STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Duval Regional Juvenile Detention Center

Department of Juvenile Justice

(State-Operated)
1241 East 8th Street
Jacksonville, Florida 32206

Review Date(s): August 6-9, 2019

Promoting Continuous Improvement and Accountability
in Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Katina Horner, Office of Program Accountability, Lead Reviewer (Standard 1)
Kimbley Jacobs, North Region Detention Services, Assistant Superintendent (Standard 2)
Gwen Nelson, Office of Program Accountability, Regional Monitor (Standard 3)
Mike Marino, Office of Program Accountability, Regional Monitor (Standard 4)
Shandricka Dowdy, North Region Detention Services, Training Coordinator (Standard 5)

Program Name: Duval Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: Duval County / Circuit 4
Review Date(s): August 6 -9, 2019

MQI Program Code: 131
Contract Number: NA
Number of Beds: 100
Lead Reviewer Code: 170

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
3.02 Licensed Mental Health and Substance Abuse Clinical Staff*	
5.02 Ten-Minute Checks *	
5.07 Vehicles and Maintenance	

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

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

Indicator Ratings

Standard 3 - Mental Health and Substance Abuse Services		
3.01	Designated Mental Health Clinician Authority (DMHCA)	Satisfactory
3.02	Licensed MH/SA Clinical Staff *	Limited
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/Consent	Satisfactory
4.05	Healthcare Admission Screening & Rescreening Form	Satisfactory
4.06	Youth Orientation to Healthcare Services/Health Education	Satisfactory
4.07	DHA/Designee Admission Notification	Satisfactory
4.08	Health-Related History	Satisfactory
4.09	Comprehensive Physical Assessment/TB Screening	Satisfactory
4.10	Sexually Transmitted Infection Screening & HIV Screening	Satisfactory
4.11	Sick Call Process	Satisfactory
4.12	Episodic/First Aid Care/Emergency Care	Satisfactory
4.13	Off-Site Care/Referrals	Satisfactory
4.14	Chronic Conditions/Periodic Evaluations	Satisfactory
4.15	Medication Management	Satisfactory
4.16	Medication/Sharps Inventory and Storage Process	Satisfactory
4.17	Infection Control/Exporsure Control/Education	Satisfactory
4.18	Prenatal Care/Education	Satisfactory

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Standard 5: Safety and Security
Detention Rating Profile

Indicator Ratings

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

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Program Overview

The Duval Regional Juvenile Detention Center is a state-owned detention facility, operated by the Department, located in Jacksonville, Florida. The center serves youth in Duval, Clay, and Nassau counties in Circuit 4. Male and female youth who are detained pending adjudication, disposition, or placement in a residential commitment program are housed in the one hundred 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 Duval County School Board. The center's management team includes the superintendent, one assistant superintendent, one training coordinator, one administrative assistant, fifty juvenile justice detention officers (JJDO), and nine juvenile justice detention officer supervisors (JJDOS). Mental health and healthcare services are provided through the contracted provider, Maxim. Mental health services are provided by a licensed mental health counselor (LMHC) who acts as the designated mental health clinician authority (DMHCA), and three non-licensed mental health counselors. One non-licensed mental health counselor resigned one day before the annual review. A contracted psychiatrist is also on-site weekly. Clinical services provided by the center include mental health and substance abuse evaluations, mental health treatment planning, individual, group and family therapy, mental health crisis intervention services, on-site psychiatric services, and availability for substance abuse services for youth with co-occurring disorders. Medical services are provided by contracted provider Maxim Healthcare Services. The following positions are provided: a medical doctor who serves as the facility's designated health authority (DHA), an advanced registered nurse practitioner (ARNP), a registered nurse (RN) who serves as the clinical manager, three full-time and one part-time licensed practical nurses (LPN). The medical clinic maintains nursing coverage seven days a week, from 6:30 a.m.to 8:00 p.m., and on weekends, from 6:30 a.m.to 7:00 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 five living modules which are divided by male and female. There are one hundred and twenty-two security cameras at the center, of which six were not operational. The center was clean and free of any noticeable graffiti, odors, or pests. At the time of the annual compliance review, the center had seventeen vacancies, which included one assistant superintendent, one non-licensed mental health counselor, thirteen JJDOs and two food service workers.

Standard 1: Management Accountability

1.01 Initial Background Screening (Critical)	Satisfactory Compliance
Background screening is conducted for all Department employees, and volunteers and all contracted provider and grant recipient employees, volunteers, mentors, and interns with access to youth and confidential youth records. A contract provider may hire an employee to a position which requires background screening before the screening process is completed, but only for training and orientation purposes. However, these employees may not have contact with youth or confidential youth records until the screening is completed, the rating is eligible and the employee demonstrates he or she exhibits no behaviors which warrant the denial or termination of employment. An Annual Affidavit of Compliance with Level 2 Screening Standards is completed annually.	

The center has a policy and procedures for the initial background screening process. Twenty-one staff, seventeen volunteers, and four contracted staff required an initial background screening since the last annual compliance review. Thirty-seven of thirty-eight screenings were completed prior to each staff's hire date and each volunteer's start date as required. The remaining volunteer's start date was three days prior to completion from the Department's Background Screening Unit (BSU). Four contracted staff were screened as required and added to the Clearinghouse employment roster. A pre-assessment tool was administered to twenty-one direct care staff, of which twenty-one received a passing score. The Annual Affidavit of Compliance with Level 2, Screening Standards was submitted to the BSU by the center on January 16, 2019 for detention center staff and on December 12, 2018 and January 7, 2019 for all teachers.

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 for the five-year rescreening process. Three staff and fourteen volunteers were applicable for a five-year background rescreening. Fourteen of sixteen staff and volunteer rescreenings were completed prior to their anniversary hire or start date as required. Two volunteer screenings were submitted fifteen and nine days late. The center attempted to contact the remaining volunteer on multiple occasions without success to complete the rescreening. As of the date of the annual compliance review, the rescreening has not been submitted.

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

The center has a policy and procedures for staff code of conduct. Seven staff training records were reviewed for code of conduct. Six of seven staff had a signed Code of Conduct form in their training record. The center transitioned to an online system where electronic versions of detention center forms are maintained. A review of the system found the remaining staff signed the Code of Conduct form electronically. None of the staff had a record of discipline. Five additional staff were reviewed for disciplinary practices. In all five violations of staff conduct cases; management responded with two oral reprimands, two written reprimands, and one suspension. None of the violations were related to abuse towards youth. Special commendations are awarded to an employee every month along with a dedicated parking space for thirty days.

Two of seven youth reported staff are disrespectful when speaking to them or other youth and five youth reported staff are respectful. Two of the seven youth reported hearing staff use profanity. One youth reported once and the remaining youth reported occasionally. Five youth reported never hearing staff use profanity. None of the seven youth reported hearing staff threatening a youth. Three of the seven youth reported they do not feel safe in the program. Two youth reported they do not feel safe because staff do not respond quickly enough to fights. The third youth reported not feeling safe in the program due to other youth who like to start trouble. The remaining four youth reported they feel safe in the center. The superintendent will address the youth issues.

Seven staff were interviewed and questioned if they have observed a co-worker use profanity when speaking to youth. Two of the seven interviewed staff stated they have heard staff use profanity on occasion and five stated never. All seven staff reported they have never observed a co-worker use threats, humiliation, or intimidation when interacting with youth. During the past year, two of seven staff stated the working conditions at the center have been fair and four stated good.

The superintendent reported staff must adhere to a Code of Conduct prohibiting any form of abuse, profanity, threats, harassment, intimidation, or personal relationships with youth. When interacting with youth, officers shall maintain professional behavior and relationships.

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

The center has a policy and procedures for the incident reporting process. During the past six months, the center reported thirty-four incidents to the Central Communications Center (CCC). Five incidents reports were reviewed and all incidents were reported within a two-hour time frame. Four of five reports were documented in the master control logbook, as required.

Seven youth were interviewed and one youth stated they have been stopped from reporting abuse. The youth reported on one occasion other youth received more food on their tray than the youth. The youth was offered an opportunity to call the Florida Abuse Hotline by a team member and declined to make the call. The remaining six youth stated their calls to the Florida Abuse Hotline have never been impeded.

Seven staff were interviewed and all seven were able to explain the process for allowing youth to call the Florida Abuse Hotline or CCC to report suspected abuse. Five staff stated they will notify the supervisor and all seven stated they will allow the youth to make the call. Three staff stated they will notify the superintendent and five stated the supervisor makes the call. Three staff stated, staff are allowed to the make the call.

The superintendent indicated all reportable incidents must be called in to the CCC within two hours of becoming aware of an incident, by a supervisor or administration.

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

The center has a policy and procedures for Protective Action Response (PAR). The center had ninety-three PAR incidents in the past six months, of which nine were reviewed. In all nine instances a PAR report was completed by all staff involved by the end of the staff's work day. None of the PAR incidents included use of mechanical restraints or resulted in serious injury to a youth or staff. The Florida Abuse Hotline was contacted as required in one of nine incidents where the youth alleged abuse during the incident. All nine reports were reviewed by a supervisor and PAR instructor to determine if policy was followed. All nine reports included a Post-PAR interview conducted with the youth by an administrator or designee within thirty minutes after the incident occurred. There were no medical findings in any of the Post-PAR interviews. After all other reviews were completed, the superintendent or designee reviewed the PAR report and made comments within seventy-two hours in all nine reports as required. The center's PAR rate during the annual compliance review period was 11.92 which is above the statewide average PAR rate of 11.75

Seven staff were interviewed and all stated staff try to talk to youth prior to using physical restraints. During an interview with the superintendent, it was stateddetention center staff shall be familiar with Florida Administrative Rule 63H-1, which establishes the statewide framework to implement procedures governing the use of verbal and physical intervention techniques, and mechanical restraints.

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

The center has a policy and procedures for pre-service and certification training requirements. Seven staff training records were reviewed for pre-service training requirements. All seven staff were certified within 180 days of hire and received all required essential skills prior to being in the presence of youth. All seven staff were Protective Action Response (PAR) certified with passing scores in the performance tests and written exams within ninety days of hire as required. The Department's Learning Management System (SkillPro) documented Phase One and Phase Two Academy Training for all nine staff.

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

The center has a policy and procedures for in-service training requirements. Seven staff training records were reviewed for in-service training requirements, including three supervisors. Each staff completed between thirty and 183 hours of training, exceeding the annual twenty-four hour requirement. All staff had current Protective Action Response (PAR) certification updates, cardiopulmonary resuscitation (CPR), first aid, and automated external defibrillators (AED) certifications. Documentation for all seven staff included suicide prevention, professionalism and ethics, and active shooter training. Two supervisors met and one exceeded the annual eight-hour requirement receiving eight, and twenty-five hours of training in management, leadership, personal accountability, employee relations, communication skills, and fiscal matters. The program has an annual in-service training calendar which is updated as changes occur. All in-service training was documented in the Department's Learning Management System (SkillPro).

During an interview with the superintendent, it was stated the superintendent receives certified public management (CPM) training. The superintendent stated staff must complete eight hours of PAR, an annual CPR, AED, and first aid update, along with all in-service trainings required by the facility's annual training calendar.

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

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

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

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

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

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

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

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

The center has a policy and procedures for entering and sharing youth alerts. Seven youth management, mental health, and healthcare records and the Department's Juvenile Justice Information System (JJIS) were reviewed for alerts. The center verifies and documents all youth alerts in JJIS. All seven youth were medically graded two through five and had a corresponding alert in JJIS created by nursing staff. Six youth had mental health alerts initiated and four were discontinued by a mental health professional. Two youth had security alerts initiated by detention staff. Youth alerts were entered into JJIS as required for all seven youth. During detention reviews, youth alerts are reviewed with administration, medical, and mental health staff.

Seven staff were interviewed and six stated they are informed of alerts regarding youth through shift briefings. All seven staff stated through daily alert sheets. Six staff stated they are informed of information from management by email. Three staff additionally stated alerts are also provided by email. Two staff stated they are informed of alerts by management during staff briefings. One staff stated during staff meetings. A shift briefing was observed during the annual compliance review and confirmed alerts were reviewed and provided to staff.

Standard 2: Assessment and Performance Plan

2.01 Admission	Satisfactory Compliance

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

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

Seven youth case management records were reviewed and each documented the Juvenile Justice Information System (JJIS) Admission Wizard was conducted and all seven youth admission requirements were completed for each record. All records contained an arrest affidavit, Detention Risk Assessment instrument (DRAI), and Suicide Risk Screening instrument (SRSI). The admission wizard documented youth searched by an officer of the same sex. The admission wizard documented medical, mental health, and substance abuse screenings. All seven youth intake phone calls and admission meal were documented. The process is in accordance with the detention center's operating procedures. A youth admission was observed during the annual compliance review. The youth reported feeling safe during the admission process.

2.02 Orientation	Satisfactory Compliance

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

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

Seven youth case management records were reviewed for orientation and each contained documentation the youth received orientation within twenty-four hours of admission. The orientation packet included all requirements. All seven youth signed an orientation acknowledgement form. A copy is maintained in the youth's record. Youth were observed watching a video presentation during orientation. The staff was professional during the process and answered any questions the youth had.

Seven youth were interviewed and four advised they were provided information on rules, regulations, schedule, education, visitation, abuse reporting, and the behavior management system upon arrival. The remaining three youth stated they were not provided the information. Administration was made aware of the three youth indicating they were not provided the information and will follow up with the youth. An admission was observed by the annual compliance review team while on-site, which included an orientation video.

2.03 Classification	Satisfactory Compliance

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

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

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

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

Seven youth case management records were reviewed for the process of the classification of youth entering the center. The classification process is outlined in the center's policy and procedures. All seven youth were classified to provide a level of safety and security. All seven youth were classified using the Juvenile Justice Information System (JJIS) Admission Wizard and Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) instruments. Youth room assignments are based on their classification and applicable alerts entered in JJIS. Youth with a history of committing sexual offenses or have been a victim of a sexual offense are placed in single rooms. The youth were also screened to determine gang affiliation or membership and if suspected, an alert is entered into JJIS.

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

Seven youth case management records were reviewed. The center's policy and procedures address the classification of gang members. Staff are informed of how to identify and address local gangs from trainings and communication with the Department's circuit gang representative and law enforcement. Three youth were identified as having gang affiliation and alerts had been appropriately entered in the Juvenile Justice Information System (JJIS).

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

Seven youth case management records were reviewed for the admission of youth's personal property. An observation of this process was observed during admission and the youth's personal property was inventoried. A Personal Property Receipt form was signed by both the youth and staff. A copy of the Personal Property Receipt form is placed in the youth's record. Each youth's record contained a letter of acknowledgement signifying an understanding unclaimed property is deemed abandoned and subject for disposal.

Seven youth were interviewed and six stated staff checked their personal property and each youth signed a property receipt.

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

All youth personal property is stored in individual property bags in a secured room with an inventory form. The date, youth's name, Juvenile Justice Information System (JJIS) number, and listing of items are placed in the property bag. Seven youth case management records were reviewed for storage of youth personal property. Four records contained documentation of valuable property which was inventoried and in a clear tamper-proof bag. The tamper-proof bag is placed in a drop safe and logged in a bound logbook. The drop safe is monitored under video surveillance twenty-four hours a day. A review of the Central Communications Center (CCC) reports for the past six months indicated there were no incidents regarding youth property being reported.

The superintendent is responsible to ensure the youth's personal property and valuables are maintained in accordance with the center's policy.

2.07 Release	Satisfactory Compliance

When releasing youth from the center, the releasing officer shall verify the court's authorization to release the youth. Care must be taken to ensure all case file information is reviewed to prevent the negligent release of a youth.

All releases from the center are court-ordered, with the exception of deaths, escapes, and expirations of detention time period. In the absence of a written order, documentation of a verbal order in open court may be used for release.

The on-duty JJDO Supervisor reviews all paperwork prior to a youth's release. The JJDO Supervisor is responsible for ensuring there are no holds, court orders, or other legal reasons not to release the youth.

Questions concerning release are presented and addressed by the superintendent, or designee, prior to release.

The releasing officer shall verify the identification of the youth.

The center has a policy in place to address youth releases. Three closed youth case management records were reviewed. The on-duty supervisor reviewed all paperwork and verified each youth's identification prior to release. A photo copy of the parent/guardian identification is verified. Both youth and parent/guardian are reminded of future court dates and all parties signed all applicable release forms. A review of Central Communications Center (CCC) reports for the past six months noted there were no unauthorized releases.

2.08 Release of Youth Personal Property	Satisfactory Compliance

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

The center has a policy and procedures in place for release of youth personal property. Three closed youth case management records were reviewed. All three records contained a property form signed by the youth and parent/guardian on the day of the youth's release. Items of the youth's personal property remain unclaimed for more than thirty days, the superintendent or designee shall arrange for their disposition. Money left unclaimed for thirty days is sent to the regional finance manager.

2.09 Release of Medication, Aftercare Instructions	Satisfactory Compliance

The center ensures there are provisions in place to ensure prescribed medication, along with medical instructions, accompanies detained youth upon release.

One release and two closed youth case management records were reviewed for release of medication, aftercare instructions. All three reviewed records contained documentation verifying the youth was released to an appropriate person with a copy of their identification filed in the youth's record. A receipt of medications form was signed by the person receiving the medication in all three closed records. The records included a reminder to the youth and the person the youth was being released to of any health, or welfare issues, including medical, mental health, and/or substance abuse needs and any pending appointments. A review of the records included

receipt forms with signatures of parent/guardian, nurse, and staff and included the date the medication was returned. This practice was observed with no issues during the annual compliance review.

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

The center has a policy and procedures regarding review of youth in secure detention. A weekly review of youth in secure and home detention is held at 10:00 a.m. by the detention review officer. Other participants include the superintendent and/or assistant superintendent, medical, mental health, education, probation, Department of Children and Families (DCF), and when applicable commitment staff. The participants shared information on each youth's case. A review of court orders, detainment beyond twenty-one days, youth pending residential placement, termination of home detention, and medical and mental health needs is completed. The census, sign-in sheet, tasks for follow up, and minutes were entered into the Facility Management System (FMS). This process was observed with no issues during the annual compliance review.

An interview with the superintendent reported, the assigned facility detention review officer conducts a detention review weekly and addresses every youth reflected on the census for secure and home detention.

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

The center has a policy and procedures in place to address the daily activity schedule. The daily activity schedule is posted in each living unit. The daily activity schedule includes meal times, visitation, recreation, personal hygiene, education, gender specific programming, life and social skills, and restorative justice programming. Observations confirmed the daily activity schedule is being followed.

Seven youth were interviewed and each confirmed the center follows a daily activity schedule. Seven staff were interviewed and each stated the center's daily schedule is followed. Each stated the center provides restorative justice activities to youth and gender-specific programming as part of the daily schedule.

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

Facility staff adhere to the daily activity schedule. A review of the logbook, observation, and interviews indicated the center adheres to the daily schedule. Seven staff were interviewed and each indicated the center follows the daily schedule. Six of the seven interviewed youth indicated the schedule is followed. One youth indicated the schedule may change due to the lack of staff.

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

The center has a policy and procedures in place for educational access. The center provides education for all youth through the Duval County School Board. Youth attend class thirty hours a week. Classes are offered twelve months. A review of the daily activity schedule and logbooks confirmed the school schedule is being followed with minimal interference. An interview with the educational personnel confirmed, youth attend school six hours a day Monday through Friday. During the review period, youth were not attending school due to the teacher planning week preparing for the new school year.

Seven youth and seven staff were interviewed and each confirmed youth attend school Monday through Friday, with minimal interference of educational instruction.

During an interview with the superintendent, it was there was minimal interference of educational instruction.

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

The center has a policy and procedures in place addressing career education. Education programs include interpersonal, decision-making, and communication skills. The center provides Type 1 Life skills group, activities, and instruction. The center also provides programs in career search, mock job interviews, and vocational interest. Education services also include budgeting and money management.

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

The center has a policy and procedure, in place to address their behavior management system (BMS). The BMS includes three levels. The youth can advance levels based on good behavior. The BMS is posted in all living areas and is explained during the orientation process. The consequences for inappropriate behavior includes loss of privileges, individual supervision, and confinement. Observation of the daily activities revealed implementation of BMS.

Three of the seven youth interviewed ranked the BMS as fair. One youth ranked it as good and three ranked it as poor.
Six of the seven staff stated the BMS is effective. All seven staff stated they discuss the consequences being imposed with youth, give the youth an opportunity to explain their behavior, and speak with the youth about alternative acceptable behavior. Four of seven staff stated they receive feedback from their supervisor as needed regarding their implementation of the BMS. The remaining three staff stated they have never received feedback.

During an interview with the superintendent, it was indicated staff shall seek to be fair and consistent in the implementation of the BMS in order to enhance safety and security as it relates to youth's behavior, and promotes the health and well-being of the youth by providing an environment fostering social, emotional, intellectual, and physical development.

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

The center has a policy and procedures in place addressing unauthorized use of punishment. Group punishment is not used as part of the center's behavior management system. The center prohibits staff from allowing a youth to punish another youth, unauthorized use of punishment, and corporal punishment. Staff cannot deprive a youth of their meals, visitation, sleep, medical,

mental health services, clothing, education, and/or snack. Consequences are based on each individual youth's behavior.

Four of the seven interviewed youth stated they have received consequences and thought it was fair. One youth reported their snack was taken, one youth stated their bedding was taken in confinement, and two youth stated nothing was taken from them as a consequence. The remaining three youth have not received any consequences. Four of seven youth advised they are not allowed to punish other youth. Two of the seven youth reported they have been sent to confinement as a consequence and the door was shut and locked. None of the seven interviewed youth reported handcuffs or leg irons are used on out of control youth.

Seven staff were interviewed and stated they cannot take anything away from youth as a consequence, have never seen a co-worker take anything away from a youth because the youth were acting out, and have not observed any staff encouraged youth to beat up other youth.

During an interview with the superintendent, it was stated corporal punishment is prohibited and all allegations of corporal punishment of any youth by center staff shall be reported to the Florida Abuse Hotline, pursuant to Chapter 39, F.S., and the Central Communications Center (CCC). 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.

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

The center has a policy and procedures regarding each youth's right to grieve and to be treated fairly, respectfully, without discrimination, and their rights are protected. The process includes an informal phase, a formal phase, and an appeal phase. Grievance forms were available in the living areas for the youth. During the past year three grievances were submitted. All grievances were resolved to the youth's satisfaction and within the required time frames as required.

Seven youth were interviewed and indicated they never filed a grievance. Seven staff were interviewed and were able to explain the grievance process.

During an interview with the superintendent, it was stated youth may file a grievance at any time if they feel their rights have been violated, treated unfairly; however, grievances do not replace the responsibility of reporting abuse. If the grievance is an allegation of abuse, it must be reported consistent with the Florida Child Abuse Hotline and Department's guidelines and shall be handled pursuant to such guidelines and no longer as a standard grievance. Officers shall attempt to resolve any dispute or issue potentially leading to the filing of a grievance prior to the actual filing. Officers utilizing effective communication skills may resolve many disputes and/or issues a youth may have prior to the initiation of the grievance process. Youth cannot be denied

the opportunity to file a grievance. Any grievance involving life safety will be called into the Central Communications Center and to the attention of the superintendent for immediate resolution. The grievance forms are stored in a binder in the assistant superintendent's office and are not disposed of.

2.18 Trauma-Informed Care	Satisfactory Compliance
The center is incorporating trauma-informed practice into current operations to deliver services and to provide care to youth in custody, acknowledging the role violence and victimization play in the lives of most of the youth entering the center. *Trauma-informed practice has many characteristics, which include the following:* • *A recognition of the high prevalence of trauma* • *Recognition of culture and practices which may be re-traumatizing* • *Collaboration of caregivers* • *Training of staff to improve trauma knowledge and sensitivity* • *Increased staff understanding of the function of behavior (rage, self-injury, etc.) as an expression of trauma* • *Use of objective and neutral language (avoids labeling of youth)*	

The center has a policy and procedures in place regarding trauma-informed care. The center is incorporating trauma-informed practice into current operations to deliver services and to provide care to youth in custody. During an interview with the superintendent, it was revealed the center has a soft room, murals throughout the center, and within the rooms to soften the aesthetics. Seven staff training records were reviewed, each staff received training in trauma-informed care as documented in the Department's Learning Management System (SkillPro).

Standard 3: Mental Health and Substance Abuse Services

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

The center has a written policy and procedures for a single licensed mental health professional who is identified as the designated mental health clinician authority (DMHCA). The DMHCA is responsible for coordinating and implementing all mental health and substance abuse services. The center's DMHCA is a licensed mental health counselor who holds a clear and active license to provide mental health and substance abuse service in the State of Florida with an expiration date of March 31, 2021. During an interview with the DMHCA, it was confirmed the responsibility for the administrative oversight and management of mental health and substance abuse services at the center. The DMHCA is scheduled to be on-site forty hours a week, Monday through Thursday for ten hours each day. The DMHCA is on-call to provide services twenty-four hours a day, seven-days a week.

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

The center utilizes a psychiatrist licensed pursuant to Chapter 458, F.S., who is board certified in Child and Adolescent Psychiatry. A review of the psychiatrist's license confirmed a licensed medical doctor status with a specialty in child and adolescent psychiatry. The psychiatrist's license was free and clear in the State of Florida with an expiration date of January 31, 2021. The contract requires an additional twenty hours of licensed mental health professional (LMHP) coverage in addition to the designated mental health clinician authority (DMHCA). There was no documentation to confirm the LMHP was on-site during the annual compliance review period prior to August 22, 2019.

It should be noted; however, the center was previously assigned a major deficiency in the Program Monitoring and Management (PMM) System by the Office of Health Services on March 21, 2019 due to not meeting the contracted required hours of a LMHP. Therefore, a new deficiency will not be entered into PMM. This deficiency was corrected and closed on August 26, 2019 as the center is meeting the requirements outlined in the contract.

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

The center is licensed under Chapter 397 by the State of Florida Department of Children and Families (DCF) to provide outpatient substance abuse services. At the time of the annual compliance review, the center's license was not active. The center was given a probation license on August 22, 2019. All substance abuse services are only provided by the designated mental health clinician authority (DMHCA) and substance abuse services are only provided when requested by the youth. The licensed DMHCA provides direct supervision for the center's three non-licensed master's-level mental health counselors. Each of the three counselors completed twenty hours of training and supervision in assessing suicide risk, mental health crisis intervention, and emergency mental health services. The training included the administration of the five Assessments of Suicide Risk. Training was documented on the Department's Non-Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk form. The DMHCA provides weekly direct supervision for the non-licensed counselors. A review of the past six months of weekly direct supervision logs indicated the three non-licensed staff received one hour a week of on-site, face-to-face interaction with the licensed mental health counselor. One non-licensed mental health counselor resigned the day before the annual compliance review. All direct supervision notes were documented on the Department's Licensed Mental Health Professionals and Licensed/Certified Substance Professionals Direct Supervision Log form and contained all required elements.

3.04 Mental Health and Substance Abuse Admission Screening [Detention Staff/Contract Provider]	Satisfactory Compliance
The mental health and substance needs of youth are identified through a comprehensive screening process ensuring referrals are made when youth have identified mental health and/or substance abuse needs or are identified as a possible suicide risk. *The superintendent has established procedures for a thorough review of preliminary screening conducted by the Office of Probation and Community Intervention.*	

The center has a written policy and procedures to ensure the mental health and substance abuse needs of the youth are identified through a comprehensive screening process. Seven youth mental health and substance abuse (MHSA) records were reviewed and all records had completed admission screenings. Each record had documentation of a completed Positive Achievement Change Tool (PACT), Suicide Risk Screening Instrument (SRSI), and Massachusetts Youth Screening Inventory – Second Version (MAYSI-2), and the Victimization and Sexually Aggressive Behavior (VSAB) completed by the probation screening staff. The seven youth MHSA records indicated the youth's admission information were documented in the Department's Juvenile Justice Information System (JJIS). A review of the seven youth IHCRs indicated each youth was placed on precautionary observation for risk of suicide, the referral process was initiated, and the mental health staff was notified. The PACT indicated a need for a comprehensive assessment to be completed for four of the seven youth records reviewed.

The superintendent stated, the juvenile probation officer, medical staff, and all mental health staff conducts the screening using the SRSI and the ASR form.

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 has a policy and procedures in place to address mental health and substance abuse evaluations. Seven youth mental health and substance abuse (MHSA) records were reviewed. Four youth records revealed an elevated scale requiring an evaluation. Three youth records did not. The four applicable youth will have a new comprehensive evaluation completed by the detention staff, if length of stay permits. None of the four youth were in the center for more than thirty-days.

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

The center has a policy and procedures in place to determine if mental health treatment services are required. Seven youth mental health and substance abuse (MHSA) records were reviewed for mental health treatment services. Two youth refused treatment services and five youth required psychiatric services. All seven youth refused substance abuse services. Four of the five youth receiving treatment services refused group therapy according to documentation and the designated mental health clinician authority (DMHCA). The five youth receiving treatment services were assigned a treatment team and the treatment plans were signed by all team members. Treatment was provided by the non-licensed mental health staff working under the licensed mental health staff. Each of the seven youth records noted a signed Authority for Evaluation (AET). All treatment notes were completed on the Department's Mental Health/Substance Abuse form. Sign in sheets for group therapy did not contain more than ten youth.

The DMHCA was interviewed and indicated services include mental health overlay services, substance abuse overlay services, and psychiatric services.

Five of the seven interviewed youth rated the mental health and substance abuse services as good and very good. Two youth did not respond to the question.

3.07 Treatment and Discharge Planning [Contract Provider]	Satisfactory Compliance
The superintendent and DMHCA or mental health and substance abuse clinical staff are responsible for ensuring the development and review of an initial and/or individualized mental health/substance abuse treatment plan for each youth receiving mental health and/or substance abuse treatment in the center. *All youth who receive mental health and/or substance abuse treatment while at the center shall have a discharge summary completed documenting the focus and course of the youth's treatment and recommendations for mental health and/or substance abuse services upon youth's release from the center.*	

The center has a written policy and procedures designed by the designated mental health clinician (DMHCA) and management staff for developing and reviewing mental health and substance abuse treatment plans. Only one youth were in the center more than thirty-days and required a treatment plan. Six youth were in the center for less than thirty-days. An initial treatment plan was developed for the one youth. The youth's assigned mini-treatment team members were involved in the development of the initial treatment plan. The plan was developed within seven days of treatment. The youth was receiving psychotropic medication. The youth received an initial diagnostic psychiatric interview within seven days. The youth's plan was completed on the proper form and signed by the appropriate parties within the proper time frame. The medication frequency of monitoring by psychiatrist was documented on the proper form. One of the seven youth mental health and substance abuse records reviewed were applicable for a mental health and substance abuse treatment discharge summary. Two additional records were requested and reviewed. Each of the three records documented a discharge summary was completed on the Department's Mental Health/Substance Abuse Treatment Discharge Summary form and was provided to the youth and parent/guardian upon release. Documentation supported each discharge summary was sent to the youth's assigned juvenile probation officer (JPO).

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

The center has a policy and procedures in place to provide psychiatric services. Seven youth records were reviewed and five youth were applicable for psychiatric services. The seven youth records had documentation services are provided by the psychiatrist. The center utilizes a psychiatrist licensed pursuant to Chapter 458, F.S., who is board certified in Child and Adolescent Psychiatry. Each applicable record noted a diagnostic psychiatric interview within fourteen days of the youth's admission to the center. The psychiatric written interviews included the required elements. All the psychiatric evaluations were conducted within thirty days of intake. The evaluations were documented on the Clinical Psychotropic Progress Note (CPPN). The CCPN included all the required documentation. Each record had consent for psychotropic medication. Each youth had documentation of monitoring for Tardive Dyskinesia, as indicated by the psychiatrist. The designated mental health clinician authority (DMHCA) indicated, the psychiatrist sees all youth admitted on psychotropic medication within two weeks of admission. The psychiatrist is responsible for medication management for youth on prescribed medications. All youth receiving treatment services have a current Authority for Evaluation and Treatment

(AET) form and a consent for psychotropic medications signed by the youth's parent/guardian. None of the reviewed records were applicable for youth in foster care or reaching eighteen years of age while at the center and requiring additional consents. The center had one youth medication reduced and one youth who requested psychiatric medication after admission.

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

The program has a suicide prevention plan which assess and protects the youth by using the least restrictive means. The plan details the suicide prevention procedures. The plan includes all the required elements including, identification and assessment, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and a review process. The plan was in accordance with Rule 63N-1., Florida Administrative Code. The plan was reviewed and approved by the center's superintendent and designated mental health clinician authority (DMHCA) on August 8, 2019.

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

The center has suicide prevention services to assess and protect youth for suicide risk in the least restrictive means and in accordance with Rule 63N-1, Florida Administrative Code. Seven youth mental health and substance abuse (MHSA) records were reviewed. All seven youth were placed on suicide precaution status upon admission due to admission screenings and the center's policy. Each record documented the completion of an Assessment of Suicide Risk (ASR) by a non-licensed master's-level clinician. The center's three non-licensed mental health staff completed the required twenty hours of training and five ASRs under the direct supervision of a license mental health professional. Each record documented the immediate notification to the center's superintendent and/or designee and the completion of a suicide precaution observation log. None of the records indicated a youth being released from the center on precautionary observation (PO) status. Each record documented a referral was made to a mental health professional, an alert was entered into the Department's Juvenile Justice Information System (JJIS), and the youth was maintained on PO until assessed. Each record had documentation of the youth transitioning to standard supervision after the completion of an ASR, consultation with the designated mental health clinician authority (DMHCA), and the consultation with the center's superintendent and/or designee as outlined in the center's suicide prevention plan. A review of the center's master control logbook showed beginning and end times were documented for youth placed on precautions.

Six of the seven interviewed youth reported not being placed on suicide watch. One youth stated the staff did not watch the youth the entire time while on suicide watch. A review of the secure observation logs indicated, staff appropriately supervised the youth on precautionary observation. It should be noted all youth are placed on PO at admission.

Seven staff were interviewed and each indicated they would notify mental health staff, search the youth's room, maintain constant sight and sound, and document youth supervision in the event a youth expresses suicidal thoughts. Seven staff were interviewed and reported if a youth expresses suicidal thoughts, staff are to notify the mental health authority. Five staff reported they are to search the youth and the youth's room for sharp objects, document supervision, and provide constant sight and sound supervision.

The superintendent stated, secure observation is used if youth behaviors indicate they need a higher level of supervision; secure observation will be used for the safety of 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 assigned to observe the youth must provide the appropriate level of supervision and record observations of the youth's behavior at intervals of no more than thirty minutes.	

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

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

The center has a written policy and procedures requiring staff to complete at least six hours of suicide prevention and implementation of suicide precautions training annually. A review of twelve staff training records supported each staff received two hours of training in the Department's Learning Management System (SkillPro) and four hours of face to face suicide prevention and suicide precaution training. A review of seven pre-service and five in-service staff training records had documentation of staff receiving the required suicide prevention training. Mock suicide drills were held for the three shifts each quarter. Mock suicide drills contained all the required elements. Seven staff interviews documented participation in suicide mock drills. At least fifty percent of the total number of staff participated in quarterly drills.

Seven staff were interviewed on the location of the knife for life kits. Five staff stated a kit is in master control. Seven stated a kit is located sub-control. One stated a kit is in medical and four stated a kit is in the shift supervisor office. Seven staff were interviewed and each reported the

suicide response kit is located in master control and sub control. Three reported in medical, five reported in the shift supervisor office, and two stated in the vehicles.

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

The center has a written policy and procedures for providing mental health crisis intervention services. The center utilizes this plan to respond to youth in crisis in the least restrictive means possible. The plan included appropriate details of the crisis intervention procedures. A review of the mental health crisis intervention plan determined the plan includes notification and alert system, means of referral, including youth self-referral, communication, supervision, and documentation and review. The emergency services plan was reviewed and signed by the designated mental health clinician authority (DMHCA) and superintendent on August 8, 2019 and included all required elements.

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

The center's emergency care plan is in accordance with the Department's Rule 63N-1.011 and Rule 63N-1.0112, Florida Administrative Code. The plan includes training, review, documentation, transport, response, communication, supervision, notifications, and authorization to transport for emergency mental health or substance abuse services for Baker Act and Marchman Act. The plan was reviewed by the center's superintendent and designated mental health clinician authority (DMHCA) on August 8, 2019. A copy of the emergency plan is accessible to all staff and is located in the supervisor office, mental health office, and the training office.

3.15 Crisis Assessments [Contract Provider] (Critical)	Satisfactory Compliance
A Crisis Assessment is a detailed evaluation of a youth demonstrating acute psychological distress (e.g., anxiety, fear, panic, paranoia, agitation, impulsivity, rage) conducted by a licensed mental health professional (LMHP), or under the direct supervision of a LMHP, to determine the severity of youth's symptoms, and level of risk to self or others. When staff observations indicate a youth's acute psychological distress is extreme/severe and does not respond to ordinary intervention, the superintendent or designee must be notified of the crisis situation and need for Crisis Assessment. A Crisis Assessment is to be utilized only when the youth's crisis (psychological distress) is not associated with suicide risk factors or suicide risk behaviors. If the youth's behavior or statements indicate possible suicide risk, the youth must receive an Assessment of Suicide Risk (ASR) instead of a Crisis Assessment.	

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

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

The center has a policy and procedures in place for youth requiring Baker and Marchman Acts. The center had two youth requiring a Baker Act during the review period. Mental health staff initiated the Baker Acts. Documentation included notifications to the youth's parent/guardian and assigned juvenile probation officer (JPO). When the youth returned to the center, the youth were placed on constant supervision. A Mental Status Examination (MSE) was conducted by the licensed mental health staff. A suicide risk alert was completed in the Department's Juvenile Justice Information System (JJIS). The level of supervision was not lowered until the youth were transitioned and follow-up assessments of suicide risk were completed, and mental health staff consulted with the superintendent. The center did not have any Marchman Acts during this review period.

Standard 4: Health Services

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

A medical doctor (MD) with a clinical specialty in internal medicine serves as the designated health authority (DHA). The DHA has a clear and active license to practice in the State of Florida, which is effective through January 2021. Documentation showed the DHA was on-site at least once a week during the past six months. Healthcare policy and procedures and an interview with the DHA indicated Maxim has an on-call physician to provide coverage if the DHA is not able to make weekly visit. The contract with the DHA and healthcare policy and procedures outline services to be provided by the DHA, which are in accordance with Department requirements. The DHA is available twenty-four hours a day, seven days a week. An advanced registered nurse practitioner (ARNP) works in collaboration with the DHA, assisting with the completion of Comprehensive Physical Assessments (CPA) and other clinical duties. The ARNP is on-site two days a week for a total of twenty hours a week. The ARNP has a clear and active license to practice in the State of Florida, which is effective through April 2021. There is a collaborative agreement between the DHA and ARNP on file at the center. Interviews with the DHA and ARNP showed they clearly understood their responsibilities at the center. Interviews with nursing staff and the review of documentation related to healthcare services, including youth records, showed the DHA provides oversite for all healthcare provided at 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 designated health authority (DHA) recently approved all healthcare policies, procedures, and protocols in July 2019. The new superintendent also signed the healthcare policies and procedures. Treatment protocols were developed and signed by the DHA as well. All nursing staff signed a form acknowledging the healthcare policies and procedures and treatment protocols. There were three nurses hired since the last annual review. Each newly hired nurse completed an orientation to healthcare services provided at the center upon hire.

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.	

Policy and procedures address obtaining Authority for Evaluation and Treatment (AET) forms, Limited Consent for Evaluation and Treatment forms, or court orders authorizing treatment. Seven youth individual healthcare records (IHCRs) were reviewed. Each IHCR contained an AET form signed by the parent/guardian, with five of the records having the original AET form and two having a legible copy of an AET form, which were marked as copies. The AETs were obtained prior to medical services being provided. During an interview with the registered nurse

who serves as the clinic manager, was knowledgeable of the process for obtaining an AET, a Limited Consent for Evaluation and Treatment, or court order for authorization of care.

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

Policy and procedures address parental notification requirements in accordance with Department requirements. Seven youth individual healthcare records (IHCRs) were reviewed, which included parental notifications for emergency care, over-the-counter medications not covered by the Authority for Evaluation and Treatment (AET) form, prescription medications, off-site care, and psychotropic medication. Written parental notifications were completed in each case. For written notifications related to psychotropic medication(s), the Department's Clinical Psychotropic Progress Note (CPPN) was completed by the psychiatrist. Telephone notifications to the parent/guardian or multiple telephone attempts to contact the parent/guardian by phone were documented for each notification. There was a witness documented for all telephone notifications. The clinic manager was able to explain the parental notification process, to include parent/guardian notification requirements for new medications, changes in dosage for medications, off-site and emergency care, and immunizations.

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

The center has a policy and procedures for healthcare admission screenings, which indicates a new screening will be completed on each youth admitted or re-admitted to the center. Seven youth individual healthcare records (IHCRs) were reviewed for healthcare admission screenings. A Medical and Mental Health Screening Form was completed on the date of admission for all records. Each screening was completed by a juvenile justice detention officer (JJDO) or JJDO supervisor during the initial intake process. Nursing staff documented a review of the healthcare screening within twenty-four hours by initialing each page of the screening in six of the seven IHCRs. The clinic manager indicated nursing staff complete an admission process within twenty-four hours, which includes a review of the Facility Entry Physical Health Screening (FEPHS) form completed by detention staff. An interview with the superintendent, indicated nursing staff complete the healthcare admission process, to include initial medical screening.

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

A review of seven youth individual healthcare records (IHCRs) found each youth received an orientation to healthcare services provided at the center and health education within twenty-four hours of admission, which was documented on the Health Education Record. The orientation and education covered all required topics, to include but not limited to, access to medical care, what constitutes an emergency, medication administration, the right to refuse care, the Prison

Rape Elimination Act (PREA) and what to do case of a sexual assault or attempted sexual assault, the sick call process, and non-disciplinary role of the healthcare providers.

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

The center has a policy and procedures addressing the notification of the designated health authority (DHA) when youth are admitted with a chronic condition. Four of the seven reviewed youth individual healthcare records (IHCRs) required notification of the DHA upon admission due to youth being admitted with a chronic condition. Notifications of the DHA and/or psychiatrist were completed within the required time frame in three of the four IHCRs. In the remaining IHCR, the youth was seen and evaluated by the advanced registered nurse practitioner (ARNP) within forty-eight hours. Each youth with a chronic condition was evaluated by the DHA or ARNP and a plan to address their chronic condition was completed. During an interview with the nurse, it was indicated the admitting nurse is to notify the DHA when a youth is admitted with a chronic condition. The admitting nurse is also to document the referral to the DHA in the physician's reference log.

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

Seven youth individual healthcare records (IHCRs) were reviewed for Health-Related History (HRH). A new (HRH was completed by a nurse within seven days of admission in six of the seven IHCRs. In the remaining IHCR, a nurse completed an update to an existing HRH within seven days of admission. The advanced registered nurse practitioner (ARNP) documented a review of the HRH in each record. When necessary, a nurse or the ARNP documented updates to the HRHs to reflect changes or updates in a youth's medical condition, medication status, and/or alerts after admission.

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

Seven youth individual healthcare records (IHCRs) were reviewed for a Comprehensive Physical Assessment (CPA). In four IHCRs, a new CPA was completed by the advanced registered nurse practitioner (ARNP) within seven days of admission. In the remaining three IHCRs, there was a current CPA completed within the past year. In these three IHCRs, the ARNP documented a review of the existing CPA and completed a focused evaluation within seven days of admission. In one of IHCR, a new CPA was completed after new information was received about the youth. Each CPA documented a tuberculosis skin test (TST) was completed within the last year. All sections of the CPA were completed or noted sections of the examination were refused by youth. For the sections the youth refused, a Refusal of Treatment form was completed. Updates to CPAs and the Department Problem Lists were documented when a youth's medical grade changed. The nurse interview reflected she was familiar with the

process for the completion of CPAs. The nurse also stated a TST is completed on all youth and updated annually.

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

The center has a policy and procedures addressing screening and testing for sexually transmitted infections (STI). Policy and procedures also address human immunodeficiency virus (HIV) services, which are provided at the center by HIV certified counselors from a community provider.

Seven youth individual healthcare records (IHCRs) were reviewed for sexually transmitted infection (STI) and HIV screening. Each IHCR documented a STI Screening form was completed by a nurse upon the youth's admission. Each STI Screening Form was reviewed by the designated health authority (DHA) or advanced registered nurse practitioner (ARNP) youth were referred for STI testing based on the screening results. Six applicable IHCRs documented youth were tested, which included three female youth in the sample. The STI testing results were documented on the Infectious Communicable Disease (ICD) form and in the lab section in each applicable record. Care for STI infections was documented, as needed, and notifications of the health department were documented when needed. Each female youth was offered a gynecological evaluation. Two of the female youth consented to the gynecological evaluation and it was completed.

All seven IHCRs in the initial sample reviewed and two additional records reviewed found each youth were offered HIV testing during the medical intake process, with each youth indicating their consent to be tested. Five youth consented to testing; although one youth later declined testing after receiving pre-test counseling. Testing was conducted for the four youth who consented, which included two pregnant youth. Pre-test and post-test counseling by a certified HIV counselor was documented for each youth receiving HIV testing. HIV test results were properly filed in sealed envelopes marked "confidential" within the three applicable youth IHCRs. The test results for the remaining youth were still pending at the time of the annual compliance review.

The clinical manager reported all youth are screened for STIs and HIV upon admission. The clinic manager indicated the ARNP or DHA will order STI testing, as needed, and youth are given the opportunity to request HIV testing, with the HIV testing being provided on-site by certified HIV counselors from the Rainbow Clinic. All seven interviewed youth reported they could ask for HIV testing.

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

Sick call is provided by nursing staff seven days a week. Youth inform staff when they want to make a request to be seen for sick call. Staff enters the sick call requests in the Facility Management System (FMS), which generates a notice of the sick call request to supervisors

and administration for review, if nursing staff are unavailable. One sick call request required a review by a supervisor within four hours due to nursing staff not being on-site, which was documented. Five sick calls were reviewed and each were documented in accordance with the Department requirements. The sick call documentation indicated youth were seen by nursing within twenty-four hours of making their request. Four sick calls were completed by a licensed practical nurse (LPN). Each was reviewed by a registered nurse (RN) within twenty-four hours. The remaining sick call was completed by a RN. All sick calls were reflected on individual youth Sick Call Indexes. A sick call log is maintained electronically through the Facility Management System (FMS). Youth initialed or signed the sick call log to acknowledge they received sick call care in four of five cases. No youth were presented with a similar complaint three times in a two-week period, even though youth were referred to the advanced registered nurse practitioner (ARNP) or designated health authority (DHA) by nursing staff for conditions beyond the scope of their care. No youth complained of pain which staff were not familiar. The clinic manager fully explained the sick call process, identifying when sick call is provided, who provides sick call, and when youth are referred to the ARNP or DHA.

Three of the seven interviewed youth stated they were seen within one day of submitting a sick call request. Two youth stated they were seen within two days and two reported they have never completed a sick call request. All youth who received sick call services stated nursing staff conducted the sick call.

Seven staff were interviewed and each reported nursing staff conducts sick call.

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

The center has a written policy and procedures addressing first aid and episodic care. Youth needing episodic care are taken to the clinic to be seen by medical staff, as medical staff are on duty during hours youth are awake at the center. Ten instances of on-site episodic care were reviewed. Each instance of episodic care was provided by medical staff and documented in accordance with Department's requirements. An episodic care log is maintained and reflected seven of the ten instances of episodic care reviewed. The three instances of episodic care not reflected in the log were provided by the same medical staff.

The designated health Authority (DHA) has identified and approved first aid kit contents. The center has first aid kits in each sub-control, master control, kitchen, intake, school, mental health, and each vehicle. Documentation indicated first aid kits were checked monthly by nursing staff to ensure all required contents were present and within expiration dates. Break away ties secure the first aid kits so it is known when first aid kits are opened, and supplies are used. Supplies are to be restocked whenever items are used or when they expire. Seven first aid kits were observed and six were fully stocked with items approved by the DHA. The remaining first aid kit was missing bandages, which were immediately replaced.

The center has four automated external defibrillators (AED), which are located in the clinic, intake, alpha dorm, and hotel dorm. The batteries and pads for each unit were within the expiration date, and the expiration date for the batteries and pads were documented on each unit to ensure they are replaced when needed. The clinic manager tested each AED in front of a member of the review team, demonstrating each AED was ready for use. Documentation indicated the AEDs were checked monthly by the clinic manager.

Policy and procedures address emergency care, to include the completion of mock emergency medical drills. Documentation of mock emergency medical drills indicated drills were conducted on each shift at least quarterly. Further, each shift had at least one quarterly drill requiring staff to demonstrate cardiopulmonary resuscitation (CPR). Half of the center's staff were reviewed for participation in a mock emergency medical drill, which reflected all staff participated. All mock emergency medical drills were properly documented. Emergency phone numbers are posted in master control and the clinic which are not accessible to youth.

A review of fourteen staff training records found all staff held current certifications for first aid, CPR, and use of an AED. Nursing staff also held current first aid, CPR, and AED certifications.

Seven interviewed staff stated they were able to call 9-1-1 in the event of a medical emergency. The nurse interview reflected the clinic manager was able to explain all processes related to episodic and emergency care, to include the locations and monitoring for first aid kits and AEDs, availability of emergency numbers, completion of medical drills, off-site emergency care, and follow-up.

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

A review of seven youth individual healthcare records (IHCRs) included five instances of off-site care. An Off-Site Summary of Care form was utilized in each case. Discharge paperwork was returned with the youth or later obtained by medical staff in each case. The Off-Site Summary of Care forms and discharge paperwork were reviewed and signed by the advanced registered nurse practitioner (ARNP) or designated health authority (DHA) upon their next visit to the center. Follow-up care was scheduled and provided, as needed, and/or information regarding follow-up care was documented on Health Discharge Summary forms if youth were released with pending scheduled appointments.

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

Four of the seven youth in the initial sample reviewed were identified with chronic conditions. An additional youth with a chronic condition was reviewed. None of the five youth were in the center over ninety days; although, initial evaluations and treatment plans for the chronic conditions were completed on each youth. Three of the youth required off-site care for their chronic condition while detained, and nursing staff worked with the off-site provider to ensure appointments were kept and the care provided. One youth received care from an off-site provider related to the youth's chronic condition prior to admission. Nursing staff obtained records of the care from the off-site provider to ensure continuity of care. All youth with chronic conditions were on the alert list. Treatment orders related to the chronic conditions were clear. Three of the five youth were documented on the chronic conditions list; although, all youth with chronic conditions and/or taking medication on a regular basis were identified in a binder maintained for the designated health authority (DHA), which the DHA reviews to ensure care. Interviews with the nurse, DHA, and advanced registered nurse practitioner (ARNP) found they were familiar with the process for evaluating and monitoring youth with chronic conditions.

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

The center has a written policy and procedures for medication management which include verification, administration, storage, inventory, and disposal of medications. The center has a Modified Class II Pharmacy permit. Documentation indicated a consultant pharmacist conducted monthly on-site reviews.

Seven youth individual healthcare records (IHCRs) were reviewed. Admission paperwork indicated five youth were prescribed medication at the time of their admission. In two records, the center had the medication in stock and an order was given by the designated health authority (DHA) or advanced registered nurse practitioner (ARNP) to provide the medication. In one IHCR, the medication was brought to the center from a residential commitment program a day after the youth's admission. In this case, a Medication receipt form was completed, the medications and prescriptions were verified, and the DHA and psychiatrist ordered the medications to be continued. In two records, the parent/guardian brought the medication to the center at the time of the youth's admission. A Medication Receipt form was completed to document the receipt of the medications in each IHCR. For one youth, the medications were verified and the DHA ordered the medications to be continued. The Medication Receipt form documented receipt of three medications for one of the youth, but documentation in the record and the youth's Medication Administration Record (MAR) indicated only two of the medications were verified and continued per the order of the DHA. Interviews with the nurse and psychiatrist revealed, the remaining medication was not continued due to it being evident the youth was not taking the medication as prescribed; although, this was not documented in the record. Nursing staff contacted the youth's parent/guardian during the review, who confirmed the medication was given back to the parent/guardian at the time of the youth's admission because the youth was not taking the medication as prescribed. A week following the youth's admission, the psychiatrist completed an evaluation of the youth and started the youth on a lower dose of the medication, to which the parent/guardian consented.

MARs were reviewed for seven youth. The center uses the Department's MAR form. Each MAR documented all required information to include the youth's name, Department's identification number, date of birth, allergies, precautions, and medical grade. The MARs were completed by month, with MARs including prescription medication and over-the-counter (OTC) medications given based on orders by the ARNP, DHA, or psychiatrist. Start and stop dates were documented for each medication. There were no lapses or medication errors noted on any of the MARs. Staff including medical staff and youth initialed the MAR for each dose of medication administered. Refusals of medication were properly documented on MARs, as well as on the Department's Refusal of Care form. Monitoring for side effects was documented on MARs each time medication was administered and observation of medication pass revealed the nurse questioned each youth about side effects when providing the youth with their medication. Weekly monitoring for side effects was documented as well.

Nursing staff administers almost all medication at the center. There is a list of non-healthcare staff who are trained and are authorized to administer medication. The non-healthcare administers medication only when nursing staff are not on-site, which includes only OTC medication in accordance with the designated health authority's (DHA) protocols or emergency medications, such as asthma inhalers or epinephrine auto-injector. Policy and procedures state

only medical staff may administer or supervise youth self-administer parenteral medication. The clinic manager reported there were no youth at the center on parenteral medication during the annual compliance review period. Medication administration by nursing staff was observed, finding it occurred in an organized manner. Youth were escorted to the clinic by direct care staff and approached the nurse at the medication cart one at a time. The nurse followed the Six Rights of Medication Administration and questioned youth regarding side effects and allergies. The direct care staff supervised youth as they waited to take their medication. There were no instances of non-healthcare staff administering medication during the review to observe. MARs reviewed did include an example of a non-healthcare staff administering medication, which was properly documented.

Five IHCRs were reviewed for youth who were taking psychotropic medication. Two youth had prescriptions for psychotropic medication at the time of their admission. The psychiatrist was contacted in each case. The psychiatrist ordered one youth to continue their medication and ordered the other youth's medication not be given, as it was evident the youth had not been taking the medication as prescribed. The psychiatrist completed a psychiatric evaluation on each youth within a week of their admission utilizing the Department's Clinical Psychotropic Progress Note (CPPN). Three youth were referred to the psychiatrist for an evaluation based on the youth previously taking psychotropic medication. The psychiatrist completed a psychiatric evaluation using the CPPN on each youth within fourteen days of the referral, resulting in each youth being prescribed psychotropic medication. Documentation indicated parent/guardian consent was received prior to youth receiving new psychotropic medication or when medication dosages were changed.

A psychiatric evaluation using the CPPN was completed on each youth within fourteen days of the medication being brought to the center.

All medications were securely stored in the clinic, with active medications stored in a secured medication cart and bulk supply or stock medication stored in a secured cabinet. There is a secured lockbox within the secured medication cart for controlled medications. Medications were separated by type such as oral, topical, drops and by youth within the medication cart. There is a secured refrigerator designated for medications requiring refrigeration. All sharps were secured in cabinets. Medications requiring disposal were disposed during consultant pharmacy visits. All disposals were properly documented.

During an interview with the nurse, it was revealed medication is given to youth almost exclusively by nursing staff. The only time non-healthcare staff would give youth medication is in emergency situations such as respiratory inhaler, epinephrine auto-injector, or in accordance with healthcare protocols for OTC medications to treat common complaints such as headaches or indigestion when nursing staff are not on-site.

One of the seven interviewed staff, reported they gives youth medication. This staff was a supervisor who is trained in medication administration.

Six of the seven interviewed youth, stated nursing staff give them their medication and one youth stated they did not take medication.

4.16 Medication/Sharps Inventory and Storage Process [Contract Provider]	Satisfactory Compliance
Any medical equipment classified as stock medications shall be secure and inventoried by using a routine perpetual inventory descending count as each sharp is utilized and disposed of or when the medication is utilized.	

The center has a policy and procedure for medication inventories. Documentation indicated all stock medications over-the-counter (OTC) and prescription are inventoried at least weekly. The stock inventories are updated perpetually as well, documenting when the medications are used, transferred to the medication cart, or disposed. All active OTCs were inventoried daily and perpetually. Sharps were inventoried weekly and perpetually. Prescription medication inventories were stored perpetually in Medication Administration Records (MAR). Controlled medications were inventoried each shift, which was documented by two staff signatures/initials, and each time the controlled medication is administered. Inventories for three sharps, three active OTC medications, three stock medications, three prescription medication, and two controlled medications were reviewed . Nursing staff counted selected sharps and medications in the presence of a member of the review team, which showed all inventories were accurate. There is a process in place to reconcile any discrepancies in inventories.

4.17 Infection Control – Exposure Control and Education [Contract Provider]	Satisfactory Compliance
The center shall have implemented infection control procedures including prevention, containment, treatment, and reporting requirements related to infectious diseases, as per OSHA federal regulations and the Centers for Disease Control and Prevention (CDC) guidelines. The comprehensive education plan shall include pre-service and in-service training for all staff. Education for youth infection control shall also be provided at the time of intake and subsequently when the need is identified.	

Infection control procedures and the exposure control plan address prevention, containment, treatment, and reporting requirements for infectious diseases. The procedures cover hand washing techniques, childhood diseases, contagious illnesses, viral and bacterial diseases, tuberculosis, hepatitis, blood borne pathogens, pediculosis, scabies, methicillin-resistant staphylococcus aureus (MRSA), food borne illnesses, bio-terror, and chemical exposures. The exposure control plan meets the requirements of Occupational Safety and Health Administration (OSHA). The plan lists the job classifications for staff at risk, procedures for maintaining the work site, specified signs and labels to communicate hazards, the proper disposal of needles and other sharps, the handling of contaminated laundry, post-exposure evaluation and follow-up, and documentation. Hepatitis B immunizations are available to all staff and staff are informed of the availability of the immunization upon hire. Staff have access to protective equipment. The program did not have any incidents related to infection control during the annual compliance review period.

Seven youth individual healthcare records (IHCRs) were reviewed, which documented all youth received training on infection control during the medical intake process. The infection control education was documented on each youth's Health Education Record. A review of fourteen staff training records found twelve staff received training on universal precautions, which was provided by a nurse. The nurse interview indicated youth are provided infection control education upon admission. The nurse provides training to staff on infection control, and the exposure control plan is available to staff.

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

Records for two pregnant youth were reviewed, which included two admissions for each youth while pregnant. An initial assessment was conducted on each youth and prenatal care along with special diet and other special accommodations were immediately ordered at each admission. There was documentation of daily monitoring of each youth and any issues with their pregnancies. Neither youth was in the detention center over thirty consecutive days. The designated health authority (DHA) was notified immediately of any pregnancy-related issues. One youth was transported to the emergency room as a result. Off-site prenatal examinations and care were documented in each case, with nursing staff at the center obtaining records from the off-site provider. Follow-up appointments were scheduled with the off-site providers by nursing staff.

Seven youth were interviewed, which three were female. Two of the female youth reported they received prenatal, obstetrical, or gynecological services when needed. The remaining youth stated they did not need such services. The interview with the nurse confirmed services are provided to pregnant youth in accordance with Department procedures. A review of fourteen staff training records for non-healthcare staff indicated eleven staff involved in the supervision or treatment of pregnant youth, received the appropriate training and education.

Standard 5: Safety and Security

5.01 Active Supervision of Youth (Critical)	Satisfactory Compliance
Staff are aware of the location of youth assigned to their supervision at all times. Staff monitor the movement of youth in their direct care from one location to another. *Youth are in sight of at least one juvenile justice detention officer (JJDO) at all times (with the exception of sleeping hours or time secured in rooms).* *Officers are responsible for the care of youth at all times. At no time shall another youth be allowed to exercise control over or provide discipline or care of any type to another youth.* *When a youth leaves the group or program area of the center for any reason, all staff assigned to supervise the youth are informed.* *Master Control authorizes all movement of youth prior to the actual movement, and no movement occurs until cleared by Master Control.* *Staff moves youth from one area of the center to another in accordance with Florida Administrative Code.*	

The center has a written policy and procedures addressing the active supervision of youth. Staff were observed during daily activities with the youth such as meals, line movement, youth dorms, and movement during transports. Staff were observed conducting active youth supervision throughout the week of the annual compliance review. Youth were not observed during school movement due to being out of school for summer break. Staff monitor movement of youth by writing in the logbook when youth move from one location to the next throughout the facility.

Seven staff were interviewed to determine if they are familiar with how often counts are to be conducted. Each stated head counts are conducted every hour and during emergency circumstances. Five of seven staff stated the facility has enough staff to provide adequate safety and security for the youth in custody. The remaining two staff stated, more staff is needed.

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.

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

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

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

The center has a total of one hundred twenty-two cameras, of which six cameras were not operational. The maximum camera recording capacity is thirty days. There were no obstructions over the room windows which staff could visually see the youth while conducting ten-minute checks. The center utilizes the Guard One Electric System (Wand). The checks are downloaded to a computer and are documented electronically. Ten-minute checks were reviewed for two different days at various times on all five living modules. On July 31, 2019, seven of forty checks were completed beyond every ten minutes on Bravo Module. On July 31, 2019 on Charlie Module, one of forty checks were completed beyond every ten minutes. On August 8, 2019, four of forty documented checks were completed beyond every ten minutes on Bravo Module. A review of the master control logbook confirmed there was no youth movement during the above dates and times for the missing bed checks. The remaining three modules completed ten-minute bed checks as required.

Seven staff were interviewed and reported room checks are conducted every ten-minutes.

5.03 Census, Counts, and Tracking	Satisfactory Compliance

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

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

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

The center has a written policy and procedures in place to track youth census and counts. Master control and module logbooks were reviewed from the last six months to determine if census counts, youth movement, and daily tracking are documented at the beginning and end of each shift. A review of all logbooks indicated counts were conducted consistently. Juvenile justice detention officers (JJDO) maintain a running log of all intakes, releases, major disturbances, and events taking place. Counts were documented at the beginning and end of each shift and hourly throughout each shift. Counts were heard over the radio and observed while in the master control room during the annual compliance review. Random counts were also documented to ensure all youth are accounted for.

Seven staff reported, emergency counts are conducted when a youth is believed to be missing, when visibility is hindered; such as electrical outage and after a major disturbance.

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

The center has a written policy and procedures related to logbook maintenance. Master control and module logbooks were reviewed from the last six months. The center has separate logbooks for master control, each youth module, contracted staff and visitors. All entries by staff were written in black ink with no erasures or white out used. All errors were struck through and initialed by staff. The master control logbook captures admissions, releases, emergency situations, incidents involving youth, drills, counts, confinement, youth movement and all other important information. The date, shift, and supervisor on duty were included in the heading of each shift. Logbook entries contained chronological record of events including the date and time, names of youth, staff involved, and a brief description of the event. Logbook entries regarding medical, special needs, and mental health alerts were highlighted. Youth placed on precautionary and/or secure observation and close watch along with the time of the precautionary and/or secure observation was initiated and the time the observation ended; was also documented in the logbooks.

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

The center has a written policy and procedures in place related to logbook reviews. A review of the center's logbooks for the previous six months revealed the superintendent or designee reviews all logbooks on a weekly basis. Module logbooks are reviewed on a daily basis by the supervisors. There was documentation of the superintendent or designee touring the youth living areas at least once during each shift. Observation revealed all required staff including the superintendent or designee and supervisors, reviewed and signed the logbooks as required. During an interview with the superintendent, it was stated the supervisors review the logbooks daily and administration is expected to review at least weekly.

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

The center has a written policy and procedures regarding key control. An inventory of all keys is maintained and was accurate, including all required information and when observed. A review of training records for all fourteen staff sampled confirmed each were trained on the center's key control process. Center keys were maintained in a secure metal storage box on the wall inside master control and in the supervisor's office. The administrative staff which includes education, maintenance, nursing, mental health staff, shift supervisors, superintendent, and assistant superintendents sign out keys in master control. Emergency keys are stored in a separate locked cabinet inside master control. Only administration and supervisors have access to emergency keys.

Floor keys are stored in a locked cabinet inside the supervisor's office and issued to staff during shift briefing by a supervisor. All floor keys are maintained on a tamper-resistant key ring and a

number is included on the ring to indicate how many keys are on the key ring. Supervisors document keys issued on a log and enters the information in the Facility Management System (FMS). All keys are returned by the juvenile justice detention officers at the end of each shift. This process was observed during the annual compliance review and found to be adequate. Staff personal keys are stored in their lockers away from the secured area and visitors turn their personal keys into master control.

Seven staff were interviewed and explained the center's daily key control, damaged, and/or missing key processes. All stated master control and the supervisors are responsible for tracking all keys. All were able to describe and identify the restricted keys within the center as medical records, master control, youth property area, mental health records, case management records, and the kitchen. All seven stated youth do not have access to any keys.

The superintendent was interviewed and stated, no staff is issued permanent keys.

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

The center has a policy and procedures for vehicles and maintenance. The center has a total of nine vehicles which are used for transportation of youth. Five vehicles were inspected during the annual compliance review. Each vehicle had the appropriate number of seat belts, seat belt cutters, window punches, suicide response kit, emergency roadside kit, fire extinguishers, and first aid kits. First aid kits are signed out from master control for every transport along with the vehicle logbook, cell phone, and vehicle keys. Vehicles are locked when not in use. As part of the transportation process, staff are to check all vehicle cages before and after transport for contraband, and document the inspection in the vehicle logbook.. Contraband checks were not documented in the vehicle logbooks for any of the five vehicles reviewed as required. Observation of a transport indicated the youth were searched before and after each transport. Maintenance documented weekly and monthly vehicle inspections for the past six months. Annual maintenance inspections were documented as required.

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

The center has a written policy and procedures for tools. The policy includes guidelines for the storage of kitchen knives or other hazardous sharps. All maintenance tools are stored and locked when not in use. Each tool is marked with an identification code and stored on a peg board. Maintenance completes weekly inspections of all tools, records the inventory on a log, and turns in the inventory sheet into the superintendent. The tool area was well organized, neat, and clean. Service vendors sign in and out when entering the center and are always accompanied by maintenance staff when they are in the secured area. When a vendor enters the center with a tool bag, it is searched and all tools are counted before and after being in a secured area.

All kitchen tools are stored in a locked drawer and counted daily at the beginning and end of each shift. The kitchen manager maintains track of the daily inventory logs. Kitchen storage at the center was clean, neat, and organized. In the event a kitchen tool is misplaced, the kitchen staff immediately report it to the superintendent or designee..

Seven staff were interviewed and stated if a tool is damaged or missing, all movement is stopped and a search of all youth, staff, and the center is conducted.

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

The center has a written policy and procedures addressing youth's access and use of tools and cleaning items. Youth are prohibited from using any medical equipment, kitchen, or maintenance tools except for mops and brooms under direct staff supervision. The clinic, maintenance, and kitchen managers confirmed youth do not have access to any of these items. Youth were not observed using tools or medical equipment during the annual compliance review.

Seven youth were interviewed and all stated they can use mops and brooms. Seven staff were interviewed and all stated youth can use mops and brooms under direct supervision.

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

The center has a written policy and procedures which addresses the inventory of all flammable, toxic, caustic, and poisonous items. The center's hazardous chemicals are stored in a shed secured by three locks in an area not accessible to youth. The storage shed was neat and organized and the center has an inventory of all chemicals documented by maintenance staff and reviewed by administration. Safety Data Sheets (SDS) are maintained in a binder inside the shed. The SDS were reviewed and contained a sheet for all chemicals present.

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

The center has a written policy and procedures which addresses access to all flammable, toxic, caustic, and poisonous items. All hazardous chemicals are stored in secured areas inaccessible to youth. Youth were not observed using chemicals during the annual compliance review.

Six of the seven interviewed youth stated they do not use any type of cleaning agents. One youth stated they witnessed a youth using a spray bottle with a cleaning agent in it, but most of the time staff will spray it and the youth will wipe.

All seven interviewed staff stated youth are not allowed to clean with substances considered toxic, flammable, or poisonous.

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

The center has a written policy and procedures addressing the disposal of flammable, toxic, caustic, and poisonous items. The maintenance staff is responsible for diluting, handling, and disposing of hazardous waste. The center reports there were no chemical spills or disposal of flammable, toxic, caustic, or poisonous items in the past six months. If flammable, toxic, or caustic materials, or items need to be disposed of; the center contacts the local Fire Department. A review of the Central Communications Center (CCC) incident reports over the six months prior to the review confirmed there were no center spills.

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

The center has a written policy and procedures regarding the use of confinement under twenty-four hours. Nine confinement reports under twenty-four hours were reviewed. In each report, the facility staff conducted ten-minute checks in compliance with policy. The confinement room was searched prior to placing the youth in the room. All youth were offered the opportunity to file a grievance. While in confinement, the shift supervisor conducts review of the youth within two hours and documents the review in the Facility Management System (FMS). The superintendent or designee conducts a review of all confinements within twenty-four hours and makes the determination to continue or end the confinement. Youth were counseled by the superintendent or designee prior to being released from confinement. Confinement rooms are free of

obstructions and were safe for youth to be in the room. During an interview with the master control operator, it was reported youth are offered hygiene items, education, showers, meals, clean clothing, and large muscle exercise daily while in confinement. The staff further advised all youth are showered daily unless the youth refuses. If a refusal is made, it is documented in the master control logbook.

Seven staff were interviewed and all responded when a youth is placed in confinement, staff must complete a confinement report, conduct and document ten-minute checks, and search the confinement room. Additionally, three staff stated a supervisor must approve the placement.

5.14 Confinement Over Twenty-Four Hours	Satisfactory Compliance
Confinement beyond twenty-four hours must be approved by the Superintendent or designee. *The Superintendent shall approve confinements extended beyond twenty-four hours and every twenty-four hours afterwards. Reasons for extended confinement must be clearly documented on the confinement report.* *The JJDOS(s) shall continue to evaluate and document the youth's status every three hours. Current youth behavior and/or conversation with the youth shall be documented on the confinement report as evidence for the need to continue or terminate confinement.* *If it is necessary to extend the confinement beyond twenty-four (24) hours, permission is needed from the regional director or designee. The regional director will notify the Assistant Secretary. This must be done every twenty-four (24) hours.* *The length of confinement shall not exceed three days unless the release of the youth into the general population would jeopardize the safety and security of the facility as documented by the Superintendent. No youth shall be held in confinement beyond three days without a confinement hearing, conducted by an employee of the Department who holds a management or supervisory position.*	

The center has a written policy and procedures regarding the use of confinement over twenty-four hours. Nine confinement reports beyond twenty-four hours were reviewed. In each report, the facility superintendent or designee was given permission to go beyond twenty hours by the regional director. Supervisor and administrative reviews were conducted within twenty-four hours. Ten-minute checks were completed as required. The confinement room was searched prior to placing the youth in the room. All youth were offered the opportunity to file a grievance. While in confinement, the shift supervisor conducted a review of the youth's behavior within two hours and documented the findings of the review in the Facility Management System (FMS). If it was determined confinement warrants longer than three days, permission was granted by the detention chief and documentation was accompanied to support the reason why the continuation of confinement was made beyond seventy-two hours. All youth were counseled by the superintendent or regional director prior to being released from confinement. Confinement rooms are free of obstructions and were safe for the youth to be in the room.

During an interview with the superintendent, it was stated a regional administrator must approve the continuance of any youth in confinement beyond twenty-four hours.

5.15 Continuity of Operations Planning (COOP) Drills	Satisfactory Compliance
COOP drills shall be conducted and documented, at minimum, twice a year, with one drill being completed prior to the hurricane season, which begins June 1st.	

The center has a Continuity of Operations Plan (COOP) to ensure the center is prepared to manage emergency and disasters. The center has completed two COOP drills on each shift since the last annual compliance review, including a weather drill prior to the beginning of hurricane season in May 2019.

Five of the seven interviewed staff stated, they have participated in weather, major disturbances, bomb threats, hostage situations, chemical spills, flooding, terrorism, and fire drills.

During an interview with the superintendent, it was stated regional detention management reviews the use of confinement, lockdown, and restraints monthly.

5.16 Escape Drills	Satisfactory Compliance
The center shall develop, implement, and maintain an escape prevention plan incorporating the Department's established policies and procedure regarding escapes. *The facility shall conduct and document quarterly mock escape drills.*	

The center has a policy and procedures addressing escapes. The center has an escape prevention plan which includes all required elements. Drills were completed monthly on each shift exceeding the requirement.

Five of the seven interviewed staff, stated they participated in an escape drill. During an interview with the superintendent, it was stated the center's comprehensive safety plan is to follow the escape prevention plan, which describes signs of escape and what to do in the event an attempt escape occurs and conduct monthly escape drills.

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

The center has a policy and procedures addressing fire drills. The center maintains documentation of all fire drills. A review of these drills confirmed the center conducted monthly fire drills on each shift. The center's evacuation plans are documented throughout the center indicating primary and secondary evacuation points.

Seven staff were interviewed and each indicated drills take place monthly. Seven youth were interviewed and stated they have been instructed on what to do in case of a fire.