to participate in the regularly scheduled visitation day. A review of the program logbooks for the past six months verified visitation and/or special visitations are conducted as required. Youth are also provided writing materials, and a self-addressed stamped envelope to send letters to approved family members. Youth have unimpeded access with the courts, attorneys, their assigned juvenile probation officer (JPO), and/or their Department of Children and Families case worker. Observation of the living cottages indicated the visitation and telephone schedules were visibly posted. Seven 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 programs 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 programs 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 programs policy, procedure, and practice confirm the program does not use controlled observation; therefore, this indicator rates as non-applicable.

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

The program has a written policy and procedures outlining the guidelines for the creation and review of safety plans for all youth. The program maintains a safety plan on each youth located in each living cottage. Observations of the location indicated it is locked and accessible to staff only. Each plan shall identify warning signs, baseline behaviors, crisis recognition, coping skills, intervention strategies, and debriefing preferences. Each initial plan shall be developed by the multi-disciplinary team, prepared with the youth parent/guardian, and clinical staff, and be completed within fourteen days of admission. The plan will incorporate any recommendations from previous or current clinical assessments and be updated every thirty days. Seven youth safety plans were reviewed. Each contained the required elements and incorporated recommendations from previous or current clinical assessments. Six initial plans were completed within the fourteen-day timeframe of the youth's admission. One was completed seventy-one days late. Five initial plans indicated participation in development by signature of the youth, clinical staff and treatment team members. One youth initial plan had only the youth's signature and the second initial plan had no signatures. None of the reviewed initial plans indicated the parent/guardian participated in the development of the plan. Each of the seven reviewed plan indicated the youth received updated safety plans every thirty-days; however, the plans were not consistently indicating the treatment team, clinical staff, or the youth participated. One youth had two updated plans with only the clinical staff signatures. The second youth had three updated plans with only the youth signatures. The third youth had one updated plan with no signatures. The fourth youth had three updated plans each with no signatures. The fifth youth had two updated plans with no signatures. A sixth youth had four updated plans with only the youth and therapist signatures. Additionally, one of the seven youth had a crisis assessment completed on December 24, 2019 due to a family member's death. The updated safety plan dated January 2, 2020 did not indicate any changes to the plan and did not reference the crisis assessment recommendations. Seven youth were interviewed and asked if they were involved in the development of their safety plan. Four stated yes, two stated not sure, and one stated no. Seven staff were interviewed and three knew where the youth safety plans are located, three did not know where, and one stated they are informed verbally about the youth safety plans.