STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Alachua Regional Juvenile Detention Center

Department of Juvenile Justice
(State-Operated)
3440 NE 39th Avenue
Gainesville, Florida 32609

Review Date(s): October 1-4, 2019

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:

Mike Marino, Office of Program Accountability, Lead Reviewer (Standard 1)
Andrea Akins, Volusia Regional Juvenile Detention Center, Assistant Superintendent (Standard 5)
Renette Crosby, Office of Education, Education Specialist (Standard 2)
Delmonica Harris, Duval Regional Juvenile Detention Center, Assistant Superintendent (Standard 2)
Gwen Nelson, Office of Program Accountability, Regional Monitor (Standard 3)
Jennifer Schad, Office of Program Accountability, Regional Monitor (Youth Interviews)
Juan Youman, Office of Program Accountability, Regional Monitor (Standard 4)

Program Name: Alachua Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: Alachua County / Circuit 8
Review Date(s): October 1-4, 2019

MQI Program Code: 89
Contract Number: NA
Number of Beds: 48
Lead Reviewer Code: 37

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 Detention Standards.

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.05 Protective Action Response (PAR)	
2.07 Release	
2.08 Release of Youth Personal Property	

Standard 1: Management Accountability
Detention Rating Profile

Indicator Ratings

Standard 1 - Management Accountability		
1.01	Initial Background Screening*	Satisfactory
1.02	Five-Year Rescreening	Satisfactory
1.03	Staff Code of Conduct	Satisfactory
1.04	Incident Reporting *	Satisfactory
1.05	Protective Action Response (PAR)	Limited
1.06	Pre-Service/Certification Requirements *	Satisfactory
1.07	In-Service Training	Satisfactory
1.08	Entering Alerts(JJIS) and Sharing of Alert Information *	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: Youth Management
Detention Rating Profile

Indicator Ratings

Standard 2 - Assessment and Performance Plan		
2.01	Admission	Satisfactory
2.02	Orientation	Satisfactory
2.03	Classification	Satisfactory
2.04	Notification of JPO Circuit Gang Rep	Satisfactory
2.05	Admission of Youth Personal Property	Satisfactory
2.06	Storage of Youth Personal Property	Satisfactory
2.07	Release	Limited
2.08	Release of Youth Personal Property	Limited
2.09	Release of Meds, Aftercare Instructions	Satisfactory
2.10	Review of Youth in Secure Detention and Home Detention	Satisfactory
2.11	Daily Activity Schedule	Satisfactory
2.12	Adherence to Daily Schedule	Satisfactory
2.13	Educational Access	Satisfactory
2.14	Career Education	Satisfactory
2.15	Behavior Management System	Satisfactory
2.16	Unauthorized Use of Punishment *	Satisfactory
2.17	Grievances	Satisfactory
2.18	Trauma-Informed Care	Satisfactory

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

Indicator Ratings

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

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Standard 4: Health Services
Detention 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 Screening & Rescreening Form	Satisfactory
4.06	Youth Orientation to Healthcare Services/Health Education	Satisfactory
4.07	DHA/Designee Admission Notification	Satisfactory
4.08	Health-Related History	Satisfactory
4.09	Comprehensive Physical Assessment/TB Screening	Satisfactory
4.10	Sexually Transmitted Infection Screening & 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 Conditions/Periodic Evaluations	Satisfactory
4.15	Medication Management	Satisfactory
4.16	Medication/Sharps Inventory and Storage Process	Satisfactory
4.17	Infection Control/Exporsure Control/Education	Satisfactory
4.18	Prenatal Care/Education	Satisfactory

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Standard 5: Safety and Security
Detention Rating Profile

Indicator Ratings

Standard 5 - Safety and Security		
5.01	Active Supervision of Youth *	Satisfactory
5.02	Ten-Minute Checks *	Satisfactory
5.03	Census Counts and Tracking	Satisfactory
5.04	Logbook Maintenance	Satisfactory
5.05	Logbook Reviews	Satisfactory
5.06	Key Control	Satisfactory
5.07	Vehicles and Maintenance	Satisfactory
5.08	Tool Inventory and Management	Satisfactory
5.09	Youth Access & Use of Tools, Cleaning Items *	Satisfactory
5.10	Inventory of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.11	Access to all Flammable, Toxic, Caustic, and Poisonous Items *	Satisfactory
5.12	Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.13	Confinement Under Twenty-Four Hours	Satisfactory
5.14	Confinement Over Twenty-Four Hours	Satisfactory
5.15	Continuity of Operations Planning (COOP) Drills	Satisfactory
5.16	Escape Drills	Satisfactory
5.17	Fire Drills	Satisfactory

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Program Overview

The Alachua Regional Juvenile Detention Center is a state-owned detention facility, operated by the Department, located in Gainesville, Florida. The center serves youth in Alachua, Baker, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee, and Union Counties, over three judicial circuits. Male and female youth who are detained pending adjudication, disposition, or placement in a residential commitment program are housed in the forty-eight-bed center. Youth are provided services which include youth orientation, behavior management, safety and emergency procedures, transportation, mental health, and healthcare services. The center's educational services are provided by the Sequel Youth and Family Services through a contract with the Alachua County School Board. The center's management team includes the superintendent, two assistant superintendents, one administrative assistant, seven juvenile justice detention officer (JJDO) supervisors, and forty-two JJDOs. Mental health and healthcare services are provided through the contracted provider, Maxim Healthcare Services. Mental health services are provided by two full-time licensed mental health professionals, one of whom serves as the designated mental health clinician authority (DMHCA), and a psychiatrist, who provides two hours of services a week. Clinical services provided by the center include mental health and substance abuse evaluations, mental health treatment planning, individual, group, and family therapy, mental health crisis intervention services, on-site psychiatric services, and availability for substance abuse services for youth with co-occurring disorders. Medical services are provided by a medical doctor (MD), who serves as the designated health authority (DHA), a full-time registered nurse (RN), who serves as the clinical manager, a part-time RN, a full-time licensed practical nurse (LPN), three part-time LPNs, a medical records clerk, and a part-time advanced registered nurse practitioner (ARNP). The medical clinic maintains nursing coverage Monday through Friday from 7:00 a.m. to 7:30 p.m. and on Saturdays and Sundays from 8:00 a.m. to 4:30 p.m. Food services are provided by Department staff and include menus, meal planning, meal schedules, special diets, nutritional analysis, daily allowance, food preparation, health certifications, food product standards, sanitation, and cleaning. Staff are responsible for the custody and control of youth in their care, providing youth supervision twenty-four hours a day, seven days a week. The center has four living modules which are divided by male and female. There are seventy-seven security cameras at the center, all of which were operational. The center was clean and free of any noticeable graffiti, odors, or pests. At the time of the annual compliance review, the center had ten vacancies, which included an assistant superintendent, an administrative assistant, a JJDO II, and seven JJDOs.

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.	

Since the last annual compliance review, six direct care staff, one food service staff, and two contracted medical staff required an initial background screening. No volunteers started at the center since the last annual compliance review. An initial background screening was completed prior to each staff's hire date, as required. A pre-assessment tool was administered to the six direct care staff, of which five received a passing score. The remaining direct care staff received additional training and was approved for hire by the Assistant Secretary of Detention Services. The contracted provider for medical and mental health services added their staff to the Clearinghouse employment roster. The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to the Background Screening Unit (BSU) by the center on January 10, 2019 for detention center staff and on December 27, 2018 for education staff.

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.	

Three staff were applicable for a five-year background rescreening. All three staff background rescreenings were completed prior to their anniversary hire date, as required. No volunteers or contracted staff were applicable for a five-year background rescreening.

1.03 Staff Code of Conduct	Satisfactory Compliance

Center staff adheres to a code of conduct prohibiting any form of abuse, profanity, threats, harassment, intimidation, "horseplay," or personal relationships with youth.

Officers shall maintain the confidentiality afforded to all youth and shall not release any information to the general public or the news media about any youth in the center or who has been in the custody of the Department.

Officers shall not verbally abuse, demean or otherwise humiliate any youth, and shall not use profanity in the performance of their job.

Officers shall not engage in or allow horseplay, either verbal or physical with and/or between any youth.

Officers shall not engage in personal relationships nor discuss personal information related to themselves or other officers with any youth.

Management takes immediate action to investigate or address all allegations or violations of the code of conduct.

All staff acknowledge the code of conduct by signature. The center took disciplinary action on five staff for violations of the code of conduct during the annual compliance review period, which included two written reprimands and three oral reprimands. None of the violations were related to abuse towards youth. The superintendent provided documentation showing staff had been nominated for awards.

Seven youth were interviewed. None of the youth said they have ever been stopped from reporting abuse. All youth said staff were respectful when speaking to them or other youth. One of the seven youth reported he/she had heard staff use profanity on occasion. All youth reported they felt safe at the center.

Seven staff were interviewed. Six of seven staff said they have never observed a co-worker using threats, humiliation, or intimidation when interacting with youth. The remaining staff reported seeing this happen once, saying "things got heated between a staff and youth," and the staff was either terminated or resigned as a result. Six of the seven staff reported hearing staff use profanity in front of youth once or occasionally, though all said this has been reduced or stopped recently, which was reflected in youth surveys. When asked about working conditions at the center in the past year, four staff rated working conditions as good, two said fair, and one said poor.

The interview completed by the superintendent stated the code of conduct ensures all communication and interaction between youth and staff and the center and the public are professional and respectful in nature. The superintendent stated the code of conduct provides directions for behaviors considered not acceptable and lists all standards of conduct for state employees.

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

During the past six months, the center reported twenty-seven incidents to the Central Communications Center (CCC). Five CCC incidents were reviewed, finding all were reported within a two-hour time frame and documented in the master control logbook, as required.

Seven staff were interviewed. Each staff said youth are allowed to call the Florida Abuse Hotline or CCC to report suspected abuse and all staff were able to explain the process for facilitating the call. The superintendent stated youth have the right to contact the Florida Abuse Hotline at any time and staff are obligated to report any instances of abuse. The superintendent also stated the CCC is contacted by the supervisor or administration when incidents meeting reporting guidelines occur.

1.05 Protective Action Response (PAR)	Limited Compliance
The center 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 center had fifty-six Protective Action Response (PAR) incidents in the past six months, of which six were reviewed. In all six instances, a PAR report, including statements from all staff involved, was completed by the end of the staff members' workday. None of the PAR incidents included use of mechanical restraints or resulted in serious injury to a youth or staff. None of the youth alleged abuse during these PAR incidents.

The PAR reports were reviewed by a supervisor and PAR instructor; however, four of the six supervisor reviews were documented prior to statements being completed by all staff involved in the PAR incident. Four of the six reports documented a Post-PAR interview conducted with the youth by an administrator or designee within thirty minutes after the incident occurred. In the remaining two reports, the Post-PAR interview was documented five days after the incident in one case and eighteen days after the incident in the other case. The center typically takes youth to the medical clinic after PAR incidents, which was documented in medical records. All PAR reports are required to be reviewed by the superintendent within seventy-two hours of the incident. The superintendent or designee review of the PAR reports was late in four of the six reports reviewed, with the reviews being completed four, seven, eight, and nineteen days late. The center's PAR rate during the annual compliance review period was 6.93, which is below the statewide Detention PAR rate of 11.75.

Seven staff were interviewed, and all said staff try to talk to youth prior to using physical restraints. The superintendent was interviewed and stated any time a PAR occurs and is documented, the Facility Management System (FMS) system generates an e-mail to administrators to notify them of the incident. The superintendent said PAR incidents are reviewed on video and reports are reviewed to ensure documentation supports the actions taken and the use of PAR was reasonable and necessary. The superintendent also reported PAR data is reviewed for behavioral and environmental trends.

1.06 Pre-Service/Certification Requirements (Critical)	Satisfactory Compliance
Staff are trained in accordance with Florida Administrative Code. Detention staff are to complete pre-service/certification requirements specified by Florida Administrative Code within 180 days of hiring.	

Seven staff training records were reviewed for pre-service training. All seven staff completed the required essential skills training prior to contact with youth to include Protective Action Response (PAR), cardiopulmonary resuscitation (CPR)/automated external defibrillator (AED), first aid, mental health and substance abuse services, suicide recognition and intervention, safety and security, Prison Rape Elimination Act (PREA), human trafficking, and detention operations. All seven staff also completed all Phase One training to include orientation, information security awareness, Department of Juvenile Justice (DJJ) and The Law for Detention, gang awareness, professional interaction with the public, quality customer services, supervision of youth, and youth management. Four of the staff were hired within the past 180 days and are pending certification. These four staff are scheduled to attend the academy and complete certification within 180 days of hire. The remaining three staff completed the academy (Phase Two Training) and were certified within 180 days of hire. All training was documented in the Department's Learning Management System (SkillPro).

1.07 In-Service Training	Satisfactory Compliance
All center staff, including food service and maintenance staff, are required to 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. *Supervisory staff must complete eight hours of training (as part of the twenty-four hours of in-service training) in the areas specified in Florida Administrative Code.*	

Seven staff were reviewed for in-service training, including three supervisors. All staff exceeded the annual requirement for twenty-four hours of training, completing between thirty-seven and 112 hours of training. All staff had current cardiopulmonary resuscitation (CPR), first aid, and automated external defibrillators (AED) certifications. Five staff had an eight-hour Protective Action Response (PAR) update and the remaining two staff were certified PAR trainers. All seven staff completed training on professionalism and ethics. Six of the seven staff completed active shooter training. All of the staff completed training on suicide prevention; however, six of seven staff completed only two hours of suicide prevention training in 2018. This was identified by the center and corrected, and all direct care staff in the center received at least six hours of training on suicide prevention in 2019. The three supervisors received at least eight hours of training in management related topics. The center has an annual in-service training calendar, which is updated as changes occur. The center's annual training plan was approved by the Office of Staff Development and Training on January 14, 2019. All in-service training was documented in the Department's Learning Management System (SkillPro).

The superintendent was interviewed and stated they received the following management training: Certified Public Manager (CPM); annual updates on the Family Medical Leave Act (FMLA), Equal Employment Opportunity (EEO), and labor laws; and leadership training during superintendent meetings. The superintendent stated staff must complete annual CPR, AED, and first aid certifications or training, an eight-hour PAR update, and complete all required trainings on the training calendar.

1.08 Entering Alerts (JJIS) and Sharing of Alert Information (Critical)	Satisfactory Compliance

Superintendents shall ensure Critical and Special Alerts are reviewed and responded to appropriately.

Upon completion of the Admission Wizard, the officer shall ensure all Critical and Special Alerts are listed in JJIS.

The JJIS alert report shall be reviewed daily by supervisors and administrators to ensure it correctly reflects the status of youth.

If the electronic system is inoperable, for any reason, the JJDO Supervisor shall ensure the last hard copy of the alerts shall have a written notification or update of the recent admissions or changes to existing alerts on the alert sheet and distribute to all staff within the center immediately.

Medical and mental health staff shall review alerts to ensure each alert is correctly tracked and managed.

The responses and updates by medical, mental health and other staff should be documented in JJIS alerts as they pertain to the specific alert.

JJDOS's shall inform staff of alerts during shift briefing. When a JJDOS receives changes to the alert list, he/she shall notify the staff affected by changes and add the information to the shift briefing for the oncoming shift upon receipt of the information.

Seven youth management, mental health, and healthcare records and the Department's Juvenile Justice Information System (JJIS) were reviewed for alerts. Alerts identified in youth records and those listed in JJIS matched. The center verifies all youth alerts, contacting parents/guardians if necessary. All seven youth reviewed had a medical grade of two to five and had a corresponding alert(s) in JJIS created by nursing staff. Each youth reviewed had a mental health alert created by mental health staff. Medical alerts were discontinued only by nursing staff and mental health alerts were discontinued only by mental health staff. Two youth had security alerts, which were entered by center administration or designees. Security alerts were discontinued by only center administration or designees.

Seven staff were interviewed. All seven staff reported they are informed of youth alerts during shift briefings, stating the alerts are read aloud from the JJIS alert list and all staff receive a copy of the JJIS alert list. Observation of a shift briefing confirmed this process.

Standard 2: Assessment and Performance Plan

2.01 Admission	Satisfactory Compliance

All youth are admitted to the center in accordance with Florida Administrative Code through a process, at a minimum, addressing the following:

1. *Review of required paperwork from law enforcement and screening staff.*
2. *All youth shall be electronically searched, frisk searched, and stripped searched by an officer of the same sex as the youth.*
3. *All youth shall be allowed to place a telephone call at the center's expense to his/her parent/guardian and the call shall be documented on all applicable forms, or document refusal to make a telephone call.*
4. *If the admission process is completed two hours or more before the serving of the next scheduled meal, youth shall be offered something to eat.*
5. *All youth shall be screened to identify medical, mental health, and substance abuse needs.*

The center has a written policy and procedures to ensure youth are admitted to the center in accordance with Florida Administrative Code. Seven youth records were reviewed for admission. All records contained an arrest affidavit/custody order or courtesy hold order, a Detention Risk Assessment Instrument (DRAI), and Suicide Risk Screening Instrument (SRSI). Six records had the admission wizard printed and placed in the record. In the remaining record, the admission wizard was completed in the Department's Juvenile Justice Information System (JJIS), but not printed and placed in the record. Each admission wizard documented youth were frisked, allowed to make a telephone call, electronically searched, stripped searched, and had medical, mental health, and substance abuse screenings. Six of the seven admission wizards documented youth were offered a snack or meal. The annual compliance review team was unable to observe an admission during the review.

2.02 Orientation	Satisfactory Compliance

Program orientation process shall occur within twenty-four hours of a youth being admitted into the center and documented according to Facility Operating Procedures. During the orientation process, youth must be advised, both verbally and in writing, at a minimum, the following:

1. *Center rules and regulations;*
2. *Grievance procedures;*
3. *Visitation;*
4. *Telephone calls;*
5. *Available medical, mental health and substance abuse services and how to access them;*
6. *How to access the Florida Abuse Hotline (or CCC for youth eighteen years old or older);*
7. *Expectations for behavior and related consequences;*
8. *Possible new law violations for destruction of property; and*
9. *Youth rights.*

Seven youth records were reviewed for orientation. Documentation revealed orientation was completed within twenty-four hours of admission to each of the youth, with youth acknowledging the orientation by signature. The orientation process included identification of key personnel, the daily activity schedule, the center's rules and regulations, youth rights, visitation, telephone calls, grievance procedures, access to medical, mental health, and substance abuse services,

access to the Florida Abuse Hotline and Central Communications Center, behavior expectations and related consequences, and possible new law violations for destruction of property. Seven youth were interviewed. All seven youth reported someone provided them with information about the center's rules and regulations, daily schedule, education services, visitation, abuse reporting, and the behavior management system.

2.03 Classification	Satisfactory Compliance

All youth admitted to the center shall be classified to provide the highest level of safety and security. Considerations shall include, at a minimum:

1. *Physical characteristics (e.g. sex, height and weight);*
2. *Age and level of aggressiveness;*
3. *Special needs (mental illness, developmental disabilities, and physical disabilities);*
4. *History of violent behavior;*
5. *Gang affiliation;*
6. *Criminal behavior;*
7. *History of sexual offenses;*
8. *Vulnerability to victimization; and*
9. *Suicide risk identified or suspected.*

Youth shall be assigned to a room based on their classification and are reclassified if changes in behavior or status are observed. Youth with a history of committing sexual offenses or a victim of a sexual offense are not to be placed in a room with any other youth. Youth with a history of violent behavior shall be assigned to rooms where it is least likely they will be able to jeopardize safety and security.

All newly admitted youth are screened to determine if he or she is a criminal street gang member or is affiliated with any criminal street gang. In the event hang involvement is suspected, center staff should enter the "other suspected gang affiliation" alert into JJIS along with as much detailed information within the alert note as possible.

The center has written classification procedures to ensure all youth admitted to the center are classified to provide the highest level of safety and security. Seven youth records were reviewed. Admission wizards were completed in each record, which included a review of the youth's history, sex, height, weight, age, level of aggressiveness, identified special needs, history of sexual offenses, the Victimization and Sexually Aggressive Behavior (VSAB) form, medical, suicide risk identified or suspected, escape, gang affiliation, and security. Two youth were applicable for a history of committing sexual offenses or being a victim of a sexual offense, and each was placed in a single room. Youth were assigned to rooms based on classification procedures. Alerts were entered the Department's Juvenile Justice Information System (JJIS), as applicable.

2.04 Notification of Juvenile Probation Officer Circuit Gang Representative	Satisfactory Compliance
Each center shall identify the juvenile probation officer (JPO) designated as the circuit gang representative to communicate suspected gang activity. *A referral for youth with suspected gang involvement shall be shared, by e-mail, with the circuit gang representative, indicating suspicions of gang activity such as youth flashing gang signs, gang tattoos, gang-related drawings, or related activity.* *Center staff should include in the e-mail pictures (when appropriate), copies of written statements, drawings, graffiti, and a description of what gang signs the youth was "flashing."*	

A review of seven youth records indicated all youth were screened for gang affiliation during intake. Information from intake is passed on to the shift supervisor regarding alleged gang information, and subsequently forwarded to the center's gang representative (currently the superintendent). According to the Juvenile Justice Information System (JJIS), the center has not identified any youth as being gang associated during the review period. The superintendent reported the center shares gang information with the youth's assigned juvenile probation officer (JPO) and local law enforcement. Gang alerts are entered in the Department's Juvenile Justice Information System (JJIS) by detention and probation staff.

2.05 Admission of Youth Personal Property	Satisfactory Compliance
The center takes possession of each youth's personal property during admission. In the presence of each youth, staff inventories all personal property in the youth's possession and records each surrendered item on the Property Receipt Form.	

Seven youth records were reviewed. Each record documented youth property was inventoried by the admitting juvenile justice detention officer (JJDO) and entered into the Department's Juvenile Justice Information System (JJIS). A Property Receipt Form was printed and signed by the youth and JJDO in each record. Youth property is placed in a bag with a copy of the Property Receipt Form and a photo of the youth, and the bag is placed in a secured room. Money and other valuable items are placed in a clear tamper-proof bag and placed in a drop safe, which is under camera surveillance. The tamper-proof bags are labeled with the youth's name, Department identification number, a listing of the items in the bag, and youth and staff signatures. A log is kept to document items placed in the drop safe. All records contained a signed Letter of Acknowledgement regarding unclaimed property. Seven youth were interviewed. Six of the seven youth reported staff checked their personal property and they signed a property receipt upon admission to the center. The remaining youth was a transfer from another detention center and stated his property was inventoried at the previous center. An interview with the superintendent confirmed the process for the receipt of youth property.

2.06 Storage of Youth Personal Property	Satisfactory Compliance
The center safeguards each youth's personal property until it can be returned to the youth and/or parent/guardian.	

Upon entering the center, youth personal property is stored within two separate areas in the center. Youth clothing is stored in a property room with access restricted to supervisors and intake personnel. Valuable property is turned over to the shift supervisor. Valuable property items are secured in a tamper-proof bag and secured in the drop safe, which is under CCTV

surveillance. Currently, only administration and the staff assistant have access to the drop safe. Valuable property is removed daily and stored into the main safe area, which is also under CCTV surveillance. Property bags are listed in binder by date order. Property is purged by the staff assistant after a youth departs the center and notice of thirty-day disposal is sent to the parent/guardian. A review of Central Communications Center (CCC) reports for the past six months indicated there were no incidents related to youth property reported. The superintendent was interviewed and clearly explained all procedures related to storage of youth personal property.

2.07 Release	Limited Compliance
When releasing youth from the center, the releasing officer shall verify the court's authorization to release the youth. Care must be taken to ensure all case file information is reviewed to prevent the negligent release of a youth. *All releases from the center are court-ordered, with the exception of deaths, escapes, and expirations of detention time period. In the absence of a written order, documentation of a verbal order in open court may be used for release.* *The on-duty JJDO Supervisor reviews all paperwork prior to a youth's release. The JJDO Supervisor is responsible for ensuring there are no holds, court orders, or other legal reasons not to release the youth.* *Questions concerning release are presented and addressed by the superintendent, or designee, prior to release.* *The releasing officer shall verify the identification of the youth.*	

Six closed records were reviewed for release documentation. The records showed the center was not consistent in photocopying the identification (ID) cards of people to whom youth were released. Two records for youth released to a parent/guardian did not have a photocopy of the ID card. For the two youth released to HUB transporters, IDs were not photocopied, and the center did not identify the transporter by name, but rather indicated youth were release to "DJJ staff." In one record, the youth was direct-filed and taken into custody by/released to law enforcement, and the law enforcement officer's name or badge number was not documented. Each of the six records documented court orders and other paperwork related to the release were reviewed by the supervisor. Each record documented the youth's identity was confirmed prior to release. One release was observed. The supervisor reviewed the release order and related paperwork. The youth was on precautionary observation at the time of his release and the notification of suicide risk was reviewed with and signed by the parent/guardian and youth. The property receipt was also reviewed with and signed by the youth and guardian.

2.08 Release of Youth Personal Property	Limited Compliance
Upon the youth's release from the center and retrieval of personal property, the releasing officer, the youth, and the youth's parent/guardian shall review and sign the Property Receipt Form and account for all of the youth's personal property.	

Six closed records were reviewed for release of youth personal property. In two records, there was not a copy of the property receipt on file. In one record, the property receipt was not signed by the youth. In another record, the property receipt was not signed by the parent/guardian. Two

records contained the property receipt with all required signatures. The valuable property logbook documented valuable property was released to youth upon release from the center. There is a process in place to purge property and send a letter to the parent/guardian informing them of the intent to dispose of the property if the property is not picked up after thirty days. The superintendent interview indicated property not picked up is either donated to the sheriff's office or discarded and unclaimed currency is forwarded to the Bureau of Unclaimed Property.

2.09 Release of Medication, Aftercare Instructions	Satisfactory Compliance
The center ensures there are provisions in place to ensure prescribed medication, along with medical instructions, accompanies detained youth upon release.	

Four examples of youth released from the center with medication were reviewed. A medication receipt form was completed in each record. All forms were signed and dated by all required parties. Observations and a review of reports found the supervisor advised medical staff a youth was being released from the center, checking to see if the youth had any medication upon their release. Medical staff will bring the medication to the lobby area, complete a review and count of the medication with the parent/guardian. The parent/guardian, medical staff, and a witness sign the medication receipt.

2.10 Review of Youth in Secure and Home Detention	Satisfactory Compliance
Detention reviews are conducted by the center on a weekly basis to ensure proper management of youth placed in secure detention, as well as home detention, and the appropriate sharing of information. The superintendent appoints an appropriate staff person to coordinate detention reviews.	

The superintendent reported the center has designated a juvenile justice detention officer II (JJDO II) to serve as the detention review specialist to coordinate detention reviews weekly on Thursdays. The superintendent advised the weekly reviews include representatives from mental health, medical, and education services at the center along with probation staff from the circuit. The superintendent indicated the meetings address youth alerts, confinements/behavior issues, current court status, any issues relative to youth's placement (if committed), education, and medical or mental health concerns. Documentation of detention reviews occurring during the past six months was reviewed and a detention review was observed. All youth on detention status were reviewed, which included any follow-up information needed from previous reviews, pending court dates, commitment status, release dates, and other pertinent information. The reviews were attended, either in person or by phone, by circuit probation staff and all departments within the center.

2.11 Daily Activity Schedule	Satisfactory Compliance
Youth are provided the opportunity to participate in constructive activities which will benefit the youth and the center. The Superintendent or designee develops a daily activity schedule, which is posted in each living area and outlines the days and times for each youth activity.	

The daily activity schedule is posted in each living area and outlines the days and times for each youth activity. Logbooks reviewed, seven youth and seven staff interviews, and observations during the annual compliance review indicated the center follows the daily activity schedule. The schedule includes times for personal hygiene, meals, visitation, education, indoor and outdoor

recreation, shift change, faith-based services, groups, shower time, bed time, and down time for youth.

2.12 Adherence to Daily Schedule	Satisfactory Compliance
Center staff shall adhere to the daily activity schedules. Documentation of all activities shall be made in all applicable logs. *The on-duty supervisor must approve any significant changes in the activity schedule and shall document the reason for the change(s) in the shift report.* *Any cancellation of visitation shall be approved by the superintendent.*	

Observations during the annual compliance review confirmed youth moved to and from class, meals, and other activities as scheduled. Logbooks documented the schedule was followed unless an emergency event or disturbance occurred. Any changes to the schedule must be approved by the shift supervisor or administration. Seven staff and seven youth were interviewed, and all reported the activity schedule is followed.

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

The center integrates educational instruction into the daily activity schedule. Each youth attends school for five hours each day. Youth are enrolled in educational programs and have the opportunity to earn course credit for completion of the education and training experience. The center provides education on a 250-day calendar over twelve months. The teachers have teacher training and planning days up to ten days a year. School was recently cancelled due to Hurricane Dorian, though the normal schedule resumed once the clearance was received. Reviewed logbooks showed youth received education services in accordance with the schedule. Seven youth were interviewed. All seven youth reported they attend school Monday through Friday and each youth identified common subjects/classes taught during school (math, English, and social studies). Seven staff and the superintendent were interviewed, all reported there is minimal interference in education activities.

2.14 Career Education	Satisfactory Compliance
The center shall collaborate with the school district to ensure implementation of a career education competency development program.	

The center provides career education to all youth. The center provides Type 1 programming, which includes life skills groups, activities, and instruction. The youth at the center receive instruction in the areas of communication, interpersonal, and decision-making skills.

2.15 Behavior Management System	Satisfactory Compliance
The center provides a system of rewards, privileges, and consequences to encourage youth to fulfill the center's expectations. *Each center shall implement and maintain a behavior management system to meet the needs of the youth and the center. The system shall include rewards for positive behavior and consequences for inappropriate behavior.* *The behavioral norms and expectations for youth shall be posted in all living areas and shall clearly specify appropriate and inappropriate behaviors.*	

The center has a behavior management system in place, which includes point cards and levels. The superintendent explained there are three levels of the behavior management system. The superintendent identified the incentives for youth obtaining Level 3, such as access to a video game room, special parties on Sundays, additional phone calls, sibling visitation, and extra snacks. A behavior matrix is posted within each module for youth to view and reference. Details are provided for the three different levels, privileges for each level, and how to move up within the level system to earn additional points/activities/items. Seven staff were interviewed. All seven staff reported staff speak with youth to discuss the consequences being imposed. Youth are given the opportunity to explain their behavior, and staff explain alternative acceptable behaviors. Six of the seven staff said they receive input from supervisors on their implementation of the behavior management system, with the input being provided weekly or as needed. Six of the seven staff said they felt the behavior management system was effective. Seven youth were interviewed and asked to rank the behavior management system. One youth rated the behavior management system as very good, two ranked it as good, three ranked it as fair, and one ranked it as poor. When asked if consequences they had received were fair or unfair, three youth said consequences they had received were fair and the remaining four youth said they had never received consequences. Observations were made daily during the annual compliance review, which included observations of use of the BMS. The BMS was also posted throughout the facility.

2.16 Unauthorized Use of Punishment (Critical)	Satisfactory Compliance
The center's behavior management system (BMS) restricts certain types of penalties on youth who demonstrate negative behaviors. *Group punishment shall not be used as a part of the center's BMS. However, corrective action taken with a group of youth is appropriate when the behavior of a group jeopardizes safety or security, and this should not be confused with group punishment.* *Corporal punishment shall not be used. All allegations of corporal punishment of any youth by center staff shall be reported to the Florida Abuse Hotline, pursuant to Chapter 39, F.S., and the Central Communications Center.* *The use of drugs to control the behavior of youth is prohibited. This does not preclude the proper administration of medication as prescribed by a licensed physician.*	

The center's behavior management system prohibits the use of group punishment, corporal punishment, or use of drugs to control youth behavior. One incident of excessive use of force was reported during the annual compliance review period. The incident was referred to the

Florida Abuse Hotline and law enforcement. The staff involved in the incident resigned. Seven staff were interviewed. All staff advised consequences for inappropriate behavior never include loss of meals, snacks, sleep, school, or other rights and they had never witnessed a co-worker utilize such a consequence. All seven staff said they have never witnessed a co-worker encourage a youth to beat up another youth. Seven youth were interviewed. None of the youth reported having rights taken away as punishment. Three youth who had received consequences stated the consequences were loss of points or reduction of level. Each of the seven youth advised they are not allowed to punish other youth.

2.17 Grievances	**Satisfactory Compliance**
The grievance procedures establish each youth's right to grieve and ensure all youth are treated fairly, respectfully, without discrimination, and their rights are protected. The process includes: 1. *Informal phase, wherein the JJDO attempts to resolve the complaint or condition with the youth using effective communication skills;* 2. *Formal phase, wherein the youth submits a written grievance resulting in a response from a JJDO Supervisor by the end of the shift (if possible), or otherwise within twenty-four hours; and* 3. *Appeal phase, wherein the youth may appeal the outcome of the formal phase to the superintendent or designee.*	

The center has policy and procedures regarding each youth's right to grieve and to be treated fairly, respectfully, without discrimination, and their rights are protected. The process includes an informal phase, a formal phase, and an appeal phase. Youth have access to grievance forms within their module area. Youth are instructed to ask staff for a pencil, so they can complete the grievance form. Forms are reviewed by staff and forwarded to the shift supervisor, who reviews the grievance. The supervisor reviewing the grievance will either resolve the issue/concern or forward the grievance to the superintendent. One grievance was filed in April 2019. This was the only grievance filed during the annual compliance review period. The grievance process and appeal were completed within the required time frame. All seven interviewed staff were able to explain the grievance process. Only one of the seven interviewed youth indicated he/she had filed a grievance, and this youth rated the grievance process as good. The superintendent interview clearly outlined the three the phases of the grievance process. The superintendent also indicated grievances are entered into and maintained in the Facility Management System (FMS).

2.18 Trauma-Informed Care	Satisfactory Compliance

The center is incorporating trauma-informed practice into current operations to deliver services and to provide care to youth in custody, acknowledging the role violence and victimization play in the lives of most of the youth entering the center.

Trauma-informed practice has many characteristics, which include the following:

- *A recognition of the high prevalence of trauma*
- *Recognition of culture and practices which may be re-traumatizing*
- *Collaboration of caregivers*
- *Training of staff to improve trauma knowledge and sensitivity*
- *Increased staff understanding of the function of behavior (rage, self-injury, etc.) as an expression of trauma*
- *Use of objective and neutral language (avoids labeling of youth)*

The superintendent interview indicated the center has a soft room, bulletin boards throughout the facility explaining processes to youth, and murals painted throughout the facility and in youth rooms. The superintendent also stated staff are trained in trauma-informed care practices. Observations and a review of fourteen staff training records confirmed the information provided in the superintendent interview.

Standard 3: Mental Health and Substance Abuse Services

3.01 Designated Mental Health Clinician Authority (DMHCA) [Contract Provider]	Satisfactory Compliance
A Designated Mental Health Clinician Authority (DMHCA) is required in each detention center. The DMHCA is responsible and accountable for ensuring appropriate coordination and implementation of mental health and substance abuse services in the facility and shall promote consistent and effective services and allow the facility superintendent and staff a specific source of expertise and referral.	

The center has a written policy and procedures for a single licensed mental health professional to serve as the designated mental health clinician authority (DMHCA). The DMHCA is responsible for coordinating and implementing all mental health and substance abuse services. The center's DMHCA is a licensed mental health counselor (LMHC). The DMHCA has a clear and active license in the State of Florida which expires March 31, 2021. An interview with the DMHCA confirmed the responsibility for the administrative oversight and management of mental health and substance abuse services at the center. The DMHCA is scheduled to be on-site forty hours a week, Monday through Thursday, for ten hours each day. Sign-in logs confirmed the DMHCA was on-site weekly for the past six months. The DMHCA is on-call to provide services twenty-four hours a day, seven-days a week. The DMHCA position description outlines the duties and responsibilities of the DMHCA.

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

The designated mental health clinician authority (DMHCA), psychiatrist, and one licensed therapist are qualified professionals licensed in accordance with the contract and Rule 63N-1, F.A.C. The licenses of all clinical staff are active and clear. The psychiatrist's license expires January 2020 and the DMHCA's and therapist's licenses expire March 31, 2021. There are no discipline or complaints associated with the licenses.

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

The center has a policy and procedures in place to address non-licensed mental health and substance abuse clinical staff. The center does not currently employ or contract with non-licensed clinical staff.

3.04 Mental Health and Substance Abuse Admission Screening [Detention Staff/Contract Provider]	Satisfactory Compliance
The mental health and substance 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 superintendent has established procedures for a thorough review of preliminary screening conducted by the Office of Probation and Community Intervention.*	

The center has a written policy and procedures to ensure the mental health and substance abuse needs of youth are identified through a comprehensive screening process. Seven youth records were reviewed, and all seven records had completed admission screenings. Each record had a Positive Achievement Change Tool (PACT)/Community Assessment Tool (CAT), Suicide Risk Screening Instrument (SRSI), Massachusetts Youth Screening Inventory – Second Version (MAYSI-2), and Victimization and Sexually Aggressive Behavior (VSAB) completed by the probation screening staff. Each youth's admission information was documented in the Department's Juvenile Justice Information System (JJIS). Six of the seven reviewed records indicated youth were placed on precautionary observation due to screening instruments identifying risks for suicide. Documentation demonstrated the referral process was initiated and a mental health professional was notified in all six records. The PACT/CAT indicated a need for a comprehensive assessment to be completed for six of the seven youth reviewed and appropriate referrals were made.

3.05 Mental Health and Substance Abuse Evaluation [Detention Staff/Contract Provider]	Satisfactory Compliance
The Probation and JAC intake/detention screening process ensures youth identified through preliminary screening as having mental health and substance abuse issues or problems receive in-depth mental health and/or substance abuse assessment shortly after intake to the juvenile justice system.	

The program has a policy and procedures in place to address mental health and substance abuse evaluations. Three of seven youth reviewed were identified during admission as requiring a comprehensive evaluation and were in the center long enough to receive the evaluation. The evaluations were completed by detention staff. Each evaluation was uploaded into the electronic medical record by mental health staff within thirty days of the referral. Mental health staff track youth who are referred for comprehensive evaluations and ensure the evaluations are received or completed within required time frames.

3.06 Mental Health and Substance Abuse Treatment [Detention Staff/Contract Provider]	Satisfactory Compliance
Mental health and substance abuse treatment planning in departmental facilities focuses on providing mental health and/or substance abuse interventions which will reduce or alleviate the youth's symptoms of mental disorder or substance abuse impairment and enable youth to function adequately in the juvenile justice setting. *Each youth determined to need mental health treatment, including treatment with psychotropic medication, or substance abuse treatment while at the center, must be assigned to a mini-treatment team.*	

The center has a policy and procedures in place to determine if mental health treatment services are required. Seven records were reviewed for mental health treatment services. Four of the seven youth required treatment services; however, one youth refused services. Three youth were receiving psychiatric services. Two youth had treatment plans completed and the treatment plan were not yet due for the remaining youth. The youth receiving treatment services were assigned to the mini treatment team and treatment plans were signed by all team members. Each of the seven records contained a signed Authority for Evaluation and Treatment (AET) form. All treatment notes were completed on the Department's Mental Health/Substance Abuse form. The center's policy and procedures prohibited mental health groups to contain more than ten youth. A review of the sign-in sheets confirmed no more than ten youth in participated in group at a time. The designated mental health clinician authority (DMHCA) interview indicated services include mental health overlay services, substance abuse overlay services, and psychiatric services.

Three of the seven interviewed youth rated the mental health and substance abuse services as good or very good. Four youth said they were not receiving any services.

3.07 Treatment and Discharge Planning [Contract Provider]	Satisfactory Compliance
The superintendent and DMHCA or mental health and substance abuse clinical staff are responsible for ensuring the development and review of an initial and/or individualized mental health/substance abuse treatment plan for each youth receiving mental health and/or substance abuse treatment in the center. *All youth who receive mental health and/or substance abuse treatment while at the center 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 center.*	

The center has a written policy and procedures designed by the designated mental health clinician authority (DMHCA) and management staff for developing and reviewing mental health and substance abuse treatment plans. Seven youth mental health records were reviewed. Only two youth were in the center more than thirty-days and required a treatment plan. The remaining five youth were in the center for less than thirty-days. An initial treatment plan was developed for the two youth. The youth's assigned mini-treatment team members were involved in the development of the initial treatment plan. The plans were developed within seven days of treatment. One of the two youth was receiving psychotropic medication. The youth received an initial diagnostic psychiatric interview within seven days. The two youth plans were completed on the proper form and signed by the appropriate parties within the proper time frame. The frequency of medication monitoring by the psychiatrist was documented on the proper form.

Both plans were developed by the thirty-first day of admission. None of seven reviewed records were applicable for a mental health/substance abuse treatment discharge summary. Three additional records were requested and reviewed. Each of the three records documented a discharge summary was completed on the Department's Mental Health/Substance Abuse Treatment Discharge Summary form, which was provided to the youth and parent/guardian upon release. Documentation supported each discharge summary was sent to the youth's assigned juvenile probation officer (JPO).

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

The center has a policy and procedures in place to provide psychiatric services. The center utilizes a psychiatrist licensed pursuant to Chapter 458, F.S., who is board certified in Child and Adolescent Psychiatry. Seven youth records were reviewed and three youth were applicable for psychiatric services. The three records had documentation of services provided by the psychiatrist. Each applicable record noted a diagnostic psychiatric interview within fourteen days of the youth's admission to the center. The psychiatric written interviews included all required elements. All psychiatric evaluations were conducted within thirty days of intake using the Department's Clinical Psychotropic Progress Note (CPPN). Each record had consent for psychotropic medication, which was witnessed by another staff member. Each youth had documentation of monitoring for Tardive Dyskinesia, as indicated by the psychiatrist. The DMHCA reported the psychiatrist sees all youth admitted on psychotropic medication within two weeks of admission. The psychiatrist is responsible for medication management for youth on psychotropic medications. All youth receiving treatment services have a current Authority for Evaluation and Treatment form (AET) and a consent for psychotropic medications signed by the youth's parent/guardian. None of the reviewed records were applicable for youth in foster care or reaching eighteen years of age while at the center and requiring additional consents.

3.09 Suicide Prevention Plan [Detention Staff] (Critical)	Satisfactory Compliance
The center 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 Rule 63N-1, Florida Administrative Code.	

The program has a suicide prevention plan. The suicide prevention plan utilized at the center outlines how to safely assess and protect the youth by using the least restrictive means. The plan includes all the required elements including identification and assessment, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response a and review process. The plan is in accordance with Rule 63N-1., Florida Administrative Code. The plan was reviewed and approved by the center's superintendent and designated mental health clinician authority (DMHCA) on September 11, 2019 and October 2, 2019.

3.10 Suicide Prevention Services [Detention Staff/Contract Provider] (Critical)	Satisfactory Compliance
Suicide Precautions are the methods utilized for supervising, observing, monitoring, and housing youth identified through screenings as having suicide risk factors or identified through assessment as a potential suicide risk. *Any youth exhibiting suicide risk behaviors must be placed on suicide precautions (precautionary observation or secure observation), and a minimum of constant supervision.* *All youths identified as having suicide risk factors by screening, information obtained regarding the youth, or staff observations must be placed on suicide precautions and receive an assessment of suicide risk.*	

The center has suicide prevention services to assess and protect youth at risk for suicide in the least restrictive means and in accordance with Rule 63N-1, Florida Administrative Code. Seven youth records were reviewed, and six of seven youth were placed on suicide precaution status upon admission because of admission screenings and the center's policy. Each record documented the completion of an Assessment of Suicide Risk (ASR) by a licensed clinician. The center does not employ non-licensed mental health clinicians. Each record documented the immediate notification to the center's superintendent and/or designee and the completion of a suicide precaution observation log. None of the records indicated a youth being released from the center on precautionary observation (PO) status. Each record documented a referral was made to a mental health professional, an alert was entered into the Department's Juvenile Justice Information System (JJIS), and the youth was maintained on precautionary observation until assessed. Each record had documentation of the youth transitioning to standard supervision after the completion of an ASR, consultation with the designated mental health clinician authority (DMHCA), and the consultation with the center's superintendent and/or designee, as outlined in the center's suicide prevention plan. A review of the center's master control logbook showed beginning and end times were documented for youth placed on precautions.

3.11 Suicide Precaution Observation Logs [Detention Staff/Contract Provider] (Critical)	Satisfactory Compliance
Youth placed on suicide precautions must be maintained on one-to-one or constant supervision. The staff assigned to observe the youth must provide the appropriate level of supervision and record observations of the youth's behavior at intervals of no more than thirty minutes.	

The center has a written policy and procedures for staff assigned to monitor youth on suicide precautions. Seven youth records were reviewed. Six youth were applicable for a suicide precaution observation log. Each record contained the Department's Suicide Precautions Observation Log form. Each record contained documentation of the youth's behavioral observations documented in real time. Each log indicated observations were completed at or below thirty-minute intervals. None of the reviewed records were applicable for observed warning signs requiring supervisory and/or mental health notification and/or consultation. Each record had the signatures of each shift supervisor, the center's mental health clinical staff, and documentation of safe housing requirements. Logs were signed by the mental health clinical staff and the shift supervisor daily. Four youth who had been on suicide precautions were interviewed. Each youth reported staff were always with them while they were on suicide precaution status.

3.12 Suicide Prevention Training [Detention Staff] (Critical)	Satisfactory Compliance
All staff who work with youth must be trained to recognize verbal and behavioral cues indicating suicide risk, suicide prevention, and implementation of suicide precautions.	

The center has a written policy and procedures requiring staff to complete at least six hours of suicide prevention and implementation of suicide precautions training annually. A review of fourteen staff training records supported each staff received two hours of suicide prevention training in the Department's Learning Management System (SkillPro) and four hours of instructor-led suicide prevention and suicide precaution training. Mock suicide drills were held for the three shifts each quarter. The mock suicide drills contained all the required elements and all reviewed staff participated in quarterly drills, as required. Seven staff were interviewed. All seven staff stated they participated in a mock suicide drill. When asked about the location of the suicide response kits, all seven staff said there are kits in master control and a closet outside the dorms, four staff said a kit is located sub-control (the girls' module), and one staff said a Knife-for-Life kit was in the medical office.

3.13 Mental Health Crisis Intervention Services [Detention Staff] (Critical)	Satisfactory Compliance
Every center must 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 must 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 center has a written policy and procedures for providing mental health crisis intervention services. The center utilizes this plan to respond to youth in crisis in the least restrictive means possible. A review of the mental health crisis intervention plan determined the plan includes: notification and alert system, means of referral, including youth self-referral, communication, supervision, and documentation and review. The emergency services plan was reviewed and signed by the designated mental health clinician authority (DMHCA) and superintendent on September 11, 2019 and October 2, 2019 and included all required elements.

3.14 Emergency Care Plan [Detention Staff] (Critical)	Satisfactory Compliance
Youth determined to be an imminent danger to themselves or others due to mental health or substance abuse emergencies occurring in the center, requires emergency care to be provided in accordance with the center's Emergency Care Plan. The Crisis Intervention Plan and Emergency Care Plan may be combined into an integrated Crisis Intervention and Emergency Services Plan which contains all the elements specified in Rule 63N-1, Florida Administrative Code.	

The center's emergency care plan is in accordance with the Department's Rule 63N-1.011 and Rule 63N-1.0112, Florida Administrative Code. The plan includes: training, review, documentation, transport, response, communication, supervision, notifications, and authorization to transport for emergency mental health or substance abuse services for Baker Act and Marchman Act. The plan was reviewed by the center's superintendent and designated mental health clinician authority (DMHCA) on September 11, 2019, and October 2, 2019. A copy of the emergency plan is located on the center's K drive, supervisor office, mental health office, and the training office.

3.15 Crisis Assessments [Contract Provider] (Critical)	Satisfactory Compliance
A Crisis Assessment is a detailed evaluation of a youth demonstrating acute psychological distress (e.g., anxiety, fear, panic, paranoia, agitation, impulsivity, rage) conducted by a licensed mental health professional (LMHP), or under the direct supervision of a LMHP, 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 superintendent or designee must 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 (ASR) instead of a Crisis Assessment.	

The center did not have any youth requiring a crisis assessment during this annual compliance review period. The center has a written policy and procedures to respond to youth in crisis. A crisis assessment is to be completed in accordance with the center's policy and procedures when a youth is identified as being in crisis. The center's crisis assessment contained all the appropriate requirements, to include reason for assessment, mental status examination and interview, determination of danger to self and others, initial clinical impression, supervision recommendations, treatment recommendations, recommendations for follow-up or further evaluation, and notification to parent/guardian of follow-up treatment. The assessments are documented on the Department's Crisis Assessment (Form MHSA 023). The assessments are completed by a licensed mental health professional and a mental health alert is completed and entered in the Department's Juvenile Justice Information System (JJIS).

3.16 Baker and Marchman Acts [Detention Staff/Contract Provider] (Critical)	Satisfactory Compliance
Individuals who are believed to be an imminent danger to themselves or others because of mental illness or substance abuse impairment require emergency mental health or substance abuse services.	

The center has a policy and procedures in place for youth requiring Baker and Marchman Act services. The center had two youth requiring a Baker Act during the annual compliance review period. Mental health staff initiated the Baker Acts. Documentation included notifications to the youth's parent/guardian and assigned juvenile probation officer (JPO). Both youth were maintained on one-to-one supervision prior to being sent out for the Baker Act services. Upon returning to the center, each youth was placed on constant supervision. A Mental Status Examination (MSE) was conducted by the licensed mental health staff. A suicide risk alert was completed in the Department's Juvenile Justice Information System (JJIS). The level of supervision was not lowered until follow-up Assessments of Suicide Risk were completed and mental health staff consulted with the superintendent or designee. There were no Marchman Acts during this annual compliance review period.

Standard 4: Health Services

4.01 Designated Health Authority/Designee [Contract Provider] (Critical)	Satisfactory Compliance
The Designated Health Authority (DHA) is clinically responsible for the medical care of all youth at the center.	

The center has a contract with Maxim Healthcare Services, Inc., to provide medical services at the center. The center has a board-certified physician who has a clear and active license, which expires January 31, 2020 and meets all the requirements to serve as the designated health authority (DHA). The DHA interview revealed the DHA evaluates and performs physical examinations for youth who require Comprehensive Physical Assessments or have an acute episode. A review of the sign-in logs for the past six months confirmed the DHA was on-site weekly for at least one hour on Tuesdays. The DHA is also available twenty-four hours a day, seven days a week by phone to address all medical concerns at the center.

The center also employs an advanced practice registered nurse (APRN). The APRN holds an unrestricted license to practice in Florida which expires on July 31, 2020. The APRN provides services on-site fifteen to twenty hours a week. The APRN works in collaboration with the DHA and there is a signed nurse practitioner protocol/collaborative practice agreement between the APRN and DHA. The APRN stated her role at the center is to complete physical exams, conduct sick calls, episodic care when on-site, and management and follow-up for chronic and acute illness. A check of all licensed medical staff confirmed all had current State of Florida medical licenses, verified by the Department of Health.

4.02 Facility Operating Procedures [Contract Provider]	Satisfactory Compliance
There shall be Facility Operating Procedures (FOP) for all health-related procedures and protocols utilized at the facility.	

The center has facility operating procedures (FOP) and treatment protocols for all health-related services provided at the center. All FOPs and treatment protocols contained the signature of the designated health authority (DHA) and the superintendent. There was documentation of an annual review of all treatment protocols by the DHA and superintendent. The review of and development of FOP, or other protocols related to psychiatric services was conducted by the psychiatrist. There was documentation of all newly employed health care personnel receiving a comprehensive clinical orientation to the Department's healthcare policies and procedures, which was provided by the registered nurse. There was documentation of the nursing staff reviewing, signing, and dating a cover pager on which all FOPs, treatment protocols, and other procedures were listed annually.

4.03 Authority for Evaluation and Treatment [Detention Staff/Contract Provider]	Satisfactory Compliance
Each center shall ensure the completion of the Authority for Evaluation and Treatment (AET) or Limited Consent for Evaluation and Treatment authorizing specific treatment for youth in the custody of the Department.	

A review of seven youth individual healthcare records revealed two had an original signed Authority for Evaluation and Treatment (AET) filed in the record. The other youth five youth had a legible copy of the AET with the word "copy" legibly hand-written or stamped on the AET.

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

A review of seven youth individual healthcare records (IHCR) found each had documented parent/guardian notification. Four of the seven youth required parental notification for over-the-counter medications not covered by Authority for Evaluation and Treatment form. Six of the seven youth required parental notification for new medication. For each parental notification, there was documentation of telephone calls, attempted calls, and verbal approvals, which were witnessed. Written notification were sent to parents as well. One youth needed required a parental notification for a new psychotropic medication and all of the requirements were met.

4.05 Healthcare Admission Screening & Rescreening Form (Medical and Mental Health Screening Form) (screening entered into JJIS)	Satisfactory Compliance
Youth are screened upon admission for healthcare concerns which may need a referral for further assessment by healthcare staff.	

A review of seven youth individual healthcare records found each youth received a medical and mental health admission screening for their most recent admission. Each of the screenings were completed on the day of admission by a juvenile justice detention officer (JJDO). There was documentation of each form being reviewed by a licensed practical nurse (LPN) or higher within twenty-four hours. None of the youth had a change in their physical custody since their arrival to the center, requiring a healthcare admission rescreening. The superintendent interview revealed the medical and mental health admission screening is completed by the admitting JJDO and reviewed by the nurse within twenty-four hours.

4.06 Youth Orientation to Healthcare Services [Contract Provider]	Satisfactory Compliance
All youth are to be oriented to the general process of healthcare delivery services at the center.	

A review of seven youth individual healthcare records revealed each youth received a general orientation to healthcare services within twenty-four hours of admission to the center. The healthcare topics included access to medical, sick call (use, how to access), what constitutes an emergency and who to notify, medication process and side effects monitoring, the right to refuse care and how it is documented, what to do in the case of a sexual assault or attempted sexual assault, and the non-disciplinary role of the healthcare providers.

4.07 Designated Health Authority/Designee Admission Notification [Contract Provider]	Satisfactory Compliance
The DHA or designee is notified when youth admitted require emergency care or routine notification in accordance with Department requirements.	

A review of seven youth individual healthcare records (IHCR) found four were applicable for notification to the designated health authority (DHA). The DHA received an immediate notification when youth were identified as possessing a medical concern or chronic condition. There was documentation of the DHA being notified within twelve hours of each of the four applicable admissions. The notifications were documented in each youth's IHCR.

4.08 Health-Related History [Contract Provider]	Satisfactory Compliance
The standard Department Health-Related History (HRH) form shall be completed for all youth admitted into the physical custody of the center.	

A review of seven youth individual healthcare records (IHCR) found each youth had a Health-Related History (HRH) form completed within seven days of admission. Four of the HRH forms were new and the other three were updated. All seven HRH forms were completed by a licensed nurse and reviewed by the designated health authority (DHA) or the advanced practice registered nurse (APRN). Each of the HRH forms were completed before the Comprehensive Physical Assessment (CPA).

4.09 Comprehensive Physical Assessment/TB Screening [Contract Provider]	Satisfactory Compliance
The Comprehensive Physical Assessment (CPA) form shall be completed for all youth admitted in-to the physical custody of the center.	

A review of seven youth individual healthcare records (IHCR) found each contained a current Comprehensive Physical Assessment (CPA). Each CPA was reviewed, initialed, and dated by the designated health authority (DHA). All CPAs were completed within seven days of admission. If a youth refused any part of the exam, the clinician documented “Youth Refused.” There was documentation of the youth signing a refusal form to reflect the refused portion on the CPA and matched the date of the exam. The Department’s Problem List was updated for each youth. Each youth had at least one verified Tuberculin Skin Test (TST) test documented in the IHCR on the Infectious and Communicable Diseases form. The Tier 1 Tuberculosis screening was completed within seventy-two hours. None of the youth had a positive TST or symptoms of Tuberculosis requiring them to be transported to the nearest hospital for further evaluation.

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

A review of seven youth individual healthcare records (IHCR) found each youth was screened and evaluated for sexually transmitted infections (STIs). Three youth were tested for STIs, which was documented on the Infectious and Communicable Diseases form. All seven youth were offered human immunodeficiency virus (HIV) testing. None of the selected youth consented to HIV testing. Additional records were requested, and one was provided for review. There was documentation of the youth consenting to HIV testing, being offered counseling, and being tested for HIV. The HIV test results were found in the youth’s IHCR filed in a confidential manner. The nurse stated youth are asked at the time of intake if they want HIV testing. If a youth consents to testing, the advance practice registered nurse (APRN) will provide pre-test counseling, draw blood, and provide post-test counseling. Seven youth were interviewed and all stated they could ask for an HIV test.

4.11 Sick Call Process [Detention Staff/Contract Provider]	Satisfactory Compliance
All youth in the center shall be able to make sick call requests and have their complaints treated appropriately through the sick call system. The center shall respond appropriately, in a timely manner, and document all sick call encounters as required by the Department. All youth in restricted housing/confinement shall have timely access to medical care, as required by Rule.	

The center has a policy and procedures in place for the completion of sick calls. A review of seven youth individual healthcare records (IHCR) found four youth requested sick calls. All sick call request forms and narrative progress notes conformed to the professional standard to include all elements of the subjective, objective, assessment, and plan (SOAP) format. Sick calls were found to be documented on the youth's Sick Call Index and the center's Sick Call log. None of the youth presented a similar sick call complaint three or more times within a two-week period. Sick calls are conducted in the medical clinic by licensed medical staff at the center. When there is not a licensed nurse on-site, the center has procedures in place for the shift supervisors to review sick call requests no longer than four hours after a request is submitted. Sick calls are scheduled Monday through Friday at 9:00 a.m. until 10:00 a.m. and 5:00 p.m. to 6:00 p.m., Saturday and Sunday 3:00 p.m. until 4:00 p.m., and as needed. There were no youth complaints regarding any severe pain with which medical staff was unfamiliar. Seven youth were interviewed. Two youth reported they never requested a sick call. The other five youth stated they could be seen immediately once they make a sick call, or within one day. Youth who had a sick call stated a nurse or doctor conduct sick calls. The medical department was rated as very good by four youth and good by two youth. One youth stated they were unable to rate the medical department due to not receiving medical services. Seven interviewed staff revealed nurses or the doctor conduct sick calls for youth.

During the annual compliance review, one sick call was observed with the youth's permission. The youth was escorted to the medical clinic by a Protective Action Response (PAR) trained supervisor. The youth was examined by a licensed medical staff. The youth was seen in a private area with no other youth present to hear or see the examination.

4.12 Episodic/First Aid & Emergency Care [Contract Provider]	Satisfactory Compliance
The center shall have a comprehensive process for the provision of episodic care and first aid care.	

The center has a policy and procedures for the provision of episodic care, first aid, and emergency care. A review of seven youth individual healthcare records (IHCR) found none of youth received episodic/first aid care from a non-healthcare staff. Additional records were requested and one was provided. The documentation in the progress notes contained all required elements. None of the seven youth were seen by medical staff for episodic care/first aid. Additional records were requested and three were provided. Each youth was seen by medical staff and episodic care was documented in the subjective, objective, assessment, and plan (SOAP) format. The center maintains an Episodic Care Log to document episodic care and first aid treatment. All four instances of episodic care reviewed were documented in the Episodic Care Log.

The center has a total of eighteen first aid kits, which are monitored monthly by medical staff and the superintendent or designee. Documentation and interviews confirmed the nursing staff review inventory and restock all first aid kits monthly, which is documented on a log located on

each first aid kit. First aid kits were found located throughout the center. There was documentation of the designated health authority approving the contents of each first aid kit.

The program has two automated external defibrillators (AED), which are located outside of the medical clinic and the Module 4 hallway. Both AEDs were tested and functional during the annual compliance review. There was documentation of the AEDs being checked monthly by medical staff. The pads expire on March 28, 2021 and the batteries expire on August 20, 2023. The pads and batteries were installed on August 20, 2018.

A review of the center's medical drills confirmed the center conducts emergency medical drills at least quarterly on each shift. The emergency drills included a CPR/AED demonstration at least once each quarter. Seven staff were interviewed and all reported they are able to call 9-1-1 if they feel necessary. All of the licensed healthcare staff have a current CPR/AED certification. A review of seven pre-service and seven in-service training records found all had current CPR/AED First Aid certification. The center has a list of emergency telephone numbers and cell phone numbers which are accessible to all staff.

4.13 Off-Site Care/Referrals [Contract Provider]	**Satisfactory Compliance**
The center shall provide for timely referrals and coordination of medical services to an off-site healthcare provider (emergent and non-emergent), and document such services, as required by the Department.	

The center has a policy and procedures in place for off-site care for youth. A review of seven youth individual healthcare records (IHCR) found none were applicable for off-site care. Additional records were requested and three were provided. The Summary of Off-Site form was completed and filed in each IHCR, along with discharge instruction documents, when applicable. There was documentation of the designated health authority (DHA) being notified of the event in each IHCR. There was documentation of the DHA reviewing the paperwork for each youth. Information was documented on the Episodic Care Log. None of the youth required follow-up testing, referrals, or appointments.

4.14 Chronic Conditions/Periodic Evaluations [Contract Provider]	**Satisfactory Compliance**
The center shall ensure youth who have chronic conditions receive regularly scheduled evaluations and necessary follow-up.	

The center has a written policy and procedures for the delivery of treatment to youth identified as having a chronic medical condition. A review of seven youth individual healthcare records (IHCR) found four youth were identified with a chronic medical condition and/or taking prescribed medications. Each youth was classified with a Medical Grade two through five. The nurse interview revealed the center monitors youth with chronic conditions by referring them to the designated health authority (DHA) at intake and every ninety days for periodic review, according to protocol. There was documentation of periodic evaluations being conducted prior to renewal of prescription medication. There were no indications of lapses in care or missed periodic evaluations. Problem Lists were updated in each of the IHCRs, as required.

4.15 Medication Management [Contract Provider]	Satisfactory Compliance
Medication shall be received, store, inventoried, and provided in a safe and effective manner which shall be demonstrated by observation, review of documentation of procedures and processes.	

The center has a written policy and procedures to ensure medication is received, stored, inventoried, and provided in a safe and effective manner. A review of seven youth individual healthcare records (IHCR) found four youth were prescribed medication prior to their admission to the center. In each of the four IHCRs, the medication was brought to the facility by the parent/guardian, verified by medical staff, and the youth was continued on the medication(s). The center used the standard Department's Medication Administration Record (MAR)/Electronic Medical Record (EMR), to document administration and refusal of medications. The MARs documented all required information including demographic information of youth, medication start and stop dates, and staff and youth initials when medication was administered. There were no lapses or errors in medication administration. The medical staff document weekly side effect monitoring on the MARs. There were no refusals documented; however, the center's practice is to clearly document refusals on the MAR and Refusal Form, when applicable. None of the youth required parenteral medication.

There was documentation of the designated health authority (DHA), designated mental health clinical authority (DMHCA), and psychiatrist being notified upon admission when youth were admitted on psychotropic medication. The initial diagnostic psychiatric interview was conducted with fourteen days of each youth's admission. There was documentation of the youth receiving medication monitoring every thirty days by the psychiatrist.

A medication pass was observed during the annual compliance review, with the youth's consent. The registered nurse (RN) verified the six rights of medication administration (right youth, right medication, right dose, right route, right time, and right documentation). After the RN gave the youth the medication, the RN verified the youth consumed the medication by checking his/her mouth. The center has a total of ten trained non-healthcare staff to assist in the delivery of medications when licensed staff are not on-site. Seven staff were interviewed, and five reported they do not give any medications to youth. Seven youth were interviewed. Five youth reported nursing staff gives them medication. The other two youth stated they do not take medications.

4.16 Medication/Sharps Inventory and Storage Process [Contract Provider]	Satisfactory Compliance
Any medical equipment classified as stock medications shall be secure 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 center has a written policy and procedures ensuring medications and sharps are secured and inventoried utilizing a perpetual inventory. The medications and sharps were found stored and locked in designated areas inaccessible to youth. Medications are stored in a locked medication cart, cabinets, and in the locked refrigerator in the medical clinic. All controlled medications were found stored behind two locks. A shift-to-shift inventory count of all controlled substances was documented on the youth's individualized Controlled Medication Inventory Record.

A random inventory of three different sharps, three prescribed medications, three over-the-counter (OTC) medications, and three controlled medications revealed each count was accurate and documented by licensed nursing staff correctly. A review of the past six months of medications revealed all counts and inventories matched medications available. The center has a policy and procedures in place for the disposal of medication. The Registered Nurse is responsible for the disposal of medication. All medication are to be inventoried prior to disposal and disposed in the presence of the pharmacy consultant. Medication is disposed by utilizing the Drug Enforcement Administration (DEA) approved Drug Buster disposal system. The center has a policy and procedures in place to identify and report discrepancies in the inventory.

4.17 Infection Control – Exposure Control and Education [Contract Provider]	**Satisfactory Compliance**
The center 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 shall 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 center has a written policy ensuring all staff and youth receive education on infection control. A review of the center's Exposure Control Plan was conducted and confirmed the plan included all required elements outlined in the Department's standards. The plan was reviewed and signed by the superintendent and designated health authority (DHA). Seven youth individual healthcare records (IHCR) reviewed found each youth received infection control training within seven days of admission. Training included guidelines for hand-washing techniques, universal/precautions, prevention/transmission of communicable diseases, prevention of blood borne pathogens, and guidelines for infection control. A copy of the Health Education Record form was maintained in each reviewed IHCR. All training and education were provided in accordance with the Center for Disease Control and Prevention guidelines. A review of fourteen staff training records confirmed staff received pre-service and in-service infection control training.

4.18 Prenatal Care/Education [Contract Provider]	**Satisfactory Compliance**
The center shall provide access to prenatal care for all pregnant youth. Health education shall be provided to both youth and staff.	

The center has a written policy and procedures in place for prenatal care for all pregnant youth. The policy and procedures also address health education for youth and training for staff on healthcare issues for girls. A review of seven pre-service and seven in-service staff training records found four staff did not receive in-service training on girls' healthcare in 2018. This was noted by the center, corrective action took place, and all staff received the training in 2019. The training addressed the monitoring, observation, and care of pregnant youth. The center did not have any youth records applicable to for this indicator.

Standard 5: Safety and Security

5.01 Active Supervision of Youth (Critical)	Satisfactory Compliance

Staff are aware of the location of youth assigned to their supervision at all times. Staff monitor the movement of youth in their direct care from one location to another.

Youth are in sight of at least one juvenile justice detention officer (JJDO) at all times (with the exception of sleeping hours or time secured in rooms).

Officers are responsible for the care of youth at all times. At no time shall another youth be allowed to exercise control over or provide discipline or care of any type to another youth.

When a youth leaves the group or program area of the center for any reason, all staff assigned to supervise the youth are informed.

Master Control authorizes all movement of youth prior to the actual movement, and no movement occurs until cleared by Master Control.

Staff moves youth from one area of the center to another in accordance with Florida Administrative Code.

The center has a written policy and procedures addressing the active supervision of youth. Staff supervision of youth was observed throughout the annual compliance review. Staff called counts in to master control and waited for clearance prior to moving youth. Staff counted youth entering and exiting doors. Youth were always in sight of at least two officers. Staff and youth interactions were always appropriate and professional. Counts were conducted three times each shift. All counts and youth status changes were documented in the logbooks. The center uses an Alpha list, which includes all youth in the facility. Also, a Daily Movement Sheet lists youth who entered the building and their movements. Seven staff were interviewed. Five of the seven staff stated they felt there are not enough staff to provide for the safety and security of the youth and staff. All seven staff reported counts are conducted at the beginning and end of each shift.

5.02 Ten-Minute Checks (Critical)	Satisfactory Compliance

Staff shall visually observe youth on standard supervision 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 conducts observations in a manner ensuring the safety and security of each youth and documents each check in real-time, manually or electronically. Documentation must include the actual time of each visual observation and initials of the staff conducting the check; pre-printed times are not acceptable.

There shall be no obstructions (e.g., clothing, memos, pictures) over windows and areas where direct line of sight is needed.

If an officer, in the course of completing visual observation, is unable to see the youth or any part of the youth's body, the officer shall, with the assistance of another officer, open the door to verify the youth's presence.

The center has a written policy and procedures to address ten-minute checks of youth while in their rooms. Checks of youth in their rooms are recorded with an electronic wand, with staff placing the wand over a piece of metal on each youth door to record the checks. Ten-minute checks were reviewed for six different dates on various shifts. All checks were documented in real time due to the use of the wand system. Checks were completed at or within ten-minute intervals with just two exceptions. Observations found there were no obstructions to view youth in their rooms. Seven staff and the superintendent were interviewed and all stated checks of youth in their rooms are conducted every ten minutes.

5.03 Census, Counts, and Tracking	Satisfactory Compliance

Officers must know the exact number and location of all youth under their supervision at all times. Census counts of youth shall be taken, called into Master Control, and documented, at a minimum:

- *At the beginning and end of each shift.*
- *Following any emergency to include power outages, evacuation due to emergency drills, and any code called outside the secure walls. In the event a code is called in any location outside the main walls of a facility, it is critical all youth counts are reconciled prior to the movement of any group of youth.*
- *Prior to and following routine group movement.*
- *Any time a population change occurs.*
- *Randomly, at least once on each shift.*

Staff should not include youth in the count who are not physically present with the staff person at the time of the count (e.g., court, clinic, confinement).

The center has a written policy and procedures in place to track all youth placed in the center. Youth movement and counts were observed throughout the annual compliance review. Youth were counted entering and exiting all doors. Staff called in counts three times each shift, at the beginning of the shift, mid-shift, and ending of the shift. Master control and mod logbooks were reviewed, which reflected counts were well documented. Youth admissions and releases were documented in the master control logbook. Seven staff were interviewed. All seven staff stated counts are conducted at the beginning and end of each shift and periodically during shifts. Five

staff stated counts are conducted when a youth is believed to be missing, three stated when visibility is hindered, such as an electrical outage, three stated during a major disturbance, and five stated during drills.

5.04 Logbook Maintenance	Satisfactory Compliance
The center maintains a chronological record of events, incidents, and activities in logbooks maintained at master control and in each living area in accordance with Florida Administrative Code. Each logbook is a bound book with numbered pages. If electronic logbook software is used by the facility, it is password-protected and configured to prevent entries from being deleted or altered after they are saved. *At a minimum, each logbook entry includes the date and time of the event, the names of staff and youth involved, a brief description of the event, the initials of the person making the entry, and the date and time of the entry. Logbook entries are made in black or blue ink, with no erasures or whiteout areas. No logbook entries are obliterated or removed; errors are struck through with a single line and initialed by the person correcting the error.* *Log entries regarding Medical, Special Needs, and Mental Health alerts, or other issues impacting facility safety and security shall be highlighted.*	

The center has a written policy and procedures regarding logbook maintenance. Logbooks are maintained for master control and each living area or module. Logbooks for the past six months were reviewed. All pages of the logbooks were bound and numbered. The date was documented at the top of each page. Logbook entries contained a chronological record of events including the time, names of youth, staff involved, and a brief description of the event. Errors were struck through with a single line and initialed by the staff making the entry. All youth movements and population counts were documented in all books. The master control logbook contained youth status changes, Central Communications Center (CCC) incidents and other significant incidents, confinements, and fire drills. Drills other than fire drills were not consistently documented, though were documented on separate forms. Significant entries were highlighted in the logbooks.

5.05 Logbook Reviews	Satisfactory Compliance
The superintendent or designee reviews all logbooks on a weekly basis. *The supervisor(s) reviews the facility logbook maintained at master control when he/she accepts responsibility for the facility.* *The juvenile justice detention officer (JJDO) supervisor(s) reviews logbooks maintained in each living area daily.* *The JJDO(s) reviews the logbook maintained in his/her assigned living area when he/she accepts responsibility for the living area at shift change.*	

The center has a written policy and procedures in place addressing logbook reviews. Master control and module logbooks were reviewed for the past six months. There was documentation of the superintendent or designee touring youth living areas at least once each shift and reviewing all logbooks at least weekly. Supervisors review logbooks daily and direct care staff documented a review of the logbook for their assigned module at the beginning of their shift.

The superintendent interview indicated supervisors are expected to review the logbooks daily and administration is expected to review logbooks weekly.

5.06 Key Control	Satisfactory Compliance
Each center is responsible for maintaining inventory and control of all facility keys. *All keys shall be placed on a tamper-resistant key ring designed to inhibit the removal of keys.* *Emergency key rings shall be maintained separately from other facility keys, in master control, in a secure location designated by the Superintendent. These keys shall be notched or otherwise identifiable by touch.* *The key(s) on these rings shall provide egress through facility exterior doors providing access to evacuation areas.* *A key inventory shall be maintained by the Superintendent or designee at all times.* *(For the entire indicator statement, please reference the Monitoring and Quality Improvement FY 2019-2020 Detention indicators.)*	

The center has a policy and procedures for key control. A review of the key inventory demonstrated all keys were accounted for on the inventory. All key sets had a tamper-resistant ring with a tag labeling the total amount of keys on the ring. Keys were stored in two separate locked boxes in master control. Staff either turn in their personal keys to master control or store them in their lockers. A shift briefing was observed, during which supervisors assigned floor keys to staff. The issuance of keys was documented in a logbook, reflecting the officer's name along with the date and time the keys were issued. The return of keys was documented in the log as well. All emergency keys are kept in master control. Youth do not have access to facility keys. There have been no instances of lost keys within the past six months. The maintenance mechanic was interviewed on the process if a key is broken and he was able to explain the process. A Master Control operator was interviewed and explained the process if a key was missing. There were two instances of staff taking keys home. In each instance, the staff returned the keys to the center within two hours. Key rings for one floor staff, the assistant superintendent, and maintenance mechanic were observed, and each key ring contained the accurate number of keys. Seven staff were interviewed. All staff stated personal keys are securely stored and there is daily tracking of center keys. Staff were able to explain the process for missing and damaged keys. The superintendent interview identified staff who are issued permanent issue keys and how these keys are tracked.

5.07 Vehicles and Maintenance	Satisfactory Compliance
The center ensures any vehicle used by the center to transport youth is properly maintained, as well as maintains documentation on the use and maintenance of each vehicle. *Youth and staff are not permitted to use tobacco products.* *Center vehicles are locked when not in use.*	

The center has a policy and procedures for vehicles and maintenance. Eight vehicles were observed. All vehicles contained a window punch, seat belt cutter, first aid kit, and a fire extinguisher. All vehicles were operational and in good condition. Annual inspections were

completed for all vehicles and inspections and invoices are maintained by maintenance staff. Each vehicle had enough gas, copies of transportation procedures, seatbelts anchored properly, and security cages. Registrations, keys, gas cards, and cell phones were present for each vehicle. Documentation of vehicle and youth searches was consistent with the observation. Other required vehicle checks were documented. One transport for a youth exiting for a doctor's appointment was observed. Staff radioed master control indicating they were beginning a contraband search on the vehicle and youth. The vehicle and youth were properly searched prior to departure for the appointment. All staff and the youth were wearing seatbelts prior to transport. One transport for youth returning from count was observed, finding procedures for notification of master control and searches were followed. All vehicles were secured at all times.

5.08 Tool Inventory and Management	**Satisfactory Compliance**
The center ensures all tools and equipment related to maintenance and kitchen area are properly maintained, stored, and inventoried.	

The center has a written policy and procedures for tool management and inventory. All maintenance and kitchen tools are stored in a locked area when not in use. Tools being used are placed on a shadow board and tools not in use are locked in a secure area. Maintenance staff and kitchen staff maintained a tool inventory log. Each time a knife was used, it was signed out on a perpetual inventory and checked back in. Maintenance and food service staff were interviewed and able to describe the process in the event of missing tools. One tool was reported broken in the kitchen and it was confirmed through the food services director the tool will not be replaced. Seven staff were interviewed and were able to explain the process to be followed if a tool is damaged or missing.

5.09 Youth Access & Use of Tools, Cleaning Items (Critical)	**Satisfactory Compliance**
Youth are forbidden to use or access any tools, including kitchen or medical equipment. *Youth may use cleaning items such as mops, brooms, buckets, and other common household items under direct supervision.*	

The center has a written policy and procedures addressing youth's access and use of tools and cleaning items. Youth are prohibited to use tools except for mops and brooms under staff supervision. Seven youth were interviewed. Five youth stated they only use brooms and mops and two youth indicated they don't use any type of tools. Seven staff were interviewed, and all seven staff indicated youth can use mops and brooms, but only when supervised by staff.

5.10 Inventory of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory Compliance
The Superintendent is responsible for the implementation of a safety plan addressing proper use, storage, and disposal of chemicals, including flammable, toxic, caustic, and poisonous items. *All flammable, toxic, caustic, and poisonous items shall be inventoried and secured when not in use. The use of hazardous material shall be consistent with the manufacturers' instruction and all safety precautions shall be followed.* *All flammable, toxic, caustic, and poisonous items shall have the Material Safety Data Sheets (MSDS) on hand in the facility. Toxic or caustic materials shall not be allowed to enter into the facility unless an MSDS is on file in an MSDS logbook and posted near items. A master copy of the MSDS logbook shall be maintained in an accessible binder for all personnel to review at all times.* *No hazardous chemicals should be mixed, as this could result in an explosion or emission of toxic gas.*	

The center has a written policy and procedures addressing the security and inventory of all flammable, toxic, caustic, and poisonous items. Most of the center's hazardous chemicals are stored in a shed outside the center. Cleaning chemicals within the center are securely stored. Youth do not have access to these storage areas. A binder with Safety Data Sheets (SDS) is kept where hazardous chemicals are stored. Maintenance maintains an inventory of all hazardous items, which was found to be accurate.

5.11 Access to all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory Compliance
Flammable, toxic, caustic, and poisonous fluids and other dangerous substances may only be drawn or acquired by authorized personnel. *Youth shall not be permitted to use, handle, or clean-up dangerous or hazardous chemicals or respond to chemical spills. Youth shall not be permitted to clean, handle, or dispose of any other person's bio hazardous material, bodily fluids, or human waste.*	

The center has a written policy and procedures which addresses access to all flammable, toxic, caustic, and poisonous items. Seven youth interviewed. Five youth stated they do not have access to flammable, toxic, caustic, and poisonous Items, though staff will spray cleaning chemicals on surfaces for youth to wipe up when assisting with cleaning. Two youth indicated they do not have access to such items. Seven staff were interviewed. Six staff indicated youth are allowed to assist with cleaning, with staff spraying cleaning agents and youth wiping up afterward. One staff indicated youth do not have access to any type of chemical.

5.12 Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory Compliance
The maintenance mechanic or other trained staff who have the safety equipment for diluting, handling, and disposing of hazardous waste and/or solid waste shall be responsible for disposing of hazardous items and toxic materials in accordance with Occupational Safety and Health Administration (OSHA) Standard 29 CFR 1910.1030 (amended 1-1-2004).	

The center has a written policy and procedures addressing the disposal of flammable, toxic, caustic, and poisonous items. There have not been any instances of chemical spills or disposed flammable, toxic, caustic, and poisonous items during the annual compliance review period. The only items disposed of were fluorescent light bulbs, which were taken to the hazardous waste center. Biohazard picks up monthly at the facility. The maintenance mechanic was interviewed and able to explain the process of disposing flammable, toxic, caustic and poisonous materials.

5.13 Confinement Under Twenty-Four Hours	Satisfactory Compliance
Staff shall use behavioral confinement as an immediate, short term response strategy during volatile situations in which a youth's sudden or unforeseen onset of behavior imminently and substantially threatens the physical safety of others or self.	

The center has a written policy and procedures regarding the use of confinement under twenty-four hours. Rooms used for confinement were not obstructed and contained no non-fixed items. Nine under twenty-four hours confinement reports were reviewed. A search of the confinement room was documented in eight of the nine reports. Eight of the nine reports were completed within one hour and reviewed by the supervisor within two hours. The remaining report was completed late. Supervisors documented speaking with youth in confinement every three hours to determine the need to continue confinement or if the youth could be released form confinement. The superintendent or designee documented a review of the confinement reports within forty-eight hours with one exception. School board officials were made aware of the youth confinement in the event youth requested school work. Seven staff interviews indicated staff must complete a confinement report. Six staff indicated ten-minute checks must be conducted. Six staff indicated the room must be searched prior to youth being placed in confinement. All seven staff indicated a supervisor must be notified of confinement. All staff reported youth must be checked every five minutes during the first hour of confinement and checked every ten minutes thereafter. The superintendent reported all confinements and physical restraints are documented and reviewed in the Facility Management System (FMS) and regional detention staff track this information monthly.

5.14 Confinement Over Twenty-Four Hours	Satisfactory Compliance

Confinement beyond twenty-four hours must be approved by the Superintendent or designee.

The Superintendent shall approve confinements extended beyond twenty-four hours and every twenty-four hours afterwards. Reasons for extended confinement must be clearly documented on the confinement report.

The JJDOS(s) shall continue to evaluate and document the youth's status every three hours. Current youth behavior and/or conversation with the youth shall be documented on the confinement report as evidence for the need to continue or terminate confinement.

If it is necessary to extend the confinement beyond twenty-four (24) hours, permission is needed from the regional director or designee. The regional director will notify the Assistant Secretary. This must be done every twenty-four (24) hours.

The length of confinement shall not exceed three days unless the release of the youth into the general population would jeopardize the safety and security of the facility as documented by the Superintendent. No youth shall be held in confinement beyond three days without a confinement hearing, conducted by an employee of the Department who holds a management or supervisory position.

The center has a written policy and procedures regarding the use of confinement over twenty-four hours. Nine confinements over twenty-four hours were reviewed. A mental health professional reviewed the confinements in seven records. No confinements exceeded three days; therefore, a hearing was not required. The regional director was notified and approved for the youth confinement to go beyond the twenty-four-hour mark. The superintendent stated a regional administrator must approve for a youth to be continued in confinement over twenty-four hours.

5.15 Continuity of Operations Planning (COOP) Drills	Satisfactory Compliance

COOP drills shall be conducted and documented, at minimum, twice a year, with one drill being completed prior to the hurricane season, which begins June 1st.

The center's disaster preparedness plan was reviewed, finding all annexes were attached. The center is required to conduct a Continuity of Operations Plan (COOP) drill quarterly. The center utilizes a drill reporting form for all drills, though the drills were not documented in the logbook. Drills were conducted at least quarterly and all staff on-duty participated in the drills. The center had a weather drill the beginning of the hurricane season. All seven staff indicated they have participated in a COOP or disaster drill.

5.16 Escape Drills	Satisfactory Compliance

The center shall develop, implement, and maintain an escape prevention plan incorporating the Department's established policies and procedure regarding escapes.

The facility shall conduct and document quarterly mock escape drills.

The center has an escape prevention policy and procedures, which is incorporated in the escape prevention plan. The center utilizes a drill reporting form for all drills. The drills were

completed quarterly, as required, on each shift, though not documented in the master control logbook. All staff were trained in escape prevention annually. Seven staff were interviewed, and all staff indicated they participated in an escape drill and are aware of the procedure for the drills. The center had no escapes during the annual compliance review period. The superintendent was interviewed and explained the center's escape prevention policy and practices.

5.17 Fire Drills	Satisfactory Compliance
Management has implemented a disaster preparedness plan and fire prevention plan. *Monthly fire drills (with procedures being approved by local fire officials) are documented and conducted under varied conditions and on each shift.*	

The center has a policy and procedures addressing fire drills. The procedures have been approved by a local fire official. The facility utilizes a drill reporting form for all drills. Fire drills were reviewed for the past six months, finding fire drills were completed twice monthly on each shift, exceeding the monthly requirement. All fire drills were documented in logbooks. All fire extinguishers were inspected annually. Seven staff interviewed and indicated fire drills are conducted at least monthly. All seven youth interviewed said they had been informed of what to do in case of a fire.