STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

# BUREAU OF MONITORING AND QUALITY IMPROVEMENT

## PROGRAM REPORT FOR

## Broward Regional Juvenile Detention Center

***Department of Juvenile Justice***

**(State-Operated)**
**222 North West 22nd Avenue**
**Fort Lauderdale, Florida 33311**

***Review Date(s): January 22-25, 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 that 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 that 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 that 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:

Gary Mogan, Office of Program Accountability, Lead Reviewer (Standard 1)
Keith Bennis. Office of Program Accountability, Regional Monitor (Standard 3)
Dedilia Finlayson. St. Lucie Regional Juvenile Detention Center, Superintendent (Standard 5)
Rondarrell George, Office of Program Accountability, Regional Monitor (Standard 2)
Marie Lockwood, Office of Program Accountability, Regional Monitor (Standard 4)
Peter Keelan, DJJ Office of Education, Education Coordinator (Standard 2)
Maryann Sanders, Office of Program Accountability, Deputy Regional Supervisor, (Youth and Staff Interviews)

Program Name: Broward Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: Broward County / Circuit 17
Review Date(s): January 22-25, 2019

MQI Program Code: 473
Contract Number: N/A
Number of Beds: 96
Lead Reviewer Code: 149

# Methodology

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) Youth Management, (3) Mental Health and Substance Abuse Services, (4) Health Services, and (5) Safety and Security, which are included in the Detention Standards.

## Persons Interviewed

☒ Program Director
☒ DJJ Monitor
☒ DHA or designee
☒ DMHCA or designee
**2** # Case Managers
**2** # Clinical Staff
**1** # Food Service Personnel
**4** # Healthcare Staff
**1** # Maintenance Personnel
**3** # Program Supervisors
**7** # Youth
**7** # Direct Care Staff
**3** # Other (listed by title): **Regional Director, Administrative Assistant**

## Documents Reviewed

☐ Accreditation Reports
☒ Affidavit of Good Moral Character
☒ CCC Reports
☒ Confinement Reports
☒ Continuity of Operation Plan
☐ Contract Monitoring Reports
☐ Contract Scope of Services
☒ Egress Plans
☒ Escape Notification/Logs
☒ Exposure Control Plan
☒ Fire Drill Log
☒ Fire Inspection Report
☒ Fire Prevention Plan
☒ Grievance Process/Records
☒ Key Control Log
☒ Logbooks
☒ Medical and Mental Health Alerts
☒ PAR Reports
☒ Precautionary Observation Logs
☒ Program Schedules
☒ Sick Call Logs
☒ Supplemental Contracts
☒ Table of Organization
☒ Telephone Logs
☒ Vehicle Inspection Reports
☒ Visitation Logs
☒ Youth Handbook
**7** # Health Records
**7** # MH/SA Records
**7** # Personnel Records
**25** # Training Records/CORE
**3** # Youth Records (Closed)
**7** # Youth Records (Open)
**6** # Other: **Volunteer records**

## Observations During Review

☒ Admissions
☒ Confinement
☒ Facility and Grounds
☒ First Aid Kit(s)
☒ Group
☒ Meals
☒ Medical Clinic
☒ Medication Administration
☒ Posting of Abuse Hotline
☒ Program Activities
☐ Recreation
☒ Searches
☒ Security Video Tapes
☒ Sick Call
☒ Social Skill Modeling by Staff
☒ Staff Interactions with Youth
☒ Staff Supervision of Youth
☒ Tool Inventory and Storage
☒ Toxic Item Inventory and Storage
☐ Transition/Exit Conferences
☒ Treatment Team Meetings
☒ Use of Mechanical Restraints
☒ Youth Movement and Counts

## Comments

Items not marked were either not applicable or not available for review.

# 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) | Satisfactory |
| 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 | Classification of Gang Members | Satisfactory |
| 2.05 | Notification of JPO Circuit Gang Rep | Satisfactory |
| 2.06 | Admission of Youth Personal Property | Satisfactory |
| 2.07 | Storage of Youth Personal Property | Satisfactory |
| 2.08 | Release | Satisfactory |
| 2.09 | Release of Youth Personal Property | Satisfactory |
| 2.10 | Release of Meds, Aftercare Instructions | Satisfactory |
| 2.11 | Review of Youth in Secure Detention and Home Detention | Satisfactory |
| 2.12 | Daily Activity Schedule | Satisfactory |
| 2.13 | Adherence to Daily Schedule | Satisfactory |
| 2.14 | Educational Access | Satisfactory |
| 2.15 | Career Education | Satisfactory |
| 2.16 | Behavior Management System | Satisfactory |
| 2.17 | * Unauthorized Use of Punishment | Satisfactory |
| 2.18 | Grievances | Satisfactory |
| 2.19 | 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 | Satisfactory |
| 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 | Satisfactory |
| 4.05 | Notification - Clinical Psychotropic Progress Note | Satisfactory |
| 4.06 | Immunizations | Satisfactory |
| 4.07 | Healthcare Admission Screening Form | Satisfactory |
| 4.08 | Medical Alerts | Satisfactory |
| 4.09 | Suicide Risk Screening Instrument | Satisfactory |
| 4.10 | Youth Orientation to Healthcare Services | Satisfactory |
| 4.11 | DHA/Designee Admission Notification | Satisfactory |
| 4.12 | Healthcare Admission Rescreening | Satisfactory |
| 4.13 | Health Related History | Satisfactory |
| 4.14 | Comprehensive Physical Assessment | Satisfactory |
| 4.15 | Female-Specific Screening/Examination | Satisfactory |
| 4.16 | Tuberculosis Screening | Satisfactory |
| 4.17 | Sexually Transmitted Infection Screening | Satisfactory |
| 4.18 | HIV Testing | Satisfactory |
| 4.19 | Sick Call Process - Requests/Complaints | Satisfactory |
| 4.20 | Sick Call Process - Visits/Encounters | Satisfactory |
| 4.21 | Restricted Housing | Satisfactory |
| 4.22 | Episodic/First Aid Care | Satisfactory |
| 4.23 | Emergency Care | Satisfactory |
| 4.24 | Off-Site Care/Referrals | Satisfactory |
| 4.25 | Chronic Conditions/Periodic Evaluations | Satisfactory |
| 4.26 | Medication Management - Verification | Satisfactory |
| 4.27 | Medication Management - Orders/Prescriptions | Satisfactory |
| 4.28 | Medication Management - Storage | Satisfactory |
| 4.29 | Medication and Sharps Inventory | Satisfactory |
| 4.30 | Medication Management - Controlled Medications | Satisfactory |
| 4.31 | Medication Administration Record | Satisfactory |
| 4.32 | Medication Administration By Licensed Staff | Satisfactory |
| 4.33 | Medications Provided By Non-Licensed Staff | Satisfactory |
| 4.34 | Psychotropic Medication Monitoring | Satisfactory |
| 4.35 | Infection Control - Surveillance, Screening, and Management | Satisfactory |
| 4.36 | Infection Control - Education | Satisfactory |
| 4.37 | Infection Control - Exposure Control Plan | Satisfactory |
| 4.38 | Prenatal Care - Physical Care of Pregnant Youth | Satisfactory |
| 4.39 | Prenatal Care - Nutrition and Education of Youth | Satisfactory |
| 4.40 | Prenatal Staff 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 | Limited |
| 5.03 | Census Counts and Tracking | Satisfactory |
| 5.04 | Logbook Maintenance | Satisfactory |
| 5.05 | Logbook Reviews | Limited |
| 5.06 | Key Control | Satisfactory |
| 5.07 | Vehicles and Maintenance | Failed |
| 5.08 | Tool Inventory and Management | Satisfactory |
| 5.09 | Kitchen Tools | Satisfactory |
| 5.10 | * Youth Access & Use of Tools, Cleaning Items | Satisfactory |
| 5.11 | Inventory of all Flammable, Toxic, Caustic, and Poisonous Items | Satisfactory |
| 5.12 | * Access to all Flammable, Toxic, Caustic, and Poisonous Items | Satisfactory |
| 5.13 | Disposal of all Flammable, Toxic, Caustic, and Poisonous Items | Satisfactory |
| 5.14 | Confinement Under Twenty-Four Hours | Satisfactory |
| 5.15 | Confinement Over Twenty-Four Hours | Satisfactory |
| 5.16 | Continuity of Operations Planning (COOP) Drills | Satisfactory |
| 5.17 | Escape Drills | Satisfactory |
| 5.18 | Fire Drills | 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).

## Program Overview

The Broward Regional Juvenile Detention Center is a state-owned detention facility, operated by the Department, located in Fort Lauderdale, Florida. The center serves youth in Broward, Miami-Dade, and Palm Beach counties in Circuit 17. Male and female youth who are detained pending adjudication, disposition, or placement in a residential commitment program are housed in the ninety-six-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 Broward County School Board. The center's management team includes the superintendent, two assistant superintendents, two administrative assistants, ten juvenile justice detention officer (JJDO) supervisors, and sixty-six JJDOs. The center also utilizes a certified therapy/service dog who is on-site a least five days a week. Mental health and healthcare services are provided through the contracted provider, Maxim Healthcare Services, Inc. who sub-contracts with Camelot Community Care, Inc. Mental health services are provided by one licensed mental health counselor (LMHC) who services as the designated mental health clinician authority (DMHCA), and one non-licensed master's-level therapist. 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 substance abuse services for youth with co-occurring disorders. Medical services are provided by one medical doctor who serves as the center's designated health authority (DHA), one advanced registered nurse practitioner (ARNP), one registered nurse (RN), two licensed practical nurses (LPN), and one medical clerk. The medical clinic maintains nursing coverage seven days a week, from 7:30 a.m. to 8:30 p.m. Monday through Friday and on weekends, from 8:00 a.m. to 8:00 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. Two of the living modules are under construction and two were being utilized at the time of the annual compliance review. There are ninety-six security cameras at the center, of which ninety-two were operational. Modules B-1 and G-1 were having new doors installed in each individual sleeping room. In addition, the bathrooms in modules B-1 and G-1 were remodeled, and the doors were replaced in modules B-2 and B-3 since the last annual compliance review. The center also had a new privacy fence installed around the perimeter, a new fence with razor wire installed behind module B-3, and the front entrance remodeled since the last annual compliance review. At the time of the annual compliance review, the center had thirteen vacancies, which included one JJDO II positions and twelve JJDO I positions.

## Strengths and Innovative Approaches

- In preparation to celebrate Christmas, Hanukkah, and Kwanzaa, the center decorated the doors, hallways, modules , staff lounge, and the dining area with festive ornaments, ribbons, bows, and pictures. The center invited local juvenile probation officers (JPOs) to judge the decorations. Treats were provided to all participants.
- In preparation for the Christmas holidays, the Seven Day Praise and Worship Ministry provided a special celebration for all youth in the center with pizza, chicken wings, sweets, and cakes. The evening ended with a voluntary spiritual service for those wanting to participate.
- Prior to the Christmas holidays, the center's administration hosted a special meal of Halloween goodies including hotdogs, hamburgers, chili, and a special holiday cake. All youth and staff received a surprise gift bag for their hard work and dedication in making the festivities a special time for youth in secure detention.
- The Broward Regional Juvenile Detention Center Art Project in collaboration with a local volunteer artist in which the female population planned, created, and completed a new mural in the main hallway. The focus of the mural was on change titled; "In the waves of change, we find our new direction." The final work was observed to be exceptional and in very good taste.
- The center's canine therapy continues to be a bright spot for youth locked in a secure area away from their family and loved ones. The canine's interaction with both the youth and staff have a relaxing effect on some of the infuriated and stressful youth by having the canine's provide unconditional love and attention. The special canine pet's have been known to turn a sad youth into a happy smiling person just by the pet's presence along with the pet's ability to interact with care.
- The center organized and hosted the Broward/Miami Pajama Party for the female youth. Female youth from the Miami-Dade Regional Juvenile Detention Center were invited to join in on the fun. Therefore, travel arrangements were organized through the Department's transportation system to transport the female youth to the center. The multi-purpose room was decorated and a variety of special foods were prepared along with games, movies, and a shirt decorating activity. Pajamas were donated and provided to all females to make the evening special.
- The United States (US) Customs and US Border Patrol Protection Dogs visited the center for a demonstration of how the dogs are trained and how they become accustomed to different locations and different scenario's. The dogs were reported to be trained for drug sniffing, cell phone detection, and agriculture. The youth had the opportunity to see the dogs work with the officers and see the dogs receive a treat or toy, which the youth indicated was interesting.
- A certified yoga instructor visits the center once a week or once every other week to provide the female youth with the basics of yoga exercises.

- A victim advocate representative of the Nancy J. Cotterman Center visits the center twice a week to discuss with both male and female youth on how to prevent being sexually exploited and abused.

| 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. A contract provider may hire an employee to a position that 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 that he or she exhibits no behaviors that warrant the denial or termination of employment. An Annual Affidavit of Compliance with Level 2 Screening Standards is completed annually.* | |

The center has a policy and procedures to ensure initial background screenings are conducted. A review of the staff roster found eighteen staff applicable for an initial background screening since the last annual compliance review. Each applicable employee had an initial background screening completed prior to their date of hire. The criminal history report was reviewed for each employee and all staff were found eligible for hire. Employees were documented on the Department's Clearinghouse Employment Roster and were reviewed through the Staff Verification System (SVS). All eighteen employees were applicable for the pre-employment assessment tool administered to direct care staff and each was noted to have a passing score. None of the applicants were identified for an exemption by the Department's Office of Inspector General (OIG), Background Screening Unit (BSU) prior to employment. An Annual Affidavit of Compliance with Level 2 Screening Standards (form IG/BSU-006) was completed and submitted to the BSU for detention staff on January 17, 2019, meeting the annual requirement. In addition, form IG/BSU-006 was submitted for Broward County Schools employees on January 17, 2019, also meeting the annual requirement.

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

The center has a policy and procedures to ensure the completion of a background rescreening for staff every five years calculated from the date of hire. A review of employee records found four staff and six volunteers were applicable for a five-year background rescreening since the last annual compliance review. A rescreening was submitted to the Department's Background Screening Unit (BSU) on January 17, 2019 for all volunteers to ensure compliance with the requirement for background rescreening at least ten days prior to the volunteer's five-year anniversary date. There were no contracted providers, interns, educational, medical, or mental health staff requiring a five-year background rescreening during this annual compliance review period. The five-year rescreening for the four staff reflected their records were submitted to the BSU on January 17, 2019, to ensure at least ten business days prior to the anniversary expiration date timeframe for compliance with the rescreening policy.

| 1.03 Staff Code of Conduct | Satisfactory Compliance |
|---|---|
| *Program staff adheres to a code of conduct prohibiting any form of abuse, profanity, threats, harassment, intimidation, "horseplay," or personal relationships with youth.*<br><br>*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 detention or who has been in the custody of the Department.*<br><br>*Officers shall not verbally abuse, demean or otherwise humiliate any youth, and shall not use profanity in the performance of their job.*<br><br>*Officers shall not engage in or allow horseplay, either verbal or physical with and/or between any youth.*<br><br>*Officers shall not engage in personal relationships nor discuss personal information related to themselves or other officers with any youth.*<br><br>*Management takes immediate action to investigate or address all allegations or violations of the code of conduct.* | |

The center has a policy and procedures detailing staff code of conduct. Staff are required to adhere to the code of conduct which prohibits any type of abuse, profanity, threats, harassment, intimidation, horseplay, or personal relationships with youth. A review of seven staff employment records verified each signed the center's code of conduct which was maintained in their employee record. Four staff were found to have disciplinary actions or code of conduct violations. Two staff were terminated on August 17, 2018 for policy violations, while two other staff were cited for improper search resulting in a training memorandum placed in their respective employee personnel files. An interview with the superintendent indicated there were eight violations for code of conduct since the last annual compliance review of March 2018 which involved four staff. An interview with the center's superintendent reflected the expectations of professionalism on and off the job, appropriate interactions with youth with suitable methods of disciplinary action, when necessary. The center's administration has a practice of rewarding staff with the following rewards; employee of the month certificate, recognizing staff for best penmanship, and perfect attendance. The superintendent reported all staff in the center receives special recognition throughout the year.

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

The center has a policy and procedures to ensure when a reportable incident occurs; the center notifies the Department's Central Communications Center (CCC) within two hours of becoming aware of the incident. The center had a total of sixty-two reportable incidents for the past six months. A review of seven incidents documented in the center's logbook indicated the incident date, time, incident type and persons involved. A review of internal incidents for the past six months found there were no additional incidents which should have been reported to the CCC. An interview with the superintendent indicated there has not been an increase in the number of reportable incidents to the CCC. The superintendent further indicated staff document incidents

in the Department's Juvenile Justice Information System (JJIS) Facility Management System (FMS) prior to the end of their shift and note the incident in the unit logbooks and master control logbook. The center's administration and the Protective Action Response (PAR) instructor review the center's incident reports and security video recordings within seventy-two hours. If abuse is observed, the center's administration practice is to notify the CCC.

| 1.05 Protective Action Response (PAR) | Satisfactory Compliance |
| --- | --- |
| *The program uses physical intervention techniques in accordance with Florida Administrative Code. Any time staff uses a physical intervention technique, such as countermoves, control techniques, takedowns, or application of mechanical restraints (other than for regular transports), a PAR Incident Report is completed and filed in accordance with the Florida Administrative Code.* | |

The center has a policy and procedures to ensure Protective Action Response (PAR) techniques are used in accordance with Florida Administrative Code 63H-1, Staff Training, Basic Curricula (PAR). A review of seven pre-service and seven in-service staff training records found each staff received PAR training approved by the Department's Office of Staff Development and Training . A review of seven PAR incidents reports found each report was completed by the end of the shift, inclusive of statements from all staff involved. None of the youth involved in the reports sustained injuries which required medical attention, or a call to the Florida Abuse Hotline. All reports were reviewed by the supervisor and PAR instructor to determine if use of force was consistent with the PAR policy and techniques approved by the Department in which all were found to be in compliance. All PAR incidents were reviewed by the superintendent and/or designee within seventy-two hours. Post-PAR interviews with youth were conducted within thirty minutes of the incidents, when warranted. Mechanical restraints were not used in any of the PAR incidents. The center's PAR rate during the annual compliance review period was 19.03, which is above the statewide Detention PAR rate of 10.87. An interview with seven staff indicated staff attempt verbal interventions prior to applying any touch control techniques and/or physical restraint. An interview with the superintendent indicated there has been a decrease in the use of PARs since the last annual compliance review.

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

The center has a policy and procedures regarding pre-service training. A review of seven staff training records indicated each completed all of the pre-service certification requirements specified by Florida Administrative Code within 180-days of hire. Required trainings included Protective Action Response (PAR) training, cardiopulmonary resuscitation (CPR), first aid, mental health services, substance abuse services, suicide recognition and intervention, emergency safety and security, Prison Rape Elimination Act (PREA), human trafficking, and detention operations. Two of the seven reviewed staff records reflected one staff was hired in November 2018 and the other staff was hired in December 2018. One staff completed the training academy in November of 2018. At the time of the annual compliance review, both staff were well within the required 180-days to complete all training requirements. A review of the staff training records verified pre-service training was documented in the Department's Learning Management System (SkillPro).

| 1.07 In-Service Training | Satisfactory Compliance |
|---|---|
| *All detention staff completes 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.*<br><br>*Supervisory staff completes eight hours of training (as part of the twenty-four hours of in-service training) in the areas specified in Florida Administrative Code.* | |

The center has a policy and procedures to ensure all detention staff complete twenty-four hours of in-service training each calendar year after completion of pre-service certification training. Supervisors are required to complete eight hours of supervisory training, annually. A review of seven staff training records found all staff received in-service training in the mandatory topics to include epinephrine auto injector training. Each reviewed staff record reflected staff met the minimum hourly requirements for training to include Protective Action Response (PAR) update, cardiopulmonary resuscitation (CPR), first aid, suicide prevention, and professionalism and ethics. Two of the seven staff identified were supervisory staff and completed in excess the required minimum of eight hours of management training. The supervisory trainings included leadership, personal accountability, employee relations, communication skills, fiscal responsibilities and medication management. Two minor exceptions were noted in which one staff did not receive training for the epinephrine auto injector, while another staff did not participate in the girls' healthcare training. The staff will participate in future trainings, once the date is scheduled by the registered nurse. All training was documented in the Department's Learning Management System (SkillPro). The center maintains an annual training plan, which is updated as needed to reflect any changes. The training plan was approved by the Department's Office of Staff Development and Training on January 17, 2019.

| 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.*<br><br>*Upon completion of the Admission Wizard, the officer shall ensure all Critical and Special Alerts are listed in JJIS.*<br><br>*The JJIS alert report shall be reviewed daily by supervisors and administrators to ensure it correctly reflects the status of youth.*<br><br>*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 facility immediately.*<br><br>*Medical and mental health staff shall review alerts to ensure each alert is correctly tracked and managed.*<br><br>*The responses and updates by medical, mental health and other staff should be documented in JJIS alerts as they pertain to that critical alert.*<br><br>*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.* | |

The center has a policy and procedures to ensure critical and special alerts are entered, reviewed, and responded to appropriately. The Department's Juvenile Justice Information System (JJIS) alerts are reviewed daily by the center's supervisors and administrators to ensure data correctly reflects the status of each youth. Updates and additional alerts may be entered by medical, detention, supervisory, and administrative staff. Information regarding youth alerts is communicated during daily shift briefings, logbook, alert forms, JJIS, and is communicated during the shift, if changes occur. Observations of a shift briefing validated the youth, applicable alerts, and youth in confinement were discussed. Alerts are also documented in the master control and module logbooks. A review of seven youth records indicated alerts were documented in the JJIS on the date identified, as required. All critical and special alerts are communicated to administration. The seven youth records reviewed had open alerts which were closed after the youth were admitted and an assessment was completed. Three youth alerts remained as ongoing due to medical conditions such as asthma and allergies to certain food groups, while other medical and mental health alerts were closed by the appropriately licensed staff. An interview with seven staff indicated staff are advised of youth alerts daily during shift debriefings, through review of alerts entered into JJIS, and through review of logbooks.

## Standard 2: Assessment and Performance Plan

| 2.01 Admission | Satisfactory Compliance |
|---|---|

*All youth are admitted to the program 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. *Review of inactive files shall be conducted, if available, to obtain useful information.*
3. *All youth shall be electronically searched, frisk searched, and stripped searched by an officer of the same sex as the youth.*
4. *All youth shall be allowed to place a telephone call at the facility'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.*
5. *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.*
6. *All youth shall be screened to identify medical, mental health, and substance abuse needs.*

The center has a written policy and procedures concerning youth admission into the center according to the statewide Detention Services Facility Operating Procedures (FOP) 2.01 Admissions. A review of seven youth case management records revealed the records contained arrest affidavits, detention risk assessment instrument (DRAI), and suicide risk screening instrument (SRSI) which is the required information for admission into the Department's secure detention centers. In addition, all seven youth records contained assessments for medical concerns, substance abuse, and mental health issues. There was no youth identified as in need of emergency medical/mental health care or under the influence of any intoxicant as each youth was initially screened in the juvenile assessment center (JAC) or came into the center through the Department's transportation system. Each record contained supporting documentation of the youth being electronically searched, frisk searched, and/or strip searched by an officer of the same gender. All records indicated documentation pertaining to the youth in the case management records. An observation of one admission was conducted and validated the youth was provided the opportunity to make a telephone call to their family and the youth was provided a snack given by the juvenile justice detention officer (JJDO). A review of the Department's Juvenile Justice Information System (JJIS) Admission Wizard indicated it was updated, as required.

| 2.02 Orientation | Satisfactory Compliance |
|---|---|

*Program orientation process shall occur within twenty-four hours of a youth being admitted into detention 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. *Facility 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;*
7. *Expectations for behavior and related consequences;*
8. *Possible new law violations for destruction of property; and*
9. *Youth rights.*

The center has a written policy and procedures regarding the youth orientation into the center. A review of seven youth case management records revealed all youth were advised both verbally and in writing of the orientation process. All seven records provided documentation of the rules and regulations, grievance procedures, visitation, telephone calls, youth rights, the behavior modification system and related consequences, how to access the Florida Abuse Hotline, including medical, mental health and substance abuse concerns and how to access the services. The staff explained the Prison Rape Elimination Act (PREA) and had the youth to view a PREA video. Seven youth were interviewed and all indicated they received an orientation to the rules and regulations of the detention center during admission. An observation of one youth admission validated the orientation process addressed all areas.

| 2.03 Classification | Satisfactory Compliance |
|---|---|

*All youth admitted to the detention 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.*

The center has a written policy and procedures regarding the classification of a youth admission into the center. Seven youth case management records were reviewed and documentation reflected each contained the classification process to ensure safety and security while in secure

detention. The consideration for potential safety and security concerns in room assignment includes gender, height, weight, age, level of aggressiveness, mental illness, intellectual disabilities, physical disabilities, gang affiliation, criminal behavior, history of sexual offenses, suicide risk, medical, and vulnerability to victimization and sexually aggressive behavior (VSAB). The center assigns a juvenile justice detention officer (JJDO) to the intake unit to conduct an intake screening and classification. All information was documented in the Department's Juvenile Justice Information System (JJIS) Admission Wizard prior to making a room assignment.

| 2.04 Classification of Gang Members | Satisfactory Compliance |
|---|---|
| *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.*<br><br>*In the event gang involvement is suspected, Detention 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 a screening process for youth newly admitted into the center to determine if the youth is a gang member or gang affiliated. Seven youth case management records were reviewed to determine if youth were identified as being a gang member or affiliated with any street gangs. Documentation confirmed each youth was screened upon admission. A review of the records revealed none of the youth were identified as gang members. However, a review of the center's Juvenile Justice Information System (JJIS) for the past six months reflected three identified gang members were admitted for secure detention. In all instances, the information was communicated to staff through the internal alert system.

| 2.05 Notification of Juvenile Probation Officer Circuit Gang Representative | Satisfactory Compliance |
|---|---|
| *Each center shall identify the Juvenile Probation Officer designated as the Circuit Gang Representative to communicate suspected gang activity.*<br><br>*A referral on a youth for suspected gang involvement shall be shared, via email, with the Juvenile Probation Officer designated as the Circuit Gang Representative indicating suspicions of gang activity such as youth flashing gang signs, gang tattoos, gang-related drawings, or related activity.*<br><br>*Detention staff should include in the email all pictures (when appropriate), copies of written statements, drawings, graffiti, and a description of what gang signs the youth was "flashing."* | |

The center has a policy and procedures on notifying the juvenile probation officer (JPO) circuit gang representative once a youth is identified as a gang member. Once a youth is admitted, the gang representative notifies the JPO by e-mail. The alert information is then entered into the Department's Juvenile Justice Information System (JJIS). Room assignments reference youth alerts in order to keep gang members in separate module. A review of three applicable youth case management records identified as gang members indicated the center provided documentation of e-mail communication to support this practice. This process was further validated by communication with the local circuit JPO delegated as the probation's gang member liaison who reported receiving notification from the detention center when a gang member is admitted.

| 2.06 Admission of Youth Personal Property | Satisfactory Compliance |
|---|---|
| *The program 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.* | |

The center has a policy and procedures for the possession of each youth's personal property during admission. The center's staff inventories all personal property in the youth's possession and document records of each surrendered item on the property receipt form. Youth property was placed in clear tamper proof bags with the youth's name clearly documented with a property form identifying the property enclosed in the bag. The center's practice is to place the tamper-proof property bags in the secure cabinet located in the supervisor's office. A notification logbook was observed on top of the secured cabinet documenting each youth's name and property. Personal property such as clothes and non-valuables are stored in a locked storage room specifically for youth property. Seven youth records were reviewed and each contained a property inventory form. Three of the seven youth records were applicable for personal items of value which contained documentation of personal valuable property being stored. A review of supporting information found there was no youth who refused to sign the property inventory form. At the time of admission, youth are informed of the unclaimed personal property procedures. Observations of one youth admission and storage of the youth's personal property validated this practice. Seven youth were interviewed and all seven responded staff checked their personal property at the time of admission and had them sign a receipt acknowledging the form.

| 2.07 Storage of Youth Personal Property | Satisfactory Compliance |
|---|---|
| *The program safeguards each youth's personal property until it can be returned to the youth and/or legal guardian.* | |

The center has a policy and procedures for storage of youth personal property. A review of three of seven youth records were applicable for the storage of youth personal property. The labeled youth property bags were stored in the supervisor's office within a secured cabinet. Non-valuable items bags are placed on shelves with the youth name facing outward for quick identification. The superintendent and assistant superintendent are the only staff with access to the storage area. Access to the youth's personal property is limited to designated staff and the drop safe is under video surveillance. An interview with the superintendent validated the youth property storage practice. In addition, the superintendent indicated there has not been any Central Communications Center (CCC) incidents involving youth personal property during the annual review period.

| 2.08 Release | Satisfactory Compliance |
| --- | --- |

*When releasing youth from detention, 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 program 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 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.*

The center has a written policy and procedures regarding the release of youth from secure detention. The releasing officer shall verify all court authorization, and the on-duty supervisor will review and validate all paperwork related to the release, prior to youth's release. A review of three closed records indicated each confirmed the youth identification (ID) was verified, the parent/guardian ID was verified, and a copy of the ID was placed in the youth records. All applicable forms were signed prior to the actual release from secure detention. An observation of a youth release validated the youth exited the center in their own clothing. A review of the Department's Central Communications Center (CCC) database and interview with the superintendent reflected there were no unauthorized releases since the last annual compliance review.

| 2.09 Release of Youth Personal Property | Satisfactory Compliance |
| --- | --- |

*Upon the youth's release from detention and retrieval of personal property, the releasing officer, the youth, and the youth's parent or legal guardian shall review and sign the Property Receipt Form and account for all of the youth's personal property.*

The center has a written policy and procedures regarding the release of youth personal property. Once a youth is released from the detention center, the personal property, the releasing officer, the youth, and the parent/guardian shall review and sign the property receipt form and account for all the youth's personal property Property not picked up within thirty-days is considered abandoned and after the thirty-day period a notice is mailed to the last known address. If the youth is on supervision of the Department, the assigned juvenile probation officer (JPO) is able to sign for and deliver the property to the youth. The superintendent shall notify the Department's Central Communications Center (CCC) and file an incident report when a youth's personal property value is fifty dollars or more, stolen and/or missing. Unclaimed personal property such as clothes are donated to Goodwill and valuables such as money is forward to the regional fiscal manager in the form of a money order. The regional fiscal manager will then forward the money order to the Department's headquarters designee in Tallahassee. The program maintains a property record of disposed cash forward to headquarters. If the youth is on probation, the assigned JPO will sign for and deliver the property to the youth. A review of three applicable closed youth records reflected the youth and the parent/guardian signed a

receipt of personal property form upon the youth's release. The Department's Juvenile Justice Information System (JJIS) Admission Wizard was observed to have been updated on the day of the youth's release. An observation of one youth release validated the center's practice.

| 2.10 Release of Medication, Aftercare Instructions | Satisfactory Compliance |
|---|---|
| *The program ensures there are provisions in place to ensure prescribed medication, along with medical instructions, accompanies detained youth upon release.* | |

The center has a written policy and procedures regarding the release of medication aftercare instructions. A review of three applicable closed youth records reflected supporting documentation verified youth was released to a parent/guardian with a copy of their identification and the Office of Health Services Medication Receipt, Transfer, and Disposition (form 053). The medication release form for each youth listed all medications at the time of the youth's release and was signed by the youth, the parent/guardian, and the center's facility staff.

| 2.11 Review of Youth in Secure and Home Detention | Satisfactory Compliance |
|---|---|
| *Detention reviews are conducted by the program on a weekly basis to ensure proper management of youth placed in secure detention and appropriate sharing of information. The superintendent appoints an appropriate staff person to coordinate detention reviews.* | |

The center has a written policy and procedures for review of youth in secure and home detention. The review of youth in secure and home detention is conducted on a weekly basis at the center facilitated by a juvenile justice detention officer supervisor (JJDOS). Observations of the weekly detention review for youth in secure and home detention confirmed discussion, tasks assigned for follow-up, discussion of previous detention reviews, and the staff member responsible for the release, when applicable. Reviewed documentation in the Department's case notebook module and in the Facility Maintenance System (FMS) for the past six months confirmed consistent participation by all parties who have responsibility for the youth and the follow-up requirements generated from each meeting. The process of the detention reviews is to provide a means to screen all youth who may be able to be terminated from home detention and to ensure cases in detention status proceed expeditiously in the court system. Mini treatment teams were included in the review process for all applicable youth. An interview with the superintendent confirmed the weekly detentions review take place at the center on Thursdays in the conference room.

| 2.12 Daily Activity Schedule | Satisfactory Compliance |
|---|---|
| *Youth are provided the opportunity to participate in constructive activities that will benefit the youth and the program. 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 center has a written policy and procedures regarding daily activities. Youth are provided the opportunity to participate in constructive activities which will benefit all youth at the same time, allowing the maximum use of staff for proper supervision. The superintendent or designee develops a daily activity schedule which was observed by the annual compliance review team members. The activity schedule is posted in each living area outlining the days and times for each youth activity. The daily activities consist of personal hygiene, meal time, visitation, education, recreation and physical actives, gender-specific program, restorative justice programing, life and social skills competency development and indoor activities which promote education, problem solving and life skills. Throughout the annual compliance review,

observations confirmed the center is following the posted activity schedule. An interview with the juvenile justice detention officer staff indicated the center addresses gender-specific curriculum during group sessions. Seven staff were interviewed and all responded the center follows the daily activity schedule. All seven interviewed staff further added the center offers gender-specific programming as a part of the daily schedule. There were seven youth interviews completed and all seven youth responded the center offers gender-specific programming.

| 2.13 Adherence to Daily Schedule | Satisfactory Compliance |
|---|---|
| *Facility staff shall adhere to the daily activity schedules. Documentation of all activities shall be made in all applicable logs.*<br><br>*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.*<br><br>*Any cancellation of visitation shall be approved by the superintendent.* | |

The center has a written policy and procedures regarding adherence to the daily activities. Observation of the daily activities and a review of master control logbook verified the center follows policy relating to adherence of the daily activity schedule. However, during the annual compliance review, youth were not able to attend classes in the outside portable buildings due to construction in the center. Seven youth were interviewed and each responded the center follows the daily activity schedule. Seven staff interviews validated the center follows the daily activity schedule.

| 2.14 Educational Access | Satisfactory Compliance |
|---|---|
| *The facility shall integrate educational instruction (career and technical education, as well as academic instruction) into their daily schedule in such a way ensuring the integrity of required instructional time.* | |

The center's educational program managed by the Broward County School Board operates on a year-round basis, providing the youth within the facility 300 days of instruction which is distributed over twelve months with a minimum of twenty-five hours weekly. School may be canceled due to natural/climatic emergencies such as hurricanes and other severe weather conditions. Upon review of the school's schedule and an interview with the school's on-site lead education counselor, teachers have nine dedicated days for professional development. A review of the center's three master control logbooks reflected school is occurring with minimal interference. This was verified by reviewing seven youth interview responses. Due to a security concern with the surrounding perimeter fence, classes were temporarily being conducted in alternative areas within the center instead of the outside portable buildings dedicated for classes. An interview with the superintendent indicated the security issue is related to the replacement of security fencing which separates the actual program and the outlaying dedicated education module units, as well as the replacement of the security doors exits to the module units.

| 2.15 Career Education | Satisfactory Compliance |
|---|---|
| *Staff shall develop and implement a career education competency development program.* | |

The center provides appropriate career education to the youth based upon the age as well as assessed cognitive and educational abilities. The career education component offered is categorized as a Type 1 career/vocational curriculum. This classification stresses “soft skills” which includes communication, decision making, as well as interpersonal skills. An interview with the lead education counselor indicated the youth are provided employment and life skills guidance through an on-site job coach who provides the youth with various exercises dealing directly to exploring career choices, corrective résumé writing, and interviewing skills. Seven youth interviews validated educational career/vocational classes are offered Monday through Friday.

| 2.16 Behavior Management System | Satisfactory Compliance |
|---|---|
| *The program provides a system of rewards, privileges, and consequences to encourage youth to fulfill the program’s expectations.*<br><br>*Each facility shall implement and maintain a behavior management system to meet the needs of the youth and the facility. The system shall be approved by the regional director and shall include rewards for positive behavior and consequences for inappropriate behavior.*<br><br>*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 written policy and procedures regarding the behavior management system (BMS). The center’s BMS provides a system of rewards, privileges, and consequences to encourage youth to follow the guidelines within the BMS. The center has implemented and maintains a BMS to meet the needs of the youth along with the safety and security of the youth and staff. The behavioral norms and expectation for the youth is posted in all living areas and clearly specifies appropriate and inappropriate behaviors. Observation of posting in all living areas clearly specify rules, norms, and expectations. Observation of staff interaction with youth while in the living modules, cafeteria and during movement appeared professional with staff offering encouragement as they interacted with the youth. A review of the center’s facility operating procedures (FOPs) on the BMS confirmed compliance with the components outlined in the center’s policies and procedures. A review of the master control logbook validated at the end of the day and prior to lights-out, entries into the module logbooks reflected youth were receiving daily points to progress within the BMS. Seven youth were interviewed to rate the effectiveness of the center’s BMS. Three youth rated the system as very good, three rated the BMS as good, while one considered the practice to be fair. Seven staff interviews concluded all staff attempt to explain to the youth their behavior and speak with them about alternative acceptable behaviors. Staff further responded only daily points and level changes can be imposed as a consequence for negative behavior. Three of the seven interviewed youth responded staff can adjust their privilege level as a consequence, while four youth replied they never had any behavioral problems. A review of the master control logbook and BMS level sheet form confirmed the center practice of ensuring rewards and consequences are given in accordance with the BMS.

| 2.17 Unauthorized Use of Punishment (Critical) | Satisfactory Compliance |
| --- | --- |
| *The center's behavior management system restricts certain types of penalties on youth who demonstrate negative behaviors.*<br><br>*Group punishment shall not be used as a part of the facility's behavior management plan. 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.*<br><br>*Corporal punishment shall not be used in detention facilities. All allegations of corporal punishment of any youth by facility staff shall be reported to the Florida Abuse Hotline, pursuant to Chapter 39, F.S., and the Central Communications Center.*<br><br>*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 has a policy and procedures in place to address the unauthorized use of punishment in the behavior management system (BMS) which restricts certain types of penalties on youth who demonstrate negative behaviors. A review of the center's internal incidents, the Department's Central Communications Center (CCC) reports, and the center's logbooks confirmed there were no instances of unauthorized use of punishment. Interviews with seven youth and seven staff verified at no time the center uses group or corporal punishment. None of the seven youth indicated youth are allowed to punish other youth. All youth responded they never witnessed a youth having leg irons applied on for out of control youth. All seven staff responded at no time would a consequence for negative behavior result in the loss of a meal, snack, sleep, or school. Further, no staff has ever witnessed another staff encouraging one youth to fight another.

| 2.18 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:*<br><br>1. *Informal phase, wherein the JJDO attempts to resolve the complaint or condition with the youth using effective communication skills;*<br>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*<br>3. *Appeal phase, wherein the youth may appeal the outcome of the formal phase to the superintendent or designee.* | |

The center has a written policy and procedures regarding the youth right to grieve and ensure all youth are treated fairly, respectfully, without discrimination, and their rights are protected. The process includes an informal phase, formal phase, and the appeal phase. A review of the center's master control logbooks, module logbooks, and the Department's Facility Management System (FMS) confirmed no grievances were filed within the last six months. The procedure in place begins with an informal phase where the juvenile justice detention officer (JJDO) attempts to resolve the complaint using effective communications skills. The second phase is the formal phase where the youth submits a written grievance if the verbal discussion with the JJDO did not resolve the youth's issue. The written grievance requires a response from the JJDO supervisor (JJDOS) by the end of the shift if possible or within twenty-four hours. Youth are

provided with a grievance form and a pencil to complete the grievance form. The grievance form is then provided to the JJDOS within two hours. The JJDOS will then document their findings on the grievance form and advise youth of what action, if any, may be taken. The youth may then appeal any unfavorable conclusion to the superintendent and/or designee, who will have seventy-two hours within receipt to take the corrective action deemed as necessary. Seven youth were interviewed and none of the youth reported filing a grievance while at the center. Seven staff were interviewed to explain the center's grievance process. All responses were consistent by which the youth completes the grievance form and submits to a supervisor to be addressed. Two staff reported once the supervisor receives the form, it is then submitted to administration.

| 2.19 Trauma-Informed Care | Satisfactory Compliance |
|---|---|

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

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

- *A recognition of the high prevalence of trauma*
- *Assessment for traumatic histories and symptoms*
- *Recognition of culture and practices that 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 center has a policy and procedures in placed regarding trauma-informed care. Reviewed training documentation confirmed the center is incorporating trauma-informed practice into current operations to deliver services and to provide care to youth in custody, acknowledging the role which violence and victimization play in the lives of most youth entering the center. During a tour of the center, observations confirmed a soft room and painting on the walls of soft colors offer an environment to comfort youth who have experienced traumatic events. The center also has a resident therapy dog which is on-site daily providing therapy and recreation for the youth. The superintendent confirmed all staff are trained on trauma-informed care training.

# 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 maintains a written policy and procedures to ensure there is a single licensed mental health professional identified as the designated mental health clinician authority (DMHCA), who is responsible for the coordination and implementation of mental health and substance abuse services. The center maintains a contract with Maxim Healthcare Services, Inc. to provide mental health and substance abuse services. Maxim Healthcare Services, Inc. subcontracts with Camelot Community Care, Inc., to provide comprehensive mental health and substance abuse services. Camelot provides a licensed mental health counselor (LMHC) who serves as the center's DMHCA. The DMHCA maintains a clear and active license to practice in the State of Florida, as verified on the Florida Department of Health website, with an expiration date of March 31, 2019. The DMHCA provides weekly direct clinical supervision to one part-time master's-level certified addiction professional and meets weekly with the psychiatrist to discuss each youth who is receiving services. A review of the documentation and an informal interview with the DMHCA confirmed the DMHCA is on-site on Monday and Tuesday from 11:00 a.m. until 7:00 p.m., Wednesday through Friday from 9:00 a.m. until 5:00 p.m., and Saturday from 9:00 a.m. until 1:00 p.m. The DMHCA is also available and on-call seven days a week, twenty-four hours a day.

| 3.02 Licensed Mental Health and Substance Abuse Clinical Staff [Contract Provider] (Critical) | Satisfactory Compliance |
|---|---|
| *The facility 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 maintains a written policy and procedures to ensure mental health services and substance abuse services are provided by individuals with appropriate qualifications. The center's contract with Maxim Healthcare Services, Inc. provides for a regional mental health and substance abuse clinical director for the south region, one full-time designated mental health clinician authority (DMHCA), and a psychiatrist for approximately two hours each week. Maxim Heath Care Services, Inc. subcontracts with Camelot Community Care, Inc. for the provision of all mental health and substance abuse services, and Camelot Community Care, Inc. subcontracts with a psychiatrist who is an osteopathic physician. The DMHCA is employed with Camelot Community Care, Inc., and the psychiatrist is subcontracted with Camelot Community Care, Inc. The DMHCA is on-site for a total of forty hours each week. The psychiatrist is scheduled to be on-site for up to four hours a week on Monday's from 2:00 p.m. until 6:00 p.m. The contract is valid from September 25, 2017 until April 30, 2019. Reviewed documentation of the visitor's log since the last annual compliance review confirmed the psychiatrist was on-site weekly, as required. A review of the licenses for the clinical staff and psychiatrist confirmed each maintained a clear and active license to practice in the State of Florida, as verified on the

Florida Department of Health's license verification website, with an expiration date of March 3, 2021 for the clinical staff and an expiration date of January 21, 2020 for the psychiatrist.

| 3.03 Non-Licensed Mental Health and Substance Abuse Clinical Staff [Contract Provider] | Satisfactory Compliance |
|---|---|
| *The facility 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 written policy and procedures to ensure mental health and substance abuse services are provided by individuals with appropriate qualifications. The center's superintendent is responsible for ensuring mental health and substance abuse services are provided by individuals with appropriate qualifications based on education, training, and experience. The center has one full-time non-licensed mental health and substance abuse clinical staff member who works under the contracted service provider. A review of the documentation reflected the master's-level non-licensed staff member has a degree with a focus on mental health counseling. Reviewed documentation reflected the non-licensed clinical staff received the required twenty hours of training and the supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. The training included five Assessments of Suicide Risk (ASR) or crisis assessments conducted on-site in the presence of a licensed mental health professional. Reviewed documentation of direct supervision logs verified a licensed mental health clinician provided at least one hour of supervision and reviewed each ASR and crisis assessment within twenty-four hours of the referral for assessment. Weekly supervision is documented on the Department's Licensed Mental Health Professionals and Licensed/Certified Substance Professionals Direct Supervision Log (MHSA 019).

| 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.*<br><br>*Detention center superintendent has established procedures for a thorough review of preliminary screening conducted by the Office of Probation and Community Intervention.* | |

The center maintains a written policy and procedures ensuring the mental health and substance abuse needs of the youth are identified through a comprehensive screening process and ensuring referrals are made when youth are identified with mental health and/or substance abuse needs or are identified with a possible risk of suicide. The procedures included a standardized screening process, which included a review of the Positive Achievement Change Tool (PACT) Mental Health and Substance Abuse Report and Referral Form, a review of the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2), and Suicide Risk Screening Instrument (SRSI). A review of seven youth mental health and substance abuse records indicated the center's staff reviewed all prior documentation completed by the juvenile probation officer (JPO) or Juvenile Assessment Center (JAC) once the youth was admitted to the center. The review also confirmed staff completed a Suicide Risk Screening Instrument (SRSI) for each youth upon intake. Each of the seven SRSIs were completed by a mental health clinical staff member. Each of the SRSIs had completed entries which also had a summary and

recommendations include in the screening results section. Each reviewed record contained a completed Positive Achievement Change Tool (PACT) and Massachusetts Youth Screening Instrument - Second version (MAYSI-2) completed in the Department's Juvenile Justice Information System (JJIS).

| 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 center maintains a written policy and procedures ensuring youth who are identified through preliminary screening, during intake and admission, as having mental health and/or substance abuse issues or needs are referred for a further in-depth mental health and/or substance abuse evaluation. The center maintains a contract with Maxim Health Services, Inc., who subcontracts services with Camelot Community Care, to ensure youth identified during the preliminary screening process receive an in-depth mental health and/or substance abuse assessment shortly after intake in the juvenile justice system. A review of seven youth mental health and substance abuse records reflected each youth was admitted within the last fourteen days of the annual compliance review. Three additional records were requested and reviewed. Reviewed documentation reflected each of the three applicable reviewed records had a completed evaluation prior to their admission to the center. Each of the three applicable youth had an updated evaluation completed within thirty days of referral. There were no youth applicable who exhibited behavior indicating a need for an assessment whose intake screening did not indicate a need for a comprehensive assessment.

| 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.*<br><br>*Each youth determined to need mental health treatment, including treatment with psychotropic medication, or substance abuse treatment while in a detention center, must be assigned to a mini-treatment team.* | |

The center has a policy and procedures regarding mental health and substance abuse treatment. Seven youth mental health and substance abuse records were reviewed for mental health and substance abuse treatment services,  two required services. One additional youth record was requested and reviewed. Three applicable records were reviewed for youth requiring mental health and/or substance abuse treatment due to observations, youth admission, or hits on their initial assessments were assigned to a mini-treatment team and were referred for services. A review of the documentation and an interview with the designated mental health clinician authority (DMHCA), confirmed each youth was offered services. Reviewed records found each youth had a copy of an Authorization for Evaluation and Treatment (AET) form as well as a signed youth consent for substance abuse treatment, Mental Health and Substance Abuse (MHSA) 012 form and youth consent for release of substance abuse treatment records (MHSA) 013 form. One reviewed youth record was applicable for treatment with psychotropic

medication. Reviewed documentation reflected each of the youth requiring treatment was assigned to a mini-treatment team consisting of mental health, medical, education, and administrative staff. Each record had documentation of weekly treatment team meetings. Each youth in need of treatment who were willing to participate in treatment received individual treatment supportive counseling with the DMHCA, as well as group therapy. Each applicable youth record contained an individualized treatment plan. Each youth's participation in treatment was documented in the mental health chronological notes. Reviewed documentation confirmed group therapy is limited to ten or fewer youth with mental health diagnoses for mental health treatment groups. Group therapy is limited to fifteen or fewer youth with substance abuse diagnoses for substance abuse treatment groups. A mini-treatment team meeting was observed on January 23, 2019, which verified the center's practice. Seven youth were interviewed and were asked to rate the mental health and substance abuse services they receive at the center. One youth rated it as good, two youth rated it as very good, and four youth reported they are not receiving mental health and/or substance abuse services at the time.

| 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 facility.*<br><br>*All youth who receive mental health and/or substance abuse treatment while in a detention facility shall have a discharge summary completed documenting the focus and course of the youth's treatment and recommendations for mental health and/or substance abuse services upon youth's release from the facility.* | |

The center maintains a written policy and procedures ensuring mental health and substance abuse treatment planning focuses on providing mental health treatment and/or substance abuse treatment which will reduce or alleviate the youth's symptoms of mental disorder or substance abuse impairment and enable the youth to function adequately. All youth receiving mental health and substance abuse treatment shall have a completed discharge summary documenting the focus and course of the youth's treatment and recommendations for mental health and/or substance abuse services upon the youth's release. A review of seven youth mental health and substance abuse records indicated one youth was applicable for an individual treatment plan. Two additional youth records were requested and reviewed. Three applicable youth mental health and substance abuse records were reviewed for treatment and discharge planning. Each applicable youth requiring mental health and/or substance abuse treatment due to observations, youth admission, or hits on their initial assessments were referred for services. One youth was applicable for treatment with psychotropic medication. Two additional records of youth requiring treatment with psychotropic medication were reviewed. There was documentation supporting an initial treatment plan was created within the required time frame for each youth which included medication management. Reviewed progress notes documented in the Department's Facility Management System (FMS) validated each youth received treatment services as stipulated in their treatment plan. The reviewed plans were signed by the youth and the mini-treatment team members to include the licensed clinician, mental health staff, center administration, and other applicable treatment team members. Attempts to contact the parent/guardian to provide verbal consent was documented on each reviewed plan. Three closed records were reviewed for treatment and discharge planning. Each applicable reviewed record contained an individualized treatment plan signed by the licensed mental health/substance abuse professional and contained all required elements. A thirty-day review of the individualized treatment plans was

applicable for one youth. Reviewed documentation confirmed the plan was reviewed and updated by the treatment team. Reviewed documentation indicated each reviewed youth who received mental health and/or substance abuse treatment while in the center had a discharge plan which was provided to the youth, the parent/guardian, and the assigned juvenile probation officer (JPO). Each reviewed discharge plan was completed on the Department's Mental Health/Substance Abuse (MHSA) Treatment Discharge Summary form 011. The center's practice is to e-mail the discharge summary to the youth's 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 maintains a written policy and procedures ensuring psychiatric services are provided to youth in need to include psychiatric evaluation, consultation, medication management, and medical supportive counseling. Psychiatric services are provided to youth in need of services, as indicated by symptoms of mental disorder or substance-related disorder, or to youth who are being treated with psychotropic medication after their admission to the center. The center has a contract with Maxim Health Services, Inc., who subcontracts psychiatric services with Camelot Community Care for the provisions of a licensed psychiatrist to provide psychiatric services for applicable youth in the center. Psychiatric services provided by the center include initial diagnostic psychiatric interviews, psychiatric evaluations, psychiatric follow-up assessments and consultations, coordination of services, crisis interventions, treatment planning, communication, and emergency procedures. Camelot Community Care provides a part-time psychiatrist who is contracted to provide services up to four hours each week. A review of the license for the psychiatrist confirmed the license is clear and active in the State of Florida, with an expiration date of January 31, 2020. A review of seven mental health and substance abuse records indicated three were applicable for receiving psychiatric services. Each applicable record contained an Authority for Evaluation and Treatment (AET) form. Each interview was completed within fourteen days of the youth's admission and included all required elements inclusive of the reason for the referral, history, mental status examination, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, treatment recommendations, prescribed medication with the explanation for the need, and frequency of medication monitoring. There were no youth applicable for prescribed medication after being admitted to the center. Each of the three youth on psychotropic medications received an in-depth psychiatric evaluation within thirty days of intake or the referral utilizing the Department's Clinical Psychotropic Progress Note (CPPN). Reviewed practice reflected the psychiatrist provided on going medication management and all CPPNs were completed in full. There were no applicable youth requiring Tardive Dyskinesia monthly monitoring. Reviewed documentation validated consent for psychotropic medication was obtained, as required. All reviewed mental health and substance abuse documentation was completed utilizing the Department's required forms.

| 3.09 Suicide Prevention Plan [Detention Staff] (Critical) | Satisfactory Compliance |
|---|---|
| *The program follows a suicide prevention plan to safely assess and protect youth with elevated risk of suicide in the least restrictive means possible, in accordance with Rule 63N-1, Florida Administrative Code.* | |

The center has a written policy and procedures outlining the center's suicide prevention plan. The suicide prevention plan was approved and signed by the superintendent and the designated mental health clinician authority (DMHCA) on December 3, 2018. The plan included the identification and assessment of at-risk youth for suicide, suicide risk alert, levels of supervision, suicide precautions, referrals, notification and communication, immediate staff response, use of extra precautions, review process, and emergency contact telephone numbers. The plan is maintained in the mental health office and training room accessible to all staff.

| 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.*<br><br>*Any youth exhibiting suicide risk behaviors must be placed on Suicide Precautions (Precautionary Observation or Secure Observation), and a minimum of constant supervision.*<br><br>*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 a written policy and procedures regarding suicide prevention services. Youth placed on suicide precautions are maintained on one-to-one or constant supervision. A review of four applicable youth mental health and substance abuse records was conducted for youth placed on precautionary observation (PO). An informal interview with the center's designated mental health clinician authority (DMHCA) and the regional director (RD) from Camelot Community Care confirmed the center had two youth placed in secure observation; however, the youth medical/mental health records were forwarded to each youth's residential commitment program. The secure observation of the records could not be reviewed. It was confirmed the center has a practice to ensure each youth placed in secure observation is supervised accordingly, and a follow-up Assessment of Suicide Risk (ASR) is completed within eight hours of placement. A review of the Department's Juvenile Justice Information System (JJIS) indicated the appropriate alerts were entered and removed for each youth on PO, as required. Reviewed documentation reflected staff observations were included on each of the Suicide Precaution Observation Logs and the ASR was completed for each youth within twenty-four hours. Three of the four ASRs were completed by a licensed mental health professional while one ASR was completed by a non-licensed clinical staff under the supervision of the DMHCA. The training record of the one non-licensed mental health staff member confirmed the staff member received the required twenty hours of training to complete an ASR, which included the five ASRs completed under the direct supervision and within the physical presence of the licensed mental health clinical staff. Reviewed logbooks reflected staff documented the beginning and ending times for when each youth was placed on precautions. Seven youth were interviewed and asked if they were ever placed on suicide watch while at the center. Six responded they have never been on suicide watch, while one reported they have. The one applicable youth reported

staff watched always while on suicide watch. Seven staff was interviewed and were asked of their responsibilities  if a youth expresses suicidal thoughts. Each of the staff reported they would notify the mental health authority, search the youth and room for sharp objects, provide constant sight and sound supervision to the youth, and document the supervision. One staff reported they would place youth in a locked room with another staff to monitor the youth.

| 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 member 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 maintains a written policy and procedures ensuring the staff assigned to monitor youth on suicide precautions must maintain one-to-one supervision or constant supervision of the youth and document their observations of the youth's behavior on the Department's Suicide Precautions Observation Log. A review of four applicable youth records of youth placed on precautionary observation (PO) reflected the Suicide Precautions Observation Logs were maintained for each youth. Each completed log documented the safe housing areas and observations were documented in real time, at required intervals. Reviewed logs supported the mental health therapist and shift supervisor(s) reviewed and signed each log, as required. An informal interview with the center's designated mental health clinician authority (DMHCA) and the regional director (RD) from Camelot Community Care confirmed the center had two youth placed in secure observation; however, their medical/mental health records were forwarded to each youth's residential commitment program. The secure observation of the records could not be reviewed.

| 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.* | |

A review of seven staff training records revealed each staff member received a minimum of six hours of annual training on suicide prevention and implementation of suicide precautions. The center maintains mock suicide drills in a centralized binder. Reviewed documentation reflected mock suicide drills were held on each shift quarterly. The mock drills included a suicide attempt or an incident of serious self-inflicted injury. Documentation of each mock suicide drill included the date, time, shift, and the participating staff. An informal interview with the superintendent confirmed staff members who are not present during a mock drill have the opportunity to review each mock drill scenario and procedures in an effort to understand the process and receive the necessary training to respond to an incident of a suicide attempt or incident of serious self-inflicted injury in the center. A review of the mental health crisis intervention plan revealed the center has a policy and procedures in place to address crisis interventions. Seven staff were interviewed and were asked on the location of the center's suicide response kits. Each of the seven interviewed staff reported a kit is in master control, sub-control, and in the medical office. Five of the seven interviewed staff also reported suicide response kits are located in the intake office, the mental health office, transportation, and on each module.

| 3.13 Mental Health Crisis Intervention Services [Detention Staff] (Critical) | Satisfactory Compliance |
|---|---|
| *Every program 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 maintains a written policy and procedures ensuring the center responds 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 center. The center maintains a mental health crisis intervention plan which was revised and approved by the superintendent and designated mental health clinician authority (DMHCA) on December 3, 2018. The plan detailed crisis intervention procedures inclusive of verbal de-escalation and Protective Action Response (PAR), as set forth in Florida Administrative Code (F.A.C.) 63H-1, notification and alert system, referrals including self-referral, crisis assessment and follow-up mental health status examination, communication, supervision, mental health supportive services, documentation, and review. The plan is maintained in the center's mental health office and within each mod's sub-control station, which is accessible to all staff.

| 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 facility, requires emergency care provided in accordance with the facility'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 maintains a written emergency care plan outlining mental health and substance abuse emergency procedures and to ensure youth who are believed as an imminent danger to themselves or others, due to mental illness or substance abuse impairment, receive emergency mental health or substance abuse services. A review of the center's emergency care plan confirmed it contained all required elements specified in the Florida Administrative Coded 63N-1 and was approved by the superintendent and designed mental health clinician authority (DMHCA) on December 3, 2018.

| 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, or under the direct supervision of a licensed mental health professional, to determine the severity of youth's symptoms, and level of risk to self or others. When staff observations indicate a youth's acute psychological distress is extreme/severe and does not respond to ordinary intervention, the 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 maintains a written mental health crisis intervention plan and procedures. The plan details crisis intervention procedures including a notification and alert system, means of referral, including youth self-referral, communication, supervision, documentation, and review. The center's plan was reviewed and approved by the designated mental health clinician authority (DMHCA) and the superintendent on December 3, 2018. An interview with the DMHCA confirmed the center had two applicable youth requiring a crisis assessment since the last annual compliance review. A review of the two completed crisis assessments found each were completed by a licensed mental health professional. Each crisis assessment was completed on the Department's Crisis Assessment Mental Health and Substance Abuse (MHSA) 023 form and each applicable youth remained on alert until a follow-up mental status examination was conducted. The Department's Juvenile Justice Information System (JJIS) was updated with the applicable alert for each. The completed crisis assessments were reviewed and electronically signed by the superintendent or designee. A review of seven staff training records confirmed all seven staff received mental health training relating to a youth in crisis.

| **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 maintains a written policy and procedures ensuring staff must immediately respond to youth presenting an imminent danger to self or others, due to a mental illness or substance abuse impairment, to protect the youth and others from harm. An interview conducted with the designated mental health authority clinician authority (DMHCA) and the regional director (RD) from Camelot Community Care confirmed the center had one applicable youth who required Baker Act procedures since the last annual compliance review in which the medical/mental health record was on-site at the center. Reviewed documentation reflected the RD,  a licensed clinical social worker (LCSW), completed the Certificate of Professional Initiating Involuntary Examination form and the youth's parent/guardian was notified, as required. The youth was maintained on precautionary observation (PO) constant supervision until transported to the crisis stabilization unit and upon return to the center until the Assessment of Suicide Risk (SAR) and mental status examination were completed. The Department's Juvenile Justice Information System (JJIS) was updated to include the initiation and discontinuation of a suicide alert. The center had no applicable Marchman Act procedures since the last annual compliance review.

# 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 facility.* | |

The center has a contractual agreement with Maxim Healthcare Services, Inc. to provide comprehensive medical, mental health, substance abuse and psychiatric services. A review of documentation found the designated health authority (DHA) is a board certified licensed physician who holds an unrestricted license to practice in the State of Florida, with an expiration date of July 31, 2020. Review of all licensed medical staff including the advanced registered nurse practitioner (ARNP), registered nurse (RN), and licensed practical nurses (LPN's) found all had current State of Florida medical licensure verified by the Department of Health (DOH). The DHA provides on-site services one day a week for three hours. A review of sign-in and out logs for the past six months and submitted time sheets found the DHA was on-site, as required. The DHA is responsible for ensuring the provision of clinical direction, policy development/review, and protocol approval for medical services. The center has a collaborative protocol last signed by the DHA and the ARNP respectively in June 2018. The ARNP provides on-site services a minimum of twenty-four hours a week. Hours for the ARNP and DHA are posted throughout the center. The DHA is responsible for ensuring communication with center staff regarding youth medical needs,  electronic availability for medical concerns, emergency care and coordination of off-site care twenty-four hours a day, seven days a week. During scheduled vacation or absences, a designated licensed physician provides services to the center.

| 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 a written policy and procedures to address health-related procedures and protocols. A review of the center's facility operating procedures (FOP) for all health-related procedures and treatment protocols utilized at the center found they were signed by the designated health authority (DHA) and the superintendent. The last annual review of treatment protocols was completed on August 2, 2018 and the last annual review of FOP's was completed on July 5, 2018. A review of the healthcare policies and procedures cover page found all newly employed healthcare staff received a comprehensive clinical orientation to the Department's healthcare policies and procedures. The nursing protocols acknowledgement form was signed by the registered nurse (RN), licensed practical nurses (LPN's), and superintendent in July 2018.

| 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.* | |

The center has a written policy and procedures addressing authorization of treatment for youth. A review of seven youth individual healthcare records (IHCRs) found each record contained an Authority for Evaluation and Treatment (AET) form. Four of the seven youth IHCRs contained an original AET and three youth IHCRs contained a copy of the AET stamped with the word "COPY." The parent/guardian signatures were present on all AET's. None of the youth IHCRs contained a Limited Consent for Evaluation and Treatment. In accordance with practice, non-emergent medical services were provided to youth after receipt of the signed and dated AET.

| 4.04 Parental Notification [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.* | |

The program has a written policy and procedures to ensure the center notifies the parent/guardian of significant changes in the youth's condition and to obtain consent when new medications and treatments are prescribed. A review of seven youth individual healthcare records (IHCRs) found three youth records were applicable for parental notification of over-the-counter (OTC) medications not covered by the Authority for Evaluation and Treatment (AET). Each of the three youth records contained documentation indicating the parent/guardian was notified. Two of the seven youth records were applicable for parental notification for newly prescribed medication. Of the two applicable records, one of the two youth records documented verbal and written notification to the parent/guardian. The remaining applicable youth record did not document verbal communication to the parent/guardian regarding newly prescribed medication; however, written notification was documented in the youth record. Two youth records were not applicable as they were not prescribed medication. A review of one of the seven youth records was applicable for and documented parental notification of off-site emergency care.

| 4.05 Notification – Clinical Psychotropic Progress Note (CPPN) [Contract Provider] | Satisfactory Compliance |
|---|---|
| *The Department's requirement to inform the parent or guardian and obtain consent for the prescription of new psychotropic medications, discontinuances or psychotropic medication adjustments.* | |

The program has a written policy and procedures to ensure the parent/guardian is informed of and provides consent for the prescription of new psychotropic medications, discontinuances, or psychotropic medication adjustments. Three of the seven youth individual healthcare records (IHCR) were applicable for psychotropic medication. One youth was in the custody of the Department of Children and Families (DCF). Each applicable record documented the youth arrived at the center with an established psychotropic medication regimen. A review of supporting documentation in all three records found conversation with the parent/guardian confirming the medication and dosage. Two youth records verified the parent/guardian arrived at the center to provide established psychotropic medication to nursing staff. None of the applicable youth had documented increases, decreases, or discontinuation of medication.

| 4.06 Immunizations [Contract Provider] | Satisfactory Compliance |
|---|---|
| *Each youth's immunization history and status shall be verified to meet state and Department requirements, and subsequently provide necessary immunizations/vaccinations (with parent/guardian consent).* | |

The program has a written policy and procedures to ensure each youth's immunization history and status is verified to meet state and Department requirements, and to provide necessary immunizations/vaccinations with parent/guardian consent. A review of seven youth healthcare records (IHCRs) found each record contained a copy of the Florida Certificate of Immunization verifying each youth received the necessary immunizations and vaccinations. Each youth record contained a signed Authority for Evaluation and Treatment (AET) form providing consent for any necessary vaccinations. No youth records documented religious exemption.

| 4.07 Healthcare Admission Screening Form (Medical and Mental Health Screening Form) (screening entered into JJIS/FMS) | Satisfactory Compliance |
|---|---|
| *Youth are screened upon admission for healthcare concerns that may need a referral for further assessment by healthcare staff.* | |

The program has a written policy and procedures to ensure youth are screened upon admission for healthcare concerns which may need a referral for further assessment by healthcare staff. A review of seven youth healthcare records (IHCRs) found each contained a Medical and Mental Health Admission Screening form completed on the date of admission by the juvenile justice detention officer (JDDO) and reviewed by the licensed practical nurse (LPN) within twenty-four hours. The information was entered into the Department's Juvenile Justice Information System (JJIS) Admission Wizard. An interview with the superintendent found the registered nurse (RN) and the licensed practical nurses completes the healthcare admission screening for youth.

| 4.08 Medical Alerts [Contract Provider] | Satisfactory Compliance |
|---|---|
| *The Department's requirement to alert staff of medical issues that may affect the security and safety of the youth in the facility.* | |

The program has a written policy and procedures to alert staff of medical issues which may affect the security and safety of youth at the center. Information pertaining to medical alerts are entered into the Department's Juvenile Justice Information System (JJIS). A review of seven youth individual healthcare records (IHCRs) found two youth were identified with allergies. Three of the seven youth were identified as having a chronic medical condition. A review of seven youth IHCRs found four youth were applicable for medication side effects associated with medication use. Seven staff were interviewed to determine how they were informed of a youth's medical alerts. Each staff reported they are informed through the alert form, review of the logbook and during shift meeting. Additionally, one staff reported being informed by reviewing the alert board. Six of seven staff reported the current process was very good for communicating information, and one staff reported the system was good. The superintendent stated the alert system is a daily print-out of all youth who have either medical alerts, gang alerts, mental health parental and/or foster care alerts. The information is uploaded daily by medical, mental health and detention review staff. It is reviewed at each briefing and staff are then made aware of all alerts. Food service receives alerts for allergies.

| 4.09 Suicide Risk Screening Instrument [Contract Provider] | Satisfactory Compliance |
|---|---|
| *A Suicide Risk Screening Instrument shall be completed within twenty-four hours of admission and filed in the Individual Health Care Record.* | |

The program has a written policy and procedures to ensure a suicide risk screening assessment shall be completed within twenty-four hours of admission and filed in the youth's individual healthcare record (IHCR). A review of seven youth IHCRs found each contained a completed Suicide Risk Screening Instrument (SRSI) completed by the mental health counselor within twenty-four hours.

| 4.10 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 facility.* | |

The program has a written policy and procedures to ensure all youth are oriented to the general process of healthcare delivery services at the center. A review of seven youth individual healthcare records (IHCRs) found each record contained a completed copy of the Health Education 013 form which documents youth orientation to healthcare services. Orientation is inclusive of a review of sick call, access to medical care, what to do in an emergency, introduction to the medication process including medication side effect monitoring, right to refuse care, what to do in the event of sexual assault or attempted sexual assault, the non-disciplinary role of healthcare providers, and a review of healthcare contacts. Youth acknowledge completion of the orientation to healthcare services by signing the medical services access form which was available in each of the reviewed seven youth IHCRs.

| 4.11 Designated Health Authority/Designee Admission Notification [Contract Provider] | Satisfactory Compliance |
|---|---|
| *The DHA or designee is notified when youth ad-mitted require emergency care or routine notification in accordance with Department requirements.* | |

The center has a written policy and procedures to ensure the designated health authority (DHA) is notified in accordance with the Department's requirements. As a required practice, the DHA is notified within twelve hours of the admission of any youth with a chronic medical condition, psychotropic medication, or medical concern. Notification is documented by licensed medical staff on the intake progress note maintained in the youth's individual healthcare record (IHCR). A review of seven youth IHCRs found none of the youth required emergency care upon admission. Seven youth IHCRs were reviewed for chronic medical conditions and none were applicable. Three additional youth records were selected and reviewed. Each of the three additional records selected were applicable for chronic medical conditions which were appropriately documented. Each of the three youth records documented the DHA was notified within twelve hours of the youth's admission to the center. Each youth was referred to the advanced registered nurse practitioner (ARNP). A review of seven youth IHCRs found three youth were taking psychotropic medication upon admission to the center. The DHA was notified as required in each instance.

| 4.12 Healthcare Admission Rescreening [Contract Provider] | Satisfactory Compliance |
|---|---|
| *A Healthcare Admission Rescreening is to be completed each time the physical custody of the youth changes and they are subsequently returned or readmitted to the facility.* | |

The center has a written policy and procedures to ensure a healthcare admission rescreening is completed each time the physical custody of the youth changes and if the youth is returned or re-admitted to the center. A review of seven youth individual healthcare records (IHCRs) found none of the youth were applicable for a change in physical custody since their admission to the center. A review of three additional youth (IHCRs) found each youth record was applicable for a change in custody since their admission to the center. A review of seven healthcare admission re-screening forms found a re-screening was completed by the juvenile justice detention officer (JJDO) for each instance in which custody changed for the three applicable youth. The re-screening review was conducted by a licensed practical nurse (LPN) within twenty-four hours.

| 4.13 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 a DJJ facility.* | |

The center utilizes and completes the standard Department Health-Related History (HRH) form for all youth admitted into the physical custody of a Department program. A review of seven youth individual healthcare records (IHCRs) found each record contained a HRH form completed by a licensed nurse within seven days of the youth's admission to the center. Each HRH was reviewed by the advanced registered nurse practitioner (ARNP) and was maintained in the youth IHCR. The HRH was completed before or at the same time as the Comprehensive Physical Assessment (CPA) for each youth.

| 4.14 Comprehensive Physical Assessment [Contract Provider] | Satisfactory Compliance |
|---|---|
| *The Comprehensive Physical Assessment (CPA) form shall be completed for all youth admitted in-to the physical custody of a DJJ facility.* | |

The center has a policy and procedures to ensure a Comprehensive Physical Assessment (CPA) form is completed for all youth admitted into the physical custody of a Department program. A review of seven youth individual healthcare records (IHCRs) found each contained a current CPA on file and completed within seven days of the youth's admission to the center. Five CPA's were reviewed, initialed, and dated by the advanced registered nurse practitioner (ARNP). Two CPA's were reviewed, initialed, and dated by the designated health authority (DHA). Two of the seven youth records were applicable for completion of a focused evaluation in which a new CPA was not initiated and a current CPA was used. The medical grade was documented on each CPA and an alert was generated in the center's alert system for youth assigned a medical grade between two and five. Three of the seven youth refused a portion of the CPA, a signed and dated refusal form was documented within their IHCR. A review of the Department's Problem List within each youth IHCR found it was updated by the nursing staff, as required.

| 4.15 Female-Specific Screening/Examination [Contract Provider] | Satisfactory Compliance |
|---|---|
| *The Department requires all adolescent girls receive gender-appropriate screenings, examinations, and tests to address their unique needs.* | |

The center has a written policy and procedures to ensure the completion of gender-specific screening. A review of seven youth individual healthcare records (IHCRs) found one record was applicable for review. The remaining six youth records were non-applicable as the youth were males. Two additional closed healthcare records were selected and were applicable for review. A review of the three applicable records found one youth refused testing for qualitative urine pregnancy screening. Two remaining youth agreed to have the testing completed, although they were identified as positive for pregnancy based upon documentation received from external providers upon their admission to the center. Each of the three applicable youth refused a gynecological examination and the designated health authority (DHA) did not provide a written order requesting the examination to be completed. Documentation of each youth's refusal was maintained in the youth's IHCR. Seven youth were interviewed to determine if they received prenatal, obstetrical, or gynecological services when in need at the program. Each youth reported they did not require these services. The Broward County Department of Health and the Cora E. Braynon Family Health Center is used by the center to provide gynecological services.

| 4.16 Tuberculosis Screening [Contract Provider] | Satisfactory Compliance |
|---|---|
| *All youth are required to be screened for Tuberculosis (TB), and accurate documentation of results shall be maintained by each facility.* | |

The center has a written policy and procedures ensuring the tuberculosis (TB) and documentation for youth. A review of seven youth individual healthcare records (IHCRs) found each contained a completed Tier 1 tuberculosis screening (TST) questionnaire located within the Medical and Mental Health Screening form as part of healthcare admission screening. A test was documented in each youth's IHCR. Results were documented on the Infectious and Communicable Disease (ICD) form and Comprehensive Physical Assessment (CPA) within seventy-two hours and maintained in the IHCR. In each of the seven youth records reviewed no further action was required, as all results were negative.

| 4.17 Sexually Transmitted Infection Screening [Contract Provider] | Satisfactory Compliance |
|---|---|
| *The facility shall ensure all youth are evaluated and treated (if necessary) for sexually transmitted infections (STIs).* | |

The center has a written policy and procedures to ensure completion of the sexually transmitted infection (STI) screening. A review of seven youth individual healthcare records (IHCRs) found nursing staff completed an STI screening form for each youth. Based upon the answers of the evaluation the youth reported to the nurse during the STI screening, a determination is made whether testing for STI's is required. Three of the seven youth records found further evaluations were required as indicated on the STI screening form and the youth were referred to the designated health authority (DHA). Laboratory results were available for two referred youth and the third youth refused to provide consent for further evaluation. The Infectious and Communicable Diseases (ICD) form was completed in each of the seven youth IHCRs reviewed.

| 4.18 HIV Testing [Contract Provider] | Satisfactory Compliance |
|---|---|
| *The facility shall routinely offer counseling, testing, and referrals for medical treatment to all youth at risk for HIV infection.* | |

The center has a written policy and procedures to address human immunodeficiency virus (HIV) counseling and testing. The center has a practice to ensure the center routinely offers counseling, testing, and referrals for medical treatment to all youth at risk for HIV infection. A review of seven youth individual healthcare records (IHCRs) found each youth was offered the opportunity to receive counseling, testing, treatment, and referral for HIV. Counseling is provided by licensed medical staff trained by the Department of Health. Three of the seven youth records documented youth provided consent for testing and information was updated on each youth health education record. Consent for testing was documented on the Department's HIV consent form. Each of the three applicable youth records documented youth received pre-test and post-test counseling by a certified HIV counselor. The name of the staff person completing the testing was documented. HIV results for the applicable youth were maintained confidentially within the youth's IHCR. No results were documented in the chronological progress notes or the internal alert system. The remaining four youth records documented each youth refused to consent for a HIV test. An interview with seven youth found each youth stated they could ask for a HIV test.

| 4.19 Sick Call Process – Requests/Complaints [Detention Staff/Contract Provider] | Satisfactory Compliance |
|---|---|
| *All youth in the facility shall be able to make Sick Call requests and have their complaints treated appropriately through the Sick Call system.* | |

The center has a written policy and procedures to ensure all youth in the center can make sick call requests and have their complaints treated appropriately. The center is currently transitioning from documenting sick calls on sick call request forms. Sick calls will be documented by staff electronically and communicated to medical staff. A review of seven youth individual healthcare records (IHCRs) found two youth were applicable for placing a sick call request. One additional youth healthcare record was selected and found applicable for placing a sick call request. Each of the three applicable records found sick call request forms were completed. Two youth were seen by the licensed practical nurse (LPN) for the sick call within twenty-four hours and one youth was seen by the designated health authority (DHA) within twenty-four hours. Youth signatures were documented on the sick call log in two of three instances. One youth was seen for sick call; however, the youth did not sign the sick call log as required in the center's established procedures. None of the sick calls required treatment or referral off-site. There were no instances in which a youth presented a similar sick call compliant three or more times in a two-week period. Seven youth were interviewed regarding how quickly they were seen once they made a sick call request. Four youth reported they were seen within one day, one youth reported being seen immediately, and two youth reported they never placed a sick call.

| 4.20 Sick Call Process – Visits/Encounters [Contract Provider] | Satisfactory Compliance |
|---|---|
| *The facility shall respond appropriately, in a timely manner, and document all Sick Call encounters as required by the Department.* | |

A review of the center's treatment protocols found the center has protocols appropriate to the level of the provider conducting sick call. Sick call services are provided by the licensed

practical nurse (LPN), registered nurse (RN), advanced registered nurse practitioner (ARNP), and designated health authority (DHA). The DHA conducts sick calls while at the center. A review of documentation found sick calls are conducted on Monday through Friday, from 9:00 a.m. to 11:00 a.m. and 6:00 p.m. to 7:00 p.m. Sick calls are conducted on the weekends from 1:00 p.m. to 3:00 p.m. A review of three applicable youth individual healthcare records (IHCRs) found sick calls were documented on the sick call index. Sick call forms documented the nature of the complaint, assessment, and plan to include subjective, objective, assessment, and plan format (SOAP). An interview with the RN indicated when there is not a licensed nurse on-site, the supervisor will review the sick calls no longer than four hours after the sick call is submitted, to determine the need for intervention. As needed, supervisors are trained to contact the DHA. No youth submitted a sick call request during the annual compliance review week; therefore, there were no sick calls to observe. Seven staff were interviewed to determine who conducts sick call and each staff reported the nurse conducts sick call. Seven youth were interviewed to determine who conducts sick call and all five youth reported the nurse conducts sick call. Two youth reported they had not made a sick call. Seven youth were interviewed regarding how they rated medical care at the center. Three youth rated services as very good, one rated services as good, one rated services as fair, and two youth reported not receiving sick call services.

| **4.21 Restricted Housing [Contract Provider]** | **Satisfactory Compliance** |
|---|---|
| *All youth in Restricted Housing/Confinement shall have timely access to medical care, as required by the Department.* | |

The center has a written policy and procedures to ensure all youth in restricted housing or confinement have timely access to medical care, as required by the Department. A review of seven youth individual healthcare records (IHCRs) found one record applicable for confinement. Two additional youth records were selected for review and were applicable for confinement. One youth was placed on confinement for behavior and two youth was placed on confinement for medical issues. Youth on confinement remain in their individual rooms. The first youth was placed on confinement for one hour, the second youth was on confinement for one day, and the last youth was on confinement for two days. A review of documentation in the youth IHCR found nursing staff made daily visits to youth to determine if the youth had any health-related complaints. Two of the youth were found to continue to receive their prescribed medications as ordered, and on time. The remaining youth was released from confinement status prior to the time of medication administration. Confinement reports were documented in the Department's Facility Management System (FMS).

| **4.22 Episodic/First Aid Care [Contract Provider]** | **Satisfactory Compliance** |
|---|---|
| *The facility shall have a comprehensive process for the provision of Episodic Care and First Aid.* | |

The center has a comprehensive process for the provision of episodic care and first aid to include episodic care performed by non-healthcare staff. The center utilizes an episodic care log to document episodic care and first aid treatment. The log contains all required information to include the date, name of youth, the youth's Department's identification number, nature of illness or injury, treatment rendered, staff initials, nurse initials, verification of who provided episodic care, and whether the youth was recommended for off-site care. A review of seven youth individual healthcare records (IHCRs) found two youth received episodic care. One additional youth record was selected for review and found applicable for episodic care. Each of the three applicable records documented problem oriented elements which were used to chart pertinent information pertaining to the nature of the youth's ailment including identification of the

subject, objective, assessment, and plan (SOAP) to address the complaint. Episodic care was administered by nursing staff in each instance. A random review of three first aid kits found each contained the required items identified on the designated health authority (DHA) inventory list. The center has nineteen first aid kits which are located throughout the program in master control, medical office, sub-control in each module, administration, kitchen, and in each van. Nursing staff conducts monthly reviews of the first aid kits and items are replenished upon use. Nursing staff seal and date the first aid kits after replenishment and review. The center has five suicide response kits maintained throughout the program in master control, medical office, sub-control units located in the modules. A random review of three suicide response kits found each kit contained the required items including knife for life, wire cutters and needle-nose pliers.

| **4.23 Emergency Care [Contract Provider]** | **Satisfactory Compliance** |
|---|---|
| *The facility shall have established processes and procedures for either directly providing Emergency Care or facilitating an appropriate response to an emergency situation.* | |

The center has a written policy and procedures to ensure emergency care and response to emergency situations. A review of emergency care procedures found the center has two automated external defibrillator (AED) units. One unit is maintained in the medical clinic and the other is maintained in master control. Units are checked weekly by the nurse. Both units were observed during the week of the annual compliance review and f both were in working order as demonstrated by the nurse. Written instructions for AED use are located inside each of the AED units and audio instructions begin once the unit is activated. New AED units were received by the center on November 13, 2018. AED batteries and pads will expire on March 28, 2021. A review of seven staff training records found all staff were trained in cardiopulmonary resuscitation (CPR), first aid, and AED. All non-healthcare staff are required to maintain certifications. Emergency contact numbers were observed posted in the medical clinic and in master control to include the number for the statewide Poison Information Center. Only healthcare and trained supervisory non-healthcare staff can administer the epinephrine auto injector for youth requiring administration, when indicated. An interview with the nurse indicated all newly hired staff receive epinephrine auto injector training within 180 days of hire and annually, thereafter. Staff are trained by a nurse. Two youth were prescribed epinephrine auto injector at the time of the annual compliance review. None of the youth required the use of the epinephrine auto injector during their time at the center as reported by the nurse. A review of quarterly mock emergency drills since the last annual compliance review found drills were conducted at least once a quarter on each shift. Documented use of life saving techniques such as CPR was noted on the mock emergency drills conducted on Alpha and Bravo shifts for the first quarter and Alpha, Bravo, and Charlie shifts for the second quarter. All documented drills included the type of medical event, time the drill/event occurred, time 9-1-1 was called, name of the supervisor/healthcare provider in charge, healthcare provider response time, type of medical care rendered, time the event concluded, clinical manager/medical staff review, and critique. A review of mock emergency drills for the third and fourth quarter found drills did not document demonstrated use of CPR and/or AED. Seven staff were interviewed to determine if they can call 9-1-1 if necessary. Each staff reported they are able to call 9-1-1 if necessary.

| 4.24 Off-Site Care/Referrals [Contract Provider] | Satisfactory Compliance |
| --- | --- |
| *The facility 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 to provide for timely referrals and coordination of medical services to ensure youth have timely access to off-site care services. A review of seven youth individual healthcare records (IHCRs) found two were applicable for off-site medical care. One additional youth record was selected for review and found applicable for off-site medical emergency care. Each youth record contained a Summary of Off-site Care form, discharge documentation, and instructions. Each record documented the designated health authority (DHA) or advanced registered nurse practitioner (ARNP) reviewed and signed all off-site care findings, instructions, and information. None of the youth required referrals for follow-up testing or appointments.

| 4.25 Chronic Conditions/Periodic Evaluations [Contract Provider] | Satisfactory Compliance |
| --- | --- |
| *The facility shall ensure youth who have chronic conditions receive regularly scheduled evaluations and necessary follow-up.* | |

The center has a policy and procedures to ensure youth with chronic conditions receive treatment, regularly scheduled evaluations, and necessary follow-up care. Youth are screened during the intake process for medical conditions warranting periodic evaluations and follow-up care. A review of seven youth individual healthcare records (IHCRs) found three youth were applicable for the existence of chronic conditions and each was taking medication. Each youth was classified with a medical grade between two and five. None of the youth were classified with a body mass index (BMI) greater than thirty. One youth was undergoing treatment for a physical health condition while the remaining three applicable youth were diagnosed with a mental health diagnosis. Treatment orders were written clearly. None of the applicable youth received periodic evaluations as they were newly admitted to the center. All four youth were placed on the chronic conditions list.

| 4.26 Medication Management – Verification [Contract Provider] | Satisfactory Compliance |
| --- | --- |
| *A youth's medication regimen shall be ascertained upon admission to the facility.* | |

The center has a policy and procedures to address medication verification. The center's practice for the nursing staff is to verify medication with the parent/guardian delivering medication to the center. The Medication Receipt, Transfer, and Disposition Form is used to document medication received in the original packaging from a licensed pharmacy with a current legible patient-specific label affixed. A review of seven youth individual healthcare records (IHCRs) identified four youth were taking prescribed medication upon admission and were applicable for medication management. Each applicable youth record documented verification of prescription medication by the nurse on the chronological notes. In each applicable record, the licensed nurse obtained an order from the designated health authority (DHA) to resume medication. All orders were signed by the practitioner.

| 4.27 Medication Management – Orders/Prescriptions [Contract Provider] | Satisfactory Compliance |
|---|---|
| *All medications shall have a current, valid order and are given pursuant to a current prescription or Practitioner Order.* | |

The center has a policy and procedures to ensure all medications have a current, valid order and are given pursuant to a current prescription or practitioner order. Youth admitted to the center are continued on psychotropic medication until completion of the initial psychiatric evaluation. A review of seven youth individual healthcare records (IHCRs) found four youth were taking medication upon admission. Each youth record contained a current, valid order given pursuant to a current prescription. Each youth record documented a practitioner order indicating medication to be continued. There were no changes to or discontinuation of medication noted in the applicable youth records. The initial Medication Administration Record (MAR) in each record matched the youth's medication list. Three youth were prescribed over-the-counter (OTC) medication which were not covered by the Authority for Evaluation and Treatment (AET). The medication administration record is updated to reflect all changes in medication including newly prescribed and discontinued medication.

| 4.28 Medication Management – Storage [Contract Provider] | Satisfactory Compliance |
|---|---|
| *All medications (e.g., prescriptions, over-the-counter, topical) are stored in separate, secure (locked) areas inaccessible to youth.* | |

The center has a policy and procedures to ensure all medications are stored in separate secure and locked areas inaccessible to youth. A review of the medical clinic found the clinic is secured under lock and key. Medical staff and trained supervisory non-healthcare staff have access to the clinic. Supervisory non-healthcare staff are trained by the nurse to assist youth with self-administration of medication. The center has nine non-healthcare staff who were trained by the nurse on October 18, 2018 to assist youth with self-administration of medication. A locked medication cart located within the medical office, houses oral prescription and over-the-counter (OTC) medications prescribed for youth. Medication in the cart is separated by each module and each youth. A second locked medication box is in the medication cart and stores controlled medication. Additional stock of OTC medication is maintained in secure and locked cabinets in the clinic. All sharps, syringes, suture removal kits, and scissors were observed in a stored designated locked cabinet. Medication requiring refrigeration is stored in a secured refrigerator designated specifically for medication storage. Observation of the refrigerator found insulin was maintained for one youth. The center has a policy and procedures for the disposal of expired prescribed and OTC medication. The consultant pharmacist arrives on-site monthly to review controlled substances and narcotics scheduled for disposal. The consultant pharmacist is contracted with Diamond Pharmacy through February 28, 2019. The nurse and pharmacist consultant are jointly responsible for the disposal of controlled substances and narcotics. The process for disposal of medication is documented in the center's policy and procedures. Unused blister-pack medications are returned to Diamond Pharmacy for credit. The center has a current modified Class II B Pharmacy Permit which expires on February 28, 2019.

| 4.29 Medication Management – Medication and Sharps Inventory [Contract Provider] | Satisfactory Compliance |
|---|---|
| *All medications and sharps shall be inventoried, as per Department requirements.* | |

The center maintains an inventory of all sharps and medical equipment classified as sharps to include syringes, butterflies, scissors, needles, and suture removal kits. Items designated as sharps are stored in a designated locked cabinet in the medical clinic and are inaccessible to youth. A review of the perpetual inventory for the past six months found sharps inventory counts to be accurate. A review of three random prescriptions and three over-the-counter (OTC) medications found counts were accurate. A review of the running daily inventory of all prescription and OTC medications matched the random count.

| 4.30 Medication Management – Controlled Medications [Contract Provider] | Satisfactory Compliance |
|---|---|
| *All controlled substances shall be inventoried, stored, and documented, as per Board of Pharmacy and Department requirements.* | |

The center has a written policy and procedures for controlled medication. Controlled substances are secured in a locked medication box which is maintained within a locked medication cart in the medical office. As outlined in the policy, shift-to-shift inventories are conducted to ensure accuracy of controlled substance counts. Nursing staff are responsible for conducting and documenting counts. A review of three random controlled medications of two active youth and one closed youth record found each medication matched the counts documented on the inventories. Inventories from the past six months were reviewed and confirmed two signatures were documented on the controlled inventory count. There were no discrepancies or lapses in the administration or documentation of controlled substances.

| 4.31 Medication Management – Medication Administration Record [Contract Provider] | Satisfactory Compliance |
|---|---|
| *The standard Department Medication Administration Record (MAR) shall be maintained at the facility for each youth who has a current, valid medication order.* | |

The center utilizes the Department's standard Medication Administration Record (MAR) to document medication administration. The MAR contained all the required elements to include the youth's name, date of birth, allergy status, precautions, medical grade, start and stop dates for medication, medical alerts, youth photograph, nursing weekly side effect monitoring, youth initials, and the initials of licensed healthcare staff administering medication. A review of seven youth individual healthcare records (IHCRs) revealed four were applicable for a MAR and each contained all the required elements addressed. Medication was administered by nursing staff. There were no documented instances in which youth received medication from non-healthcare staff since the last annual compliance review. Trained non-healthcare staff are instructed to document their supervision of youth self-administration of medication on the perpetual inventory log and MAR.

| 4.32 Medication Management – Medication Administration by Licensed Staff [Contract Provider] | Satisfactory Compliance |
| --- | --- |
| *Medication Administration shall occur as scheduled in a comprehensive, accurate, and organized manner in the facility, only by a licensed nurse.* | |

The center has a written policy and procedures to ensure medication administration by licensed staff. Medication pass is conducted each day from 7:00 a.m. to 9:00 a.m., at 5:00 p.m. and 7:00 p.m. to 9:00 p.m. Observation of a medication pass was conducted during the annual compliance review. Youth were escorted to the medical clinic by center staff. Observed practice indicated the nurse interacted with the youth and reviewed the Medication Administration Record (MAR) while confirming the youth's name, name of medication to be administered, side effects, and allergy status. The five rights of administration were verified for each youth. Nursing staff engaged the youth after medication administration to ensure medication was consumed. Any refusal of medication is documented on the MAR and on the Department's Refusal of Treatment Form, which is maintained in the youth's individual healthcare record. Observation of a medication pass during the annual compliance review found one youth refused medication. The refusal was documented on the required forms. Seven youth were interviewed to determine who administers medication at the center. Six youth reported they do not take medication, while one youth reported the nurse administers medication at the center.

| 4.33 Medication Management – Medication Provided by Non-Licensed Staff [Detention Staff/Contract Provider] | Satisfactory Compliance |
| --- | --- |
| *Trained, non-healthcare staff may assist youth with self-administration of oral prescription medications or over-the-counter (OTC) medications, only when licensed nurses are not available on site. The nurse shall delegate the delivery, supervision, and oversight of youth during self-administration of medications.* | |

The center has a written policy and procedures to direct medication administration by non-licensed staff. Trained non-healthcare supervisory staff may assist youth with self-administration of oral prescription medication or over-the-counter (OTC) medications, only when licensed nurses are not available on-site. The registered nurse (RN) is responsible for training the juvenile justice detention officer supervisors (JJDOS) to assist youth with self-administration of medication. During the annual compliance review period there were nine trained JJDOS staff who completed training on October 18, 2018. There were no documented instances of non-licensed staff supervising self-administration of medication since the last annual compliance review. Seven staff were interviewed to determine whether they provide medication to youth. Three staff reported providing medication to youth and four staff reported they do not provide medication to youth. Seven youth were interviewed to determine who administers medication at the center. Six youth reported they do not take medication, one youth reported the nurse provides medication at the center.

| 4.34 Medication Management – Psychotropic Medication Monitoring [Contract Provider] | Satisfactory Compliance |
| --- | --- |
| *The facility shall have a comprehensive process in place for the monitoring of psychotropic medications, to ensure youths' safety and as required by the Department.* | |

The center has a written policy and procedures to address psychotropic medication monitoring. A review of three applicable youth individual healthcare records (IHCRs) found each youth was prescribed psychotropic medication upon admission. Each youth continued to receive their respective medication until they received the initial diagnostic psychiatric interview conducted by

the psychiatrist within fourteen days of their admission. Each youth was referred to the psychiatrist by a mental health professional. Each youth received their evaluation within the required time frame. The Clinical Psychotropic Progress Note (CPPN) for each youth documented the youth's name, the youth's Department identification number, date of birth, allergy status, prescribing practitioner, facility name, chief compliant/physical symptoms, mental status exam findings, diagnosis, medication history, therapy psychiatric history, medical history, personal history, substance use history treatment planning recommendations and practitioner signature. None of the three youth required monitoring for symptoms of Tardive Dyskinesia as reported by the nurse. Each of the three youth were newly admitted to the center and were not in the center long enough to receive monthly reviews by the psychiatrist. There were no standing orders, emergency orders, or as-needed orders were observed in the individual youth healthcare records.

| **4.35 Infection Control – Surveillance, Screening, and Management [Contract Provider]** | **Satisfactory Compliance** |
|---|---|
| *The facility 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 center has a written infection control plan in accordance with the Department's Florida Administrative Code 63M. The infection control plan was last approved by the designated health authority (DHA) on July 5, 2018 and addresses infection control procedures including prevention, containment, treatment, and reporting requirements. The plan also addressed common childhood infectious diseases, tuberculosis, hepatitis A, B and C, human immunodeficiency virus (HIV), bloodborne pathogens, food borne illness, protocols for needlestick injuries, chemical exposures, methicillin resistant staphylococcus aureus (MRSA) outbreaks of pediculosis, other outbreaks and epidemics, bioterrorism agents, and staff access to personal protective equipment. There were no reportable incidents for which the local county health department, Centers for Disease Control and Prevention (CDC), and the Department's Central Communications Center (CCC) should have been notified of an infectious disease since the last annual compliance review.

| **4.36 Infection Control – Education [Contract Provider]** | **Satisfactory Compliance** |
|---|---|
| *The facility's comprehensive Infection Control education plan shall include pre-service and in-service training for all staff, and youth infection control education, as per Centers for Disease Control and Prevention (CDC) guidelines.* | |

The center has a written policy and procedures to address infectious and communicable diseases. Staff and youth at the center receive education regarding infection control to include hand washing techniques, prevention, transmission of communicable diseases, vaccinations and universal standards and precautions. A review of seven youth individual healthcare records (IHCRs) verified each youth received infection control education within seven days of their admission. Seven staff training records verified six staff completed training on infection control, bloodborne pathogens, and exposure control training. At the time of the review, it was unclear in one out of the seven staff records reviewed did not participate in the woman's wellness training. The staff will participate in the next training; however, the registered nurse (RN) conducting the training schedules training classes as deemed necessary.

| 4.37 Infection Control – Exposure Control Plan [Contract Provider] | Satisfactory Compliance |
|---|---|
| *The facility's exposure control plan shall meet the requirements of OSHA standards (29 CFR 1910), with maintenance and documentation of the plan, as per the requirements of the Department.* | |

The center has a written policy and procedures to address infectious and communicable diseases. The exposure control plan is written in accordance with Occupational Safety and Health Administration (OSHA) guidelines and Florida Administrative Code 63M-2.050. The exposure plan address risk assessment to include a list of job specifications in which employees have the potential for exposure and tasks or procedures causing staff to have occupational exposure. Methods of compliance include infection control practices and engineering workplace controls including handwashing facilities, proper disposal of needles and sharps, procedures for handling contaminated laundry and procedures for post-exposure evaluation and follow-up. There were no incidents involving a contagious disease requiring the quarantine or hospitalization of at least ten percent of the total population of youth or staff since the last annual compliance review.

| 4.38 Prenatal Care – Physical Care of Pregnant Youth [Contract Provider] | Satisfactory Compliance |
|---|---|
| *The facility shall provide prenatal care at recommended intervals. High-risk pregnant youth will be provided additional testing and services, as recommended.* | |

The center has a written policy and procedures for the care of pregnant youth to include procedures for medical issues, nutrition, education, and medication. A review of seven youth individual healthcare records (IHCRs) identified one female youth record and six male youth records. Review of the female youth IHCR  found the youth was not applicable as the youth was not pregnant. Two closed youth records were applicable for review since the last annual compliance review. Each youth arrived at the center with a positive confirmation of pregnancy and prenatal care protocols were implemented. Alerts were entered into the Department's Juvenile Justice Information System (JJIS),  youth vital signs and other relevant information such as weight was recorded on the Medication Administration Record (MAR). One youth left the center the day of admission and the second youth left three days after admission. Seven youth were interviewed to determine if they received prenatal, obstetrical, or gynecological services when deemed necessary at the program. Each youth reported they did not require these services.

| 4.39 Prenatal Care – Nutrition and Education of Youth [Contract Provider] | Satisfactory Compliance |
|---|---|
| *The facility shall provide nutritious foods in sufficient quantities meeting the standards of the minimum daily allowances for pregnant youth. Each pregnant adolescent shall receive prenatal, postpartum, and parenting education including topics directly related to healthcare issues and medical risk for pregnant adolescents.* | |

The center has a written policy and procedure to address the provision of health education to pregnant youth. Two closed youth individual healthcare records (IHCRs) were applicable for review since the last annual compliance review. Documentation found each of the applicable youth received pre-natal education to include alcohol and drug use, smoking, nutrition, sexually transmitted infections, contraception, prenatal care, birthing process, postpartum care, basic baby care, child/infant development, and parenting skills. While at the center, licensed health

care staff monitored each youth for weight and nutritional status. A pregnancy alert was entered into the Department's Juvenile Justice Information System (JJIS) for both youth.

| 4.40 Prenatal Staff Education [Contract Provider] | Satisfactory Compliance |
| --- | --- |
| *All non-healthcare staff involved in the supervision or treatment of pregnant youth shall receive appropriate education.* | |

The center has a practice to ensure all non-healthcare staff involved in the supervision and treatment of pregnant youth receive education on female healthcare. A review of seven staff training records verified six staff received training specific to working with pregnant youth. Staff training is provided by the registered nurse (RN) at the time of hire and annually, thereafter. At the time of the annual compliance review, it was unclear in one out of the seven staff records reviewed did not reflect the woman's wellness training. The staff will participate in the next training; however, the registered nurse (RN) conducting the training schedules training classes as deemed necessary

## 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 facility 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 facility to another in accordance with Florida Administrative Code.*

The center has a written policy and procedures to ensure youth are under direct supervision of detention staff at all times. The center conducts headcounts at the beginning and end of each shift. Status checks are conducted throughout each shift. All counts are documented in the facility logbooks. A review of the center's logbooks revealed counts are conducted pursuant to policy. Detention officers are required to know the location of all youth assigned to the area and the exact number of youth under their supervision. During the annual compliance review, youth were observed daily being properly supervised by staff. The youth remained under constant supervision of detention officers at all times. Staff were observed monitoring youth around the area with interaction appearing to be positive. The center utilizes radios to communicate between staff and management. Master control initiates the headcounts and all movement stops until the count is cleared. Master control operators and staff have a major responsibility to ensure all youth are accounted for. There were no inappropriate interactions observed between the staff and the youth. Observations of youth movements were reflected during meals, transports, line movements, nurse runs, escorts, group control, youth engaging in counseling, and classrooms participation. The center is equipped with ninety-two closed circuit television (CCTV) surveillance cameras. There were no issues or violations observed during the annual compliance review . Master control authorizes all movements with headcounts being conducted at the beginning and end of each shift. Status checks are conducted throughout the shift. A review of the center's master control and module logbooks confirmed counts were being conducted throughout the shift, as required. The only time a youth is out of the view of the camera is for sleeping purposes and when youth are in the shower area. Youth are not permitted to enter doors with "red" dots.

| 5.02 Ten-Minute Checks (Critical) | Limited 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.*<br><br>*Staff conducts observations in a manner ensuring the safety and security of each youth and documents real-time observation 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.*<br><br>*There shall be no obstructions (e.g., clothing, memos, pictures) over windows and areas where direct line of sight is needed.*<br><br>*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 ensure the safety and security of each youth placed in a room whether for sleeping, confinement, or medical. Detention staff are required to conduct visual observation checks every ten-minutes or less depending on the level of supervision to ensure the safety of each youth. The center has ninety-two working surveillance cameras throughout the facility. There are no cameras located inside the youth sleeping units; however, there are cameras inside the confinement cells. The center uses both Visual Observation Report (VOR) and the electronic wand system. The center's policy requires staff to physically observe the youth before verifying the check. During the annual compliance review, a random selection of the security tapes was reviewed. The VOR sheets were compared to the actual checks being conducted and found staff were conducting the checks, as required. However, observation of four rounds observed found staff did not look inside the youth cell prior to documenting the checks. Staff conducting checks using the wand system on the overnight C-shift were observed in violation of the centers policy. On December 23, 2018, one check was conducted twenty minutes late on digital video recorder (DVR) number one channel ten between 3:46 a.m. and 4:06 a.m. On December 31, 2018, a check was conducted fifty-seven minutes late on DVR number one channel five, between 3:11 a.m. and 4:08 a.m. The visual observation reports were handwritten and were documented as completed. During this time when the checks were conducted late, staff were observed having the appearance of sleeping or engaging in conversation with other staff members.

| 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 for tracking daily census. Counts are conducted at the beginning, throughout, and at the end of each shift. Staff are responsible for knowing the exact number and location of youth placed in an area. During the annual compliance review , several staff members were questioned on the number of youth under their supervision, each time the count was accurate. A review of the center's logbooks, physical counts of youth are conducted at the beginning and end of each shift. Census counts are tracked using the Department's Juvenile Justice Information (JJIS) census and logbook. All new admissions and daily releases are documented in the facility logbooks. During each meal a new census is printed with each youth's name checked off to verify the youth received a meal. This information is also entered in the Facility Management System (FMS) database. Daily census reports are printed and distributed to master control and key staff members. The center has a practice of conducting status checks throughout the shifts. All youth movements, headcounts, transports, and emergency counts are documented in the center's logbooks. All important information such as alerts are highlighted.

| 5.04 Logbook Maintenance | Satisfactory Compliance |
| --- | --- |

*The program 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. The center has multiple locations for maintaining logbooks. Logbooks were observed in master control, in each

living module, in the lobby for visitor's registration, and in transportation. The master control logbook captures reports made to the Department's Central Communications Center (CCC), drills, incidents involving youth, abuse calls, law enforcement entering the center, and all other important information. A review of the previous six months revealed each logbook is bound with numbered pages. All entries included the date and the time of the entry. All entries impacting the safety and security of the center including special needs and mental health alerts were highlighted. Errors were struck through by pen with staff initials.

| 5.05 Logbook Reviews | Limited Compliance |
|---|---|
| *The superintendent or designee reviews all logbooks on a weekly basis.*<br><br>*The supervisor(s) reviews the facility logbook maintained at master control when he/she accepts responsibility for the facility.*<br><br>*The Juvenile Justice Detention Officer (JJDO) Supervisor(s) reviews logbooks maintained in each living area daily.*<br><br>*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. A review of the center's logbooks for the past six months revealed the superintendent or designee reviews all logbooks on a weekly basis. Documentation in the logbooks indicated supervisors are conducting their reviews as required along with the superintendent and/or designee. However, supervisors were not consistent when documenting and accepting the responsibility for the shift change. No documentation from the supervisors, regarding their observations of the logbooks was being recorded. The only information recorded by the supervisor and/or designee is the number of pages reviewed.

| 5.06 Key Control | Satisfactory Compliance |
|---|---|
| *Each facility is responsible for maintaining inventory and control of all facility keys.*<br><br>*All keys shall be placed on a tamper-resistant key ring designed to inhibit the removal of keys.*<br><br>*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.*<br><br>*The key(s) on these rings shall provide egress through facility exterior doors providing access to evacuation areas.*<br><br>*A key inventory shall be maintained by the Superintendent or designee at all times.*<br>*(For the entire indicator statement, please reference the Monitoring and Quality Improvement FY 2016-2017 Detention indicators.)* | |

The center has a written policy and procedures to ensure the proper use, storage and general security of all facility keys. The center has a system addressing assignment, tracking, storage, disposing, and replacement of lost or damaged keys. All keys are placed on a tamper resistant key ring designed to inhibit the removal of keys. All staff including the provider staff have

assigned keys. The shift supervisors have the responsibility of issuing facility keys. The center has several logbooks and a key tracking form to track all keys. The superintendent maintains a master key log with all keys and the capabilities inside their office. Each time the inventory changes it requires the signature of the superintendent. All keys issued to staff or providers requires a signature or the initial of an acknowledgment form indicating they accept the responsibility of securing the keys. At the end of each shift, all non-permanently assigned keys must be returned prior to departing the center. Four staff were randomly selected to verify the number of keys on a specific key ring, the number of key rings assigned to the staff and the purpose of each key assigned. All staff were familiar with the process for distributing keys, and with the process of reporting lost or stolen keys.. An inventory was taken and found all keys were accounted for. The center did not have missing or lost keys within the past six months. The superintendent updated the key inventory during the annual review .

| **5.07 Vehicles and Maintenance** | **Failed Compliance** |
|---|---|
| *The program ensures any vehicle used by the program to transport youth is properly maintained, and maintains documentation on the use and maintenance of each vehicle.*<br><br>*Youth and staff are not permitted to use tobacco products.*<br><br>*Program vehicles are locked when not in use.* | |

The center has a written policy and procedures to ensure vehicles transporting youth are inspected annually and in good repair. The center has ten, fifteen-passenger vans used for transports. A review of the preventative maintenance invoices provided during the annual compliance review indicated all vans had an annual inspection completed. A security check was conducted of the vehicles when not in use and all were observed secure except for one. All vehicles used to transport youth were equipped with all the required safety equipment. Each vehicle is inspected prior to transport in which the daily form used at the time did not capture all the required elements. There was no documentation on-site to verify the maintenance mechanic conducted weekly or monthly inspections of the vehicles for the entire annual compliance review period. There was no documentation the vehicles were being checked for contraband after returning from a transport. At the time of annual compliance review the maintenance mechanic position was vacant.

| **5.08 Tool Inventory and Management** | **Satisfactory Compliance** |
|---|---|
| *The program ensures all tools and equipment related to maintenance are properly maintained, stored, and inventoried.* | |

The center has written policy and procedures addressing tool inventory and tool management. The center has a perpetual inventory of tools. All observed tools were stored in a locked room inaccessible to staff and detention officers with only the superintendent, assistant superintendent, and the maintenance supervisor having access. Observation of the room used to secure the tools was locked and secured with a red dot on the door. An interview with the center's administrators and detention staff stated youth and detention officers do not have access to this area. Tool inventory is conducted and verified monthly by the center's administrators and or maintenance supervisor. The center's superintendent stated there were no tools reported missing or lost within the past six months. The center has a shadow board where all the tools are returned and secured. An inventory was conducted on-site where it was discovered three tools listed on the inventory sheet were missing the Department of Juvenile

Justice (DJJ) identification (ID) numbers. This was immediately corrected while the annual compliance review team was on-site. All service vendors are properly identified and escorted in and out of the secure area by trained detention staff or the facility maintenance mechanic. At no time, are vendors left unaccompanied.

| 5.09 Kitchen Tools | Satisfactory Compliance |
|---|---|
| *Kitchen knives and other hazardous kitchen sharps are stored in a locked cabinet, drawer, or toolbox containing an inventory list.*<br><br>*All storage areas, including cabinets and drawers, are secured when not in use.*<br><br>*Kitchen staff conducts an itemized inventory of all equipment, including kitchen knives and other hazardous kitchen implements, upon reporting for duty.*<br><br>*All equipment is accounted for prior to the departure of the kitchen staff. Any discrepancy must be reported to the Superintendent or designee.* | |

The center has a policy and procedures in place to ensure tools and equipment which can cause death or serious injury such as kitchen knives or other hazardous kitchen sharps are securely stored in a cabinet, drawer, or toolbox. The policy prohibits youth to use or access any tools, including kitchen or medical equipment. The center's kitchen tools are secured inside a locked cabinet when not in use. The center has a secure location in the kitchen where all kitchen tools and utensils are stored. Youth or staff members are not allowed to enter this area. During the annual compliance review , a count was conducted to ensure inventory accuracy. There were no noted discrepancies . Counts are verified three times a day and documented in the inventory log record. Food service personnel were interviewed and all were familiar with the process of reporting missing or damaged tools. Seven youth were interviewed and only one indicated they had access to kitchen tools.

| 5.10 Youth Access & Use of Tools, Cleaning Items (Critical) | Satisfactory Compliance |
|---|---|
| *Youth are forbidden to use or access any tools, including kitchen or medical equipment.*<br><br>*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 in place to ensure youth are prohibit to use or access any tools or cleaning items which could cause harm. During a tour of the center, there were no tools or chemicals observed in the secure area. Youth are not permitted to use tools, including kitchen and medical equipment. Youth can conduct daily building and module cleaning by using only a broom, mop, and mop bucket. Observations by the annual compliance review team found there were no tools or chemicals in the secure area of the center. All tools were secured in an area away from the youth. Seven youth interviews indicated they only have access to mops, brooms, and mop buckets.

| 5.11 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.*<br><br>*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.*<br><br>*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.*<br><br>*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 in place to address the proper use, storage and disposal of flammable, toxic, caustic, and poisonous items. All chemicals are inventoried and inaccessible to youth at all times. The chemicals are stored outside in a secured shed, with limited access. The administrators have the responsibility to ensure all chemicals are inventoried and properly secured. Safety Data Sheets (SDS) were in the area located inside a binder. The chemicals were checked against the SDS in which there were four SDS missing. This was corrected while the annual compliance review team was on-site. Seven youth were interviewed and each indicated they have never handled chemicals while in the center.

| 5.12 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.*<br><br>*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 in place prohibiting youth to handle flammable, toxic, caustic, and poisonous items while in the center. Only authorized personnel are permitted access to flammable, toxic, caustic, and poisonous items. All chemicals are securely stored in a locked shed not attached to the facility. Youth are not permitted to enter this area. During the annual compliance review , there were no chemicals observed in the secure area of the center. The center does not currently have a maintenance staff. The superintendent and the assistant superintendents are the only personnel who have access to the chemical shed. All items are inventoried, if an item is removed the item is documented inside a binder which is kept inside the secured area.

| 5.13 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 safety plan addressing proper use, storage, and disposal of toxic, caustic, and poisonous items. The program adheres to the Occupational Safety and Health Administration (OSHA) requirements when disposing of toxic items. The plan outlines procedures to follow in the event a chemical leak or spill occurs. The superintendent indicated there were no chemical spills or leaks since the last annual compliance review in March of 2018. Seven youth were interviewed and all indicated they never handled chemicals while in the center. The food service kitchen area prepare food with ovens and steamers. The preparation of food which requires the use of grease is not utilized. The medical department utilizes Stericycle for the disposal of medical waste.

| 5.14 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 maintains a written policy and procedures addressing confinement under twenty-four hours. The center utilizes separate individual rooms outside of the youth's assigned module for confinement purposes. Youth who are placed in confinement have no contact with other youth. All non-fixed items are removed from the rooms. Confinements are documented in the Department's Facility Management System (FMS). A review of seven randomly selected confinement reports found all reports documented the rooms were searched prior to youth being placed in a room. Each report documented confinement being reviewed by a supervisor within two hours of placement to determine appropriateness. The juvenile justice detention officer supervisor (JJDOS) further assessed any special needs and alerted the appropriate staff for medical, mental health, and education. Each confinement report indicated the superintendent and/or designee reviewed the confinement reports within forty-eight hours. All five confinements were communicated to school personal. Five staff were interviewed and confirmed a confinement report must be completed for youth placed in confinement. The youth's room must be searched, ten-minute checks must be conducted and documented. An interview with the superintendent indicated all youth placed in confinement are documented in the Department's Juvenile Justice Information System (JJIS) and a log for ten-minute checks will be completed along with a medical evaluation. A review of security video is conducted and if the video supports the use of confinement, the use of confinement is continued. If not, the youth is returned to their assigned module.

| 5.15 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 to address confinement over twenty-four hours. A review of the Department's Juvenile Justice Information System (JJIS) for the past six months found the center utilized confinement beyond twenty-four hours, 126 times. No youth remained in confinement greater than seventy-two hours. A review of seven randomly selected confinement reports found the superintendent approved all extended confinements beyond twenty-four hours and every twenty-four hours, thereafter. In all instances, the supporting documentation noted both the juvenile justice detention officer supervisors (JJDOS) and the licensed mental health professional (LMHP) reviewed the youth status at a minimum of once every three hours.. In all seven confinements the superintendent forwarded an electronic message to the regional director (RD) requesting confinement extensions, including a justification for the request.

| 5.16 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 has a written policy and procedures in place pertaining the continuity of operations plan (COOP). The program is required to conduct COOP drills twice a year, once before hurricane season. The initial COOP drill took place on May 2, 2018, before the official start of the hurricane season. A written scenario and staff sign in sheets for each staff participating in the drill was reviewed. The center's COOP was approved and signed by the superintendent and the regional director (RD) on March 21, 2018. Seven interviewed staff all stated they participated in an escape drill and a fire drill. One staff stated they participated in a bomb threat drill, two responded they participated in a major disturbance drill, two responded they participated in a flooding drill, while three staff responded they participated in a weather drill.

| 5.17 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.*<br><br>*The facility shall conduct and document quarterly mock escape drills.* | |

The center has a written policy and procedures regarding drills. The center has an escape prevention plan incorporated within the continuity of operations plan (COOP), which requires all staff to remain alert, and attentive to the attitudes and behavior of the youth. The plan addresses procedures to follow when an escape attempt occurs during youth movement and transportation. The center is required to conduct escape drills quarterly. A review of the center drills documented the program conducts escape drills at a minimum of once a quarter on all three shifts. Drills critique results are kept in a drill binder. A review of the center's logbook documented drills are logged as required in the master control logbook. A review of seven staff pre-service and in-service training records documented all staff received escape prevention training.

| 5.18 Fire Drills | Satisfactory Compliance |
| --- | --- |
| *Management has implemented a disaster preparedness plan and fire prevention plan.*<br><br>*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 written policy and procedures regarding drills. The center has evacuation plans posted throughout the center. Each plan defined primary and secondary exit routes and the location of emergency equipment to include fire extinguishers and first aid kits. A review of the center's documented drills indicated the program conducted drills on all three shifts at a minimum of once a month for the past six months. A review of the center's logbook documented unannounced drills were both documented in the logbooks and in the mock drill binder. Interviews with seven youth indicated they have been instructed on what to do in the event of a fire. Seven staff were interviewed and each indicated they have participated in monthly fire drills.

Program Name: Broward Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: Broward County County / Circuit 17
Review Date(s): January 22-25, 2019

MQI Program Code: 473
Contract Number: N/A
Number of Beds: 96
Lead Reviewer Code: 149

## Overall Rating Summary

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

| Limited Ratings | Failed Ratings |
| --- | --- |
| 5.02 * Ten-Minute Checks | 5.07 Vehicles and Maintenance |
| 5.05 Logbook Reviews | |