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): October 13-16, 2020

Promoting Continuous Improvement and Accountability
in Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Juan Youman, Office of Accountability and Program Support, Lead Reviewer (Standard 1)
Warren Garrison, Office of Accountability and Program Support, Regional Monitor (Standard 3)
Benjamin Marrufo, Office of Accountability and Program Support, Technical Assistance Specialist (Standard 2)
Gwen Nelson, Office of Accountability and Program Support, Regional Monitor, (Standard 4)
Micah Youmas, Leon Regional Juvenile Detention Center, Juvenile Justice Detention Officer Supervisor (Standard 5)

Program Name: Duval Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: Duval County / Circuit 4
Review Date(s): October 13-16, 2020

MQI Program Code: 131
Contract Number: N/A
Number of Beds: 100
Lead Reviewer Code: 141

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.01 * Initial Background Screening	
5.09 Vehicles and Maintenance	

Standard 1: Management Accountability
Detention Rating Profile

Indicator Ratings

Standard 1 - Management Accountability		
1.01	Initial Background Screening*	Limited
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	Grievances	Satisfactory
1.09	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	Trauma-Informed Care	Satisfactory

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

Indicator Ratings

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

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Standard 4: Health Services
Detention Rating Profile

Indicator Ratings

Standard 4 - Health Services		
4.01	Designated Health Authority/Designee*	Satisfactory
4.02	Facility Operating Procedures	Satisfactory
4.03	Authority for Evaluation and Treatment	Satisfactory
4.04	Parental Notification/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/Exposure 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	Behavior Management System	Satisfactory
5.03	Unauthorized Use of Punishment *	Satisfactory
5.04	Ten-Minute Checks *	Satisfactory
5.05	Census Counts and Tracking	Satisfactory
5.06	Logbook Maintenance	Satisfactory
5.07	Logbook Reviews	Satisfactory
5.08	Key Control	Satisfactory
5.09	Vehicles and Maintenance	Limited
5.10	Tool Inventory and Management	Satisfactory
5.11	Youth Access & Use of Tools, Cleaning Items *	Satisfactory
5.12	Inventory of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.13	Access to all Flammable, Toxic, Caustic, and Poisonous Items *	Satisfactory
5.14	Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.15	Confinement Under Twenty-Four Hours	Satisfactory
5.16	Confinement Over Twenty-Four Hours	Satisfactory
5.17	Continuity of Operations Planning (COOP) Drills	Satisfactory
5.18	Escape Drills	Satisfactory
5.19	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 of Juvenile Justice, 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 100 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, two assistant superintendents, one administrative assistant, nine juvenile justice detention officer (JJDO) supervisors, and 43 JJDOs. Mental health and healthcare services are provided through the contracted provider, Camelot Community Care Inc. Mental health services are provided by a licensed mental health counselor who serves as the designated mental health clinician authority (DMHCA), one licensed mental health professional, and one non-licensed mental health personnel under supervision. 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 a medical doctor who serves as the designated health authority (DHA), one registered nurse (RN), two licensed practical nurse (LPN), and one advance practice registered nurse (APRN). The medical clinic maintains nursing coverage seven days a week. The RN is on-site Monday through Friday from 8:00 a.m. – 5:00 p.m. and on the weekends for ten to fifteen hours. The LPNs are on-site during the first shift on Monday through Friday and ten to fifteen hours on the weekends. The APRN is on-site once weekly.

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 116 security cameras at the center, of which all 116 were operational. At the time of the annual compliance review, the center had twenty-six vacancies.

Standard 1: Management Accountability

1.01 Initial Background Screening (Critical)	Limited 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 contracted provider may provide training and orientation to a potential employee before the screening process is completed. However, these individuals may not have contact with youth or confidential youth records until the screening is completed, the determination is "Eligible," a copy of the criminal history report has been reviewed, and the employee demonstrates he or she exhibits no behaviors warranting the denial of employment. An Annual Affidavit of Compliance with Level 2 Screening Standards is completed annually.	

A review of the employee and volunteer roster at Duval Regional Juvenile Detention Center revealed the detention center hired a total of nineteen staff and no volunteers since the last annual compliance review. Each staff received a background screening prior to their hire or start day. The pre-employment assessment passing score was found in each employee's record. The Annual Affidavit of Compliance with Level 2 Screening Standards was not completed and sent to Background Screening Unit by the January 31 deadline. It was completed October 13, 2020 as well as the annual screening for teachers paid by the school board, or funding by the school board or Department of Education.

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.	

A review of the employee and volunteer roster at the center found seven staff were eligible for a five-year rescreening. There was documentation of each rescreening submitted to the Background Screening Unit/Clearinghouse at least ten business days prior to each staff's five-year anniversary date.

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.*	

A review of nineteen staff personnel records found each staff signed a code of conduct. An interview with the superintendent revealed two staff received disciplinary actions for violations of the code of conduct. One staff were terminated and the remaining staff received a written reprimand. The superintendent revealed five staff received promotions since the last annual compliance review. The center has a process in place for allowing youth to call the Florida Abuse Hotline or the Central Communications Center (CCC) to report suspected abuse. Seven staff interviews revealed the process for allowing staff and youth to call the Florida Abuse Hotline or CCC to report suspected abuse is to notify the supervisor and superintendent and allow the staff or youth to make the call. Once the call is completed, the staff obtains the identification number of the person receiving the call.

Six of the seven staff revealed they have not observed a co-worker use profanity when speaking to youth. The remaining staff revealed hearing a co-worker use profanity when speaking to youth. The superintendent revealed staff will be retrained on the policy. Seven staff interview revealed none observed a co-worker using threats, intimidation, or humiliation when interacting with the youth. Four staff interviews revealed working conditions had been very good, two stated good, and the remaining staff stated poor.

An interview with six youth revealed four youth never had to report abuse. One youth stated they had never been stopped from reporting abuse to the Florida Abuse Hotline. The remaining youth stated they was stopped from reporting abuse to the Florida Abuse Hotline. The superintendent was notified and the youth was offered to make the abuse call but refused the call. Five of the six interviewed youth stated staff were respectful when talking with them and other youth. Three youth stated they have never heard staff use profanity when speaking with them or other youth. One youth responded once, one responded occasionally, and one responded often. Five youth revealed they had never heard staff threatened them or other youth. The remaining youth stated once to the same question. Five of the six interviewed youth revealed they felt safe at the center and the remaining youth responded they did not feel safe. The superintendent was notified and spoke with the youth about the youth concerns. The six

interviewed youth revealed never exchanging emails, telephone numbers, or social media contact information with staff.

The superintendent revealed all staff must adhere to a code of conduct prohibiting any form of abuse, profanity, threats, harassment, intimidation, or personal relationship with youth. If physical abuse, threats, or profanity is used towards the youth; the staff will receive a written reprimand or up to termination.

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 concerning incident reporting. The center had a total of seventy-four Central Communications Center (CCC) reports since the last annual compliance review. A random selection review of seven reports was conducted. Each of the reports were reported within the required time frame of two hours. Four of the seven reports were documented in the center's logbook. The superintendent revealed whenever a reportable incident occurs, the detention superintendent, or designee, notifies the Department's CCC within two hours of the incident or within two hours of becoming aware of the incident. All incidents are called in with the basic information such as who, what, when, where and how. A review of internal incidents grievances revealed there were not any reportable to the CCC. The program experienced an increase in the number of reportable incidents to the CCC due to the Coronavirus (COVID-19) pandemic.

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 to be completed and filed in accordance with the Florida Administrative Code.	

The center has a policy and procedures concerning the use of Protective Action Response (PAR). A random selection of nine PAR reports were reviewed. Six of the nine reports were completed by the end of the staff member's workday and included statements from all staff involved. One of the reports had seven staff involved and two of the staff statements were four days late and the remaining staff statement was one day late. The remaining incident involved three staff and one statement was six days late, while the remaining statement was seven days late. None of the reports involved mechanical restraints being used. None of the PAR resulted in serious injury to youth or staff. Each of the nine reports were reviewed by a supervisor and a PAR instructor to determine if use of force was consistent with policy. The post-PAR interview was conducted with the youth by the administrator less than thirty-minutes after the incident for each incident. In eight of the nine reports, there was documentation of the superintendent, or designee, reviewed the report after all other reviews and made comments, if appropriate within seventy-two hours. The remaining one report was reviewed thirty-four minutes late. The center's PAR rate is 11.43 compared to the statewide rate of 14.25. The superintendent's interview revealed all administrators and staff are trained annually in PAR. Seven staff interviews revealed staff attempt to talk to youth prior to using physical or 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.	

Five staff training records were reviewed for pre-service/certification training. Each of the staff were certified within 180-days of the hire date. The training records revealed each staff were trained in all of the prerequisite classes to include Protective Action Response (PAR), cardiopulmonary resuscitation (CPR)/automated external defibrillator (AED), first aid, mental health services, substance abuse services, suicide recognition, prevention and intervention, safety, security, and supervision to include emergency plans and procedures, and Department's detention facility operations prior to any contact with youth. The staff were also trained in essential skills, orientation, information security awareness, legal, The Department's: organization, gang awareness, interpersonal/ communication skills, and detainee behavior and consequences. Pre-service training is delivered through instructor-led, web-based, and on the job training. All trainings were documented in the Department's Learning Management System (SkillPro). All the staff receive training at the academy. The center maintains a pre-service training plan and calendar for all new 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.	

Four staff and three supervisor training records were reviewed for in-service training. Each staff completed the required number of hours of training. The training records revealed each staff were trained and certified in protective action response (PAR) update, cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), professionalism and ethics. Each of the staff received the minimal requirements of six hours of suicide prevention training. Each of the reviewed supervisor records revealed at least eight hours of supervisory training was completed. All three supervisors received training in medication administration and epinephrine auto-injector. All the trainings were documented in the Department's Learning Management System (SkillPro). The program has an annual in-service training calendar which is updated as changes occur. The superintendent indicated they completed certified public manager (CPM), certified supervisory manager, and program review training. The superintendent revealed the Department shall offer multi-disciplinary training opportunities for employees. Training shall provide staff with the tools required to successfully perform their duties, while simultaneously challenging them as a function of professional growth.

1.08 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 documenting the grievance process. An interview with the superintendent revealed the center did not have any grievances within the last twelve months. A tour of the center revealed grievance forms were available for youth access. The superintendent revealed the center's grievance process consist of three phases to include an informal phase where the juvenile justice detention officer (JJDO) attempts to resolve the complaint with the youth, a formal phase where the youth submits a handwritten grievance which results in a response from a JJDO supervisor by the end of the shift, if possible, or within twenty-four hours. The final stage is the appeal stage in which the superintendent or designee has the final response.

The JJDO enters the grievance into the Department's Facility Management System (FMS) on behalf of the youth. The completed grievance form is then submitted to the JJDO supervisor within two hours. In the final phase, the superintendent or designee reviews the completed grievance form within seventy-two hours of receipt; excluding weekends and holidays. In the final phase, the superintendent's decision is final. The youth signs a hard copy of the grievance form which is maintained in a separate grievance file uploaded in FMS. An interview with six youth revealed each of the youth were knowledgeable of the grievance process. Three youth revealed never filing a grievance. The remaining youth rated the grievance process as good, fair, and poor. Five of the interviewed seven staff revealed they were knowledgeable of the center's grievance process.

1.09 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 juvenile justice detention officer supervisor (JJDOS) 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.* *JJDOSs 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.*	

A copy of the center's alerts was provided to the annual compliance review team from the Department's Juvenile Justice Information System (JJIS). There was documentation in the center's logbooks and internal alerts to identify youth with medical, mental health, suicide, gang, and security issues. All medical alerts are removed by medical staff. Mental health alerts are closed by mental health staff. Information regarding youth alerts are available to all staff during pre-shift meeting. Each staff received a copy of the alerts during their shift.

Seven staff interviews revealed staff are informed of alert specific to youth during shift debriefings, logbook, JJIS, and alert forms. The staff interviews also revealed management informs staff on issues within the center through logbooks, staff debriefings, alerts, meetings, and emails. Five youth records were reviewed for alerts. Each of the five youth had a least one alert entered into the system while at the center. Each of the alerts were documented in the logbook. All of the alerts were removed by the appropriate staff. The superintendent interview indicated the center has an alert system in place to alert staff when mental health, medical, or security issues exist which may affect the security and safety of the youth in the center. The superintendent revealed the medical alert system is intended to be highly flexible and serve as a quick reference for staff to use in the event an issue arises which might affect the youth's health, safety, or daily staff interactions.

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, full body visual 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 records were reviewed for the detention admission process. All youth records contained a copy of the Juvenile Justice Information System (JJIS) Admission Wizard. The JJIS Admission Wizard review confirmed each of the seven youth had all admission requirements completed. The Admission Wizard documented all youth were searched by staff of the same sex, received a telephone call to the youth's parent/guardian or the youth's refusal of the call, and documented the youth were offered a meal. All seven records contained the youth's arrest report, Detention Risk Assessment Instrument (DRAI), Suicide Risk Screening Instrument (SRSI), and their medical, mental health, and substance abuse screening. A youth admission was observed during the week of the annual compliance review. The staff followed all of the admission procedures documented in the policy.

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.*

A review of seven youth records revealed the center completed the orientation within twenty-four hours of admission for each youth. All seven youth signed the orientation acknowledgement form stating they were provided all information from the orientation and a copy of the signed form was found in each youth's record. A youth admission was observed during the week of the annual compliance review. The youth was prompted by the staff conducting the admission to

observe the orientation video which was playing on the monitor. The staff conducting the admission was polite with the youth.

Six youth were interviewed during the week of the annual compliance review and youth advised they were provided information on the center's rules and regulations, grievance procedures, visitation, telephone calls, medical, mental health services, substance abuse services, Florida Abuse Hotline, and the behavior management system. One interviewed youth advised they was not provided with the required orientation information. Administration was informed and followed up with the youth. The youth informed administration they really did not mean what was stated in the interview.

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 classification of youth entering the center. The classification process is outlined in the center's facility operating procedures. All seven youth were classified to provide a level of safety and security which were based on the Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB), Suicide Risk Screening Instrument (SRSI), Massachusetts Youth Screening Instrument-Version 2 (MAYSI-2), and the Juvenile Justice Information System (JJIS) Admission Wizard instruments. The youth were also screened to determine gang affiliation or membership and if suspected, an alert is entered into JJIS. Each youth were assigned to a room based on their classification. Youth are reclassified if changes in behavior or status are observed. The superintendent interview revealed all youth identified by screening of the MAYSI-2, SRSI, or by staff observations or behavior after admission are referred for further in-depth mental health and/or substance abuse evaluation. The superintendent revealed mental health status, physical health status, cognitive performance, age, and prior victimization are considered when assigning youth to rooms.

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 facility operating 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. None of the seven selected youth were applicable for gang involvement or affiliation. Three additional youth records were requested for youth who were identified as having gang affiliation. The center only had two youth who had gang affiliations records to review. There was no evidence of notification to the juvenile probation officer (JPO) circuit gang representative in the two youth's record. The superintendent stated the youth were already identified as either a gang member or affiliated with a gang prior to admission to the detention center. The Juvenile Justice Information System (JJIS) was reviewed for the two identified youth and there were appropriate gang alerts entered. 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. The gang representative was unavailable for interview during the week of the annual compliance review.

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. A Personal Property Receipt form was signed by each youth and the detention center staff. A copy of the property receipt was placed in the youth's case management record and in the property bag assigned to the youth. One of the seven youth had valuables placed in a tamper-proof bag which was placed in a drop safe. The drop safe bound logbook included the date, time, youth's name, department's identification number, printed name of the officer who secured the property, and the officer's signature. Each of the seven youth records contained a letter of acknowledgement signifying an understanding unclaimed property is deemed abandoned and subject for disposal.

During the annual compliance review, an observation of the admission of youth personal property process was observed during admission and the youth's personal property was inventoried and documented on the personal property receipt. Six interviewed youth stated when they arrived at the center, the staff checked their personal property and signed a form stating the personal property was correct. The superintendent revealed being responsible to ensure the youth's personal property and valuables are maintained in accordance with the policy. The intake staff is responsible to ensure all youths' personal and valuable property is inventoried on the Department's Juvenile Justice Information System (JJIS) Property Sheet. The

superintendent stated valuable property is placed in a clear tamper-proof bag which is signed by both the youth and intake officer and placed in a drop safe. The safe is under video surveillance at all times.

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 observed youth personal property was stored in individual bags with the inventory form in a secured room. The inventory form included the date of admission, youth's name, the youth's Juvenile Justice Information System (JJIS) number, and a list of the youth's personal property. Seven youth case management records were reviewed for storage of youth personal property. One of the seven youth records contained documentation of valuable property which was inventoried and placed in a clear tamper-proof bag. The youth's valuable property was logged in the admission logbook and the safe logbook. The youth's case management record documents the parent/guardian of the youth picked up the valuable property. The safe logbook did not have any documentation indicating the youth's valuable property was released to the parent/guardian. The valuable property is first logged into the logbook during the admission process and then dropped in a locked drop box in a secured room. The secure drop box is monitored under video surveillance twenty-four hours a day. The supervisory staff will check the admission logbook and determine if there was any valuable property logged in. The supervisory staff will sign the admission logbook and remove the valuable property from the secure drop box and transfer the property to the front safe. The supervisory staff will log the valuable property in the safe logbook once the property is placed in the safe.

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 stated the youth property is stored in a secure property room and valuable property is maintained in a drop safe under video surveillance twenty-four hours a day. The superintendent revealed any property not picked up within thirty days will be considered abandoned. After thirty days, a Notice of Impending Disposal of Property is mailed to the last known address. For youth who are on supervision, the juvenile probation officer signs for and delivers property to the youth. If the youth or parent/guardian cannot be located, the superintendent or designee center ensures all money and property are counted and inventoried. A money order is then sent to the regional fiscal manager. The regional fiscal manager forwards the money order to the designee in Headquarters.

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 facility operating procedures in place to address youth releases. Three closed youth case management records were reviewed. All the youth's case management records revealed the on-duty supervisor reviewed the required paperwork prior to the youth's release. The parent/guardian's identification was photocopied and the copy was placed in the youth's case management record. The youth and parent/guardian were reminded of all upcoming court dates. The youth and parent/guardian signed all applicable release paperwork. A review of the Central Communications Center reports for the past six months revealed there were no unauthorized releases.

2.08 Release of Youth Personal Property	Satisfactory Compliance

Upon a 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 facility operating procedures (FOP) in place for release of youth with personal property. Three closed youth case management records were reviewed. Two of the three records contained a property release form signed by both the youth and parent/guardian on the day of the youth's release. One of the three youth was released to the custody of the local sheriff's office. A copy of a letter was in the youth's record notifying the parent/guardian to pick up the youth's personal property. Any unclaimed property left at the detention center for thirty days will be disposed of by the superintendent or the designee by mailing it to the last known address of the youth. A youth release was observed during the week of the annual compliance review, all procedures were followed and based on the center's FOP.

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.

Three closed youth records for youth released on medication were requested. The center was able to provide two records. Two youth's records were reviewed for release of medication and

aftercare instructions. The two 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 both closed records. Both records included reminders to the youth and person receiving the youth of any medical, mental health, and/or substance abuse needs and if there were any pending appointments. The two closed youth's case management records contained receipt forms with the signatures of the youth, parent/guardian, nurse, and staff and included the date the medication was returned. An observation of the release of medication procedures was observed and there were no issues noted during the annual compliance review.

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

The center has facility operating procedures regarding review of youth in secure detention. The center conducts detention reviews at the center on a weekly basis to ensure proper management of youth placed in secure detention and the appropriate sharing of information. A detention review was observed during the week of the annual compliance review. The participants included a detention review officer, the superintendent or designee, medical staff, mental health staff, education staff, probation staff, a Department of Children and Families caseworker, and commitment staff; when applicable. The participants shared information on each youth's case. The review covered all court orders, detainment beyond twenty-one days, youth pending residential placement, termination of home detention, and medical or mental health needs of the youth. The census, sign-in sheet, tasks for follow up, and minutes were entered into the Facility Management System. An interview with the superintendent reported the assigned facility detention review officer conducts the weekly detention reviews and addresses all youth on the census in the detention center and on 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 facility operating procedures in place which addresses the daily activity schedule. The daily activity schedule was observed to be posted in each living unit. The daily activity schedule includes wakeup, personal hygiene, mealtimes, visitation, recreation, education, gender specific programming, life and social skills, and restorative justice programming. A review of the master control and living unit logbooks revealed the daily schedule is followed with minimal interruptions. Seven youth were interviewed and each confirmed the detention center follows the daily activity schedule. Seven staff were interviewed and each stated the center's daily schedule is followed.

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.	

A review of the logbook, observation, and interviews indicated the center adheres to the daily schedule. Seven youth were interviewed and each confirmed the detention center adheres to and follows the daily schedule. Seven staff were interviewed and each confirmed the centers adheres to and follows the daily schedule. Shift reports were reviewed to verify any significant changes in the activity schedule.

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 to provide for educational access. The center provides education services through the Duval County School Board. The center integrates education into the daily schedule to ensure the youth are receiving the required minimum instruction time distributed over a twelve-month period. The district and daily school calendars were reviewed and incorporated the required 250-days of instruction with ten days used for teacher planning. This schedule provided four seventy-five minute class periods fulfilling the weekly requirement of twenty-five hours of instructional time. Youth receive credit for course completions as appropriate.

An interview with the lead educator verified the youth are attending school according to the daily schedule. A review of the logbook and confirmation with the lead educator, indicated students were communicating with teachers through Microsoft Teams virtual platform due the COVID-19 pandemic. During this time, students were also given educational material in packets to complete in units during regular scheduled school hours. The center has resumed face-to-face instruction in all classrooms. Five youth were interviewed and each stated school is attended Monday through Friday, with minimal interference of educational instruction. An interview with the superintendent revealed 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 to provide for career education. An interview with the lead teacher revealed the center offers provides Type 1 career education development which includes career learning strategies such as interviewing skills and techniques, career interest, inventories, budgeting, résumé writing, as well as completing employment applications. The center also provides character education including lessons in citizenship, integrity, and good moral character traits.

2.15 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 facility operating procedures in place regarding trauma-informed care. The center incorporated trauma-informed care practices into current operations to deliver services and to provide care to youth in custody. An interview with the superintendent revealed the center has a soft room and murals throughout the detention center to soften the aesthetics. Seven staff training records were reviewed and 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 center. The DMHCA is responsible and accountable for ensuring appropriate coordination and implementation of mental health and substance abuse services in the center and shall promote consistent and effective services and allow the superintendent and staff a specific source of expertise and referral.	

The designated mental health clinician authority (DMHCA) is responsible for the coordination and implementation of mental health and substance abuse services at the center. The center has two licensed clinical staff with one serving as the DMHCA. The DMHCA holds an active license as a mental health counselor which expires on March 30, 2021. A review of sign-in sheets verified the DMHCA is on-site weekly for forty hours, Monday through Friday. The license and agreement with Camelot Community Care Inc., delineates the scope of work. The DMHCA interview revealed the specialized mental health and substance abuse overlay services are provided to youth by the mental health staff. The DMHCA is responsible for coordinating all mental health and substances abuse services, as determined by the interview.

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

The center contracts for mental health and substance abuse services with Camelot Community Care Inc. The mental health and substance abuse services are provided by mental health substance abuse clinical staff with appropriate training and qualifications. The center utilizes two licensed mental health substance abuse clinical staff, ensuring the center's staffing is in accordance with the contract and Rule 63N-1. A review of the two mental health and substance abuse clinical staff's licenses determined one clinical staff holds an active license as a mental health counselor and the remaining clinical staff holds an active license as a clinical social worker pursuant to Chapter 491, F.S.

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.	

A review of the staff roster and the contract with Camelot Community Care determined the center utilizes one non-licensed staff, as mental health and substance services are provided by non-licensed clinical staff with appropriate qualifications. The non-licensed clinical staff holds a master's-level degree. The staff provides substance abuse and mental health services. A review of training determined the non-licensed staff completed the required twenty-hours of training in

assessing suicide risk and completed the five Assessment of Suicide Risks (ASR) conducted on-site in the physical presence of the licensed mental health professional (LMHP) and documented on the Documentation of Non-Licensed Mental Health Clinical Staff Person's Training in Assessment of Suicide Risk form (MHSA 022). According to the Rule 63N-1, the training specified in the Rule confirmed the training reviewed for the non-licensed clinical staff was accurate. The clinical non-licensed staff works under the direct supervision of the licensed designated mental health clinician authority (DMHCA).

A review of the direct supervision logs verified the clinical staff receives one hour a week of on-site, face-to-face supervision by the DMHCA. The service provider is Camelot Community Care Inc., as the DMHCA is contracted by the center who provider is licensed under Chapter 397. Documentation of direct supervision was recorded on the appropriate Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log(MHSA 019).

The DMHCA and the licensed mental health professional (LMHP) are responsible for reviewing and signing each ASR and follow-up ASR, crisis assessment and the follow-up, the comprehensive substance abuse evaluations, updates, and initial and individual treatment plans prepared by the non-licensed clinical staff.

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

The youth's mental health and substance abuse needs are addressed in the center's facility operating procedures (FOP). Procedurally, mental health and substance abuse and suicide risk screenings are accomplished by administering the Department's Suicide Rick Screening Instrument (SRSI) and reviewing the Massachusetts Youth Screening Instrument, Version II (MAYSI-2). According to the center's policy, the juvenile justice detention officers (JJDO) review the MAYSI-2, administer the SRSI, refer youth for an ASR, and consult with the designated mental health clinical authority (DMHCA).

Seven youth records were reviewed including their community assessment tool (CAT) pre-screen and SRSI. Each youth had a mental health and substance abuse assessment completed and suicide risk screening completed during intake by a JJDO in the Department's Juvenile Justice Information System (JJIS). The SRSI had complete entries.
Three assessments indicated a need for further assessment. The three youth were reported to the mental health clinical staff referred for an Assessment of Suicide Risk (ASR). Each youth had a MAYSI-2 completed and each youth had a SRSI completed. Each youth's MAYSI-2 or SRSI either had a positive "Yes" response on the SRSI, their MAYSI-2 indicated an elevated suicide risk subscale, or the youth had all negative responses on the scored MAYSI-2 form. As a result, the center placed each of the three youth on suicide precautions and a mental health referral was completed.

The superintendent reported all youth are accessed during intake. Youth with any mental health and substance abuse or suicide risks signs are immediately addressed by utilizing the center's

procedures. Seven staff were interviewed and reported they notify mental health staff when a youth exhibits any suicide risk behavior. Seven youth were interviewed and one youth rated the mental health services as poor, one youth rated the services as good, and four reported they did not receive any mental health and substance abuse services.

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 with 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.	

A review of the center's facility operating procedures (FOP) determined the center has established procedures to track the receipt of the Comprehensive Assessments. During intake, youth identified with mental health and substance abuse needs referred for further in-depth mental health and/or substance abuse assessments. Procedurally, comprehensive mental assessments are accomplished by a community provider. Youth in need of assessments are referred to a community provider by the Juvenile Assessment Center (JAC) screener or juvenile probation officer (JPO) and within fourteen days are to be notified of the status. Youth who are detained and who were referred for an assessment, the center utilizes Camelot Community Care, Inc. to complete the assessment within the first thirty-one days in the center.

Seven youth records were reviewed and each were detained at the center. Two of the seven youth's intake screenings indicated a need for a comprehensive assessment. Each of the evaluations were completed on Comprehensive Substance Abuse/Mental Health (SAMH) form in the youth's electronic medical record.

3.06 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/substance abuse treatment in the center. *All youth who receive mental health and/or substance abuse treatment while in 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.*	

A review of the center's operating procedures (FOP) determined the superintendent, designated mental health clinical authority (DMHCA), and the mental health and substance abuse clinical staff are responsible for the development and review of the initial and individualized mental health/substance abuse treatment plan for each youth at the center.

Seven youth records were reviewed and three youth were applicable for mental health and/or substance abuse treatment. Each of the three youth had an initial treatment plan developed on the Initial Mental Health/Substance Abuse Treatment Plan (MHSA 015) . Each of the initial treatment plans were developed within seven days of the onset of treatment. Each of the initial plans were signed by the licensed mental health and substance abuse clinical staff completing the form or by a non-licensed staff and reviewed by the licensed clinical supervisor, within ten days of completion. Each plan was also signed by mini-treatment team members. Each of the

three youth required psychiatric services, as the psychotropic medication and frequency of monitoring was included in the initial treatment plan.

Seven youth records were reviewed and three youth were determined in need of mental health and/or substance abuse treatment. Each of the three youth had an individualize treatment plan developed on the Individualized Mental Health/Substance Abuse Treatment Plan (MHSA 016)within thirty days. Each of the individualized plans were signed by the licensed mental health and substance abuse clinical staff completing the form or by a non-licensed staff and reviewed by the licensed mental health professional. The initial plans indicated three youth required psychiatric services and the psychotropic medication and frequency of monitoring were included in the individualized treatment plan. One youth required a review of their individualized treatment plan, as the center completed a review on the Individualized Mental Health/a Substance Abuse Treatment Plan (MHSA 017). None of the youth were an alleged victim of a Prison Rape Elimination Act (PREA). Three additional youth closed records were reviewed. Each of the three closed youth records received mental health and substance abuse treatment while at the center. The discharge plans were provided to the youth, the parent/guardian, and the juvenile probation officer.

3.07 Mental Health and Substance Abuse Treatment [Detention Staff/Contract Provider]	Satisfactory Compliance
Mental health and substance abuse treatment planning in Department facilities focuses on providing mental health and/or substance abuse interventions which will reduce or alleviate a youth's symptoms of mental disorder and/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 in at the center, must be assigned to a mini-treatment team.*	

Seven youth records were reviewed for mental health and substance abuse treatment. Three youth records were applicable for mental health treatment including treatment with psychotropic medication or substance abuse treatment while in at the center. Each of the three youth declined substance abuse services; however, each youth had signed documentation of proper consent for treatment on the required Youth Consent for Substance Abuse Treatment form (MHSA 012) and the Youth Consent for Release of Substance Abuse Treatment Records (MHSA 013). There were no additional open youth records requiring substance abuse services.

Each of the three youth had an initial and individualized mental health plan based on the findings in the Comprehensive Mental Health Evaluation. Each of the three youth were assigned to a mini-treatment team. Mini-treatment teams were comprised of all the appropriate team members which included mental health clinical staff, one staff from a different service area, and the youth. The parent/guardians were not available during the mini-treatment teams, as documentation by the center determined. Each of the applicable youth records had documentation of receiving individual, group, or family counseling by the licensed mental health professional or in some cases, the non-licensed mental health clinical staff working under the direct supervision of the licensed mental health professional, in accordance with their treatment plan. Service frequency reflects diagnoses and treatment needs, as some youth were detained more than a six weeks. Regardless of any refusals, each of the three youth records had a signed Authorization for Evaluation and Treatment (AET) forms. Reviewed sign-in sheets

determined groups included fifteen or less youth. Notes were documented on the Counseling/Therapy Progress Notes (MHSA 018).

The designated mental health clinician authority (DMHCA) reported mental health and substance abuse overlay services are provided on-site to youth and psychiatric services are provided to youth.

Six youth were interviewed and one youth rated the mental health services as poor, one youth rated the services as good, and four reported not receiving any mental health and substance abuse services.

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's policy and procedures allows for psychiatric services to include psychiatric evaluations, psychiatric consultations, medication management, and medical supportive counseling to be provided to youth. Each youth with a mental disorder and receiving psychotropic medication receive services. The center utilizes a psychiatrist who is board certified in Child and Adolescent Psychiatry pursuant of Chapter 458. A review of services outlined in the psychiatrist's contract determined the center complies with Rule 63M and 63N, provisions regarding psychiatric services. The current and updated copy of the official collaborative practice protocol between the supervising psychiatric and advanced practice registered nurse (APRN) was maintained on-site in the designated medical services location within the secured facility.

Seven youth records reviewed and three youth entered the center on psychotropic medication. Each of the three applicable youth received an initial diagnostic interview within fourteen days of admission. The initial diagnostic psychiatric interview included elements specified in Rule 63N-1 F.A.C. Each youth received an in-depth psychiatric evaluation on the Clinical Psychotropic Progress Note (CPPN) within thirty days of admission and all appropriate documentation was included. Each applicable youth had a written and verbal consent by the parent/guardian. None of the youth were in the care of the Department of Children and Families. Each of the three youth were at the center long enough to have documentation of a monthly CPPN/medication review. The CPPN was completed for each of the three youth including page three of the CPPN. Page three for each of the three youth documented all the required information; the identifying data, diagnosis, symptoms, description, prescribed medication, along with dose, orders, frequency, and if there were any changes and why, side effects, compliance with medication, height, weight, blood pressure, and drug level, telephone contact with the parent/guardian, signature, and date of signature were included on the page. Each youth had documentation of monitoring for Tardive Dyskinesia, as documented by the psychiatrist.

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

The program has a suicide prevention plan. The suicide prevention plan utilized at the center safely assess and protect 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.

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, available information, or staff observations 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 at a minimum of constant supervision.* *All youth 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 (ASR).*	

Seven youth records were reviewed and three had suicide risk factors based on assessments. The three applicable youth were placed on precautionary observation. The Juvenile Justice Information System (JJIS) suicide alert was updated for each of the three youth, as the center placed the three youth on suicide precautions. Each youth was documented to participate in selected activities. A health status check was completed for each youth.

A review of the superintendent's established review process for every serious suicide attempt or serious self-inflicted injury and a mortality review for a completed suicide included a multidisciplinary review of the circumstances surrounding event, procedures relevant to the incident, training, medical and mental health services, precipitating factors, and recommendations.

Each youth had an Assessment of Suicide Risk (ASR). None of the youth needed a follow up ASR. Each youth received an ASR within eight hours. The non-licensed mental health professional completed each ASR, as the licensed mental health professional reviewed each of the three ASRs. Each youth was transitioned to a lower level of supervision. In each youth's record, the non-licensed mental health staff consulted with both the superintendent and licensed staff and documented the actual date and time prior to the three youth being discontinued from precautionary observation. The three youth were transitioned directly to standard supervision, as they were placed on precautionary observation prior to their ASR and were no longer a potential suicide risk. None of the youth were placed in secure observation due to disciplinary confinement. A review of logbooks determined the center documented the beginning and ending times for each youth. None of the youth had documentation of misbehaving or required a level of observation and control beyond precautionary observation. Each ASR was completed in real time.

Seven staff were interviewed and each stated 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. Six youth were interviewed and four reported the question were non applicable as they were not placed on suicide precautions. Two reported the staff never left them alone while on suicide precautions. One of the two youth reported staff did not leave them alone and explained to the youth they were on suicide precautions during the intake process. No other youth left an explanation.

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.	

Seven youth records were reviewed and three youth were applicable for a suicide precaution observation log. Logs documented staff observations of the youth's behavior every thirty minutes. None of the youth exhibited any "warning" signs as noted on the logs. Logs were signed by the mental health clinical staff and the shift supervisor. None of the youth were on suicide precautions over twenty-four hours. Logs were maintained on the Department's Suicide Precautions Observation Log (MHSA 006).

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 had documentation of twelve staff receiving the required suicide prevention training. Mock drills were held for both shifts each month for the last twelve months, as fifty percent of center's staff were reviewed. Mock drills contained all the required elements including lifesaving measures such as cardiopulmonary resuscitation (CPR), suicide response kit, and contacting other center staff, medical personnel, and emergency medical services. Five staff interviews documented participation in suicide mock drills.

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 provided documentation of their 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 the notification and alert system, means of referral, including youth self-referral, communication, supervision, and documentation and review.

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 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.	

A review of the mental health emergency services plan includes all the proper procedures. All youth determined to be an imminent danger are applicable for services under this plan. 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, and authorization. The plan was approved on July 29, 2020 and is located in master control and the training room.

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 had a sample size of one youth requiring a crisis assessment during the annual compliance review period. The assessment contained all the appropriate requirements including 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 assessment was documented on the Department's Crisis Assessment form (MHSA 023). The assessment was completed by the licensed mental health professional. A review of the policy outlines the process to address crisis assessments. An alert was completed in the Department's Juvenile Justice Information System (JJIS). The youth was not an alleged victim of a Prison Rape Elimination Act (PREA).

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 had a sample size of one youth requiring a Baker Act during the annual compliance review period. Mental health staff initiated the Baker Act. Documentation included notifications to the youth's parent/guardian and assigned juvenile probation officer. Upon arrival to the center, the youth was placed on constant supervision. A Mental Status Examination (MSE) was conducted by the licensed mental health staff. A suicide risk alert was completed in the

Department's Juvenile Justice Information System. The level of supervision was not lowered until the youth was administered a follow-up assessment of suicide risk (ASR) by the licensed mental health professional. Mental health staff consulted with the superintendent. A review of the center's policy determined procedures conducted by the center were appropriate.

Standard 4: Health Services

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

The designated health authority (DHA) is responsible for the medical care of all youth at the center. The DHA is a medical doctor certified as an internal medicine physician with a clear and active license to practice in the State of Florida, through January 2021. The contract with the DHA outline services to be provided by the DHA in accordance with Department requirements. A review of the center's visitation sign-in sheets denoted the DHA was on-site once a week during the past six months as required by the contract. The DHA survey indicated another physician from the current contract provider will provide coverage if the DHA is not able to make weekly visit. The DHA is available twenty-four hours a day, seven days a week.

An advanced practice registered nurse (APRN) works in collaboration with the DHA, assisting with the completion of Comprehensive Physical Assessments (CPA) and other clinical duties. The APRN is on-site two days a week for a total of twenty hours a week. The APRN 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 APRN on file at the center. The DHA and APRN assigned duties indicated a clear understanding of each responsibilities at the center. Interviews with medical staff and the review of documentation related to healthcare services, including youth records confirmed 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) approved all healthcare policies, procedures, and protocols on July 1, 2020. The superintendent also signed the healthcare policies and procedures. The DHA also developed and signed the treatment protocols. All nursing staff signed a form acknowledging the healthcare policies and procedures and treatment protocols. A new medical services contract provider, Camelot Community Care, Inc., began on March 17, 2020. The clinic manager, a register nurse, and the advanced practice register nurse were hired under the new provider. 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.	

The center has a policy and procedures to obtain Authority for Evaluation and Treatment (AET) forms, Limited Consent for Evaluation and Treatment forms, or court orders authorizing treatment. Seven youth individual healthcare records (IHCR) were reviewed. Six of the seven IHCR contained an AET form signed by the parent/guardian. One of the youth was in the

custody of the Department of Children and Families (DCF) and the record contained a court order authorizing treatment. The remaining six youth records had the original AET forms. The AETs were obtained prior to medical services being provided. The clinic manager acknowledges 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.	

The center has a policy and procedures for parental notification in accordance with Department requirements. A review of seven youth individual healthcare records (IHCR) had original 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 for six of the youth and Department of Children and Families (DCF) notifications were completed for the remaining youth. The Department's Clinical Psychotropic Progress Note (CPPN) was completed by the psychiatrist for written notifications related to psychotropic medication(s), telephone notifications to the parent/guardian or multiple telephone attempts to contact the parent/guardian by telephone were documented for each notification. Written documentation of witness for all telephone notifications. The clinic manager explained 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. A new screening is completed on each youth admitted or re-admitted to the center. Seven youth individual healthcare records (IHCR) 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 each 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/Health Education [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 (IHCR) indicated 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. Seven youth individual healthcare records (IHCR) were reviewed and one youth 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 four IHCRs. Each youth with a chronic condition was evaluated by the DHA or advance practice registered nurse (APRN) and a plan to address their chronic condition was completed. During an interview with the clinic manager, it was indicated the medical staff is to notify the DHA when a youth is admitted with a chronic condition. The medical staff also 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 the center.	

The center has a policy and procedures to review the youth's health-related history (HRH). Seven youth individual healthcare records (IHCR) were reviewed for Health-Related History (HRH). A new HRH was completed by the staff within seven days of admission in each of the seven IHCRs. The advanced practice registered nurse (APRN) documented a review of the HRH in each record. As needed, a clinical staff or the APRN 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 into the physical custody of the center.	

The center has a policy and procedures to conduct comprehensive physical assessment and tuberculosis (TB) screening. Seven youth individual healthcare records (IHCR) were reviewed for a Comprehensive Physical Assessment (CPA). Each record had a new CPA completed by the advanced practice registered nurse (APRN) within seven days of admission. Each CPA documented a tuberculosis skin test (TST) was completed within the last year. All sections of the CPA were completed. Two youth medical grade was listed as two, three youth had a medical grade listed as five, one was listed as a medical grade one, and the remaining youth had a medical grade of four. Updates to CPAs and the Department Problem Lists are documented when a youth's medical grade changed. All youth with a medical grade between

two and five were documented in the Department's Juvenile Justice Information System (JJIS). The clinic manager was familiar with the process for completing CPAs. The clinic manager stated 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 (STI) and HIV risk factors.	

The center has a policy and procedures addressing screening and testing for sexually transmitted infections (STI) and human immunodeficiency virus (HIV) services provided by HIV certified counselors from a community provider. Seven youth individual healthcare records (IHCR) were reviewed for STI and HIV screening. Each IHCR documented an STI screening form was completed by medical staff upon the youth's admission. Each STI screening form was reviewed by the designated health authority (DHA) or advanced practice registered nurse (APRN) were referred for STI testing based on the screening results.

Seven IHCRs documented youth were tested. The STI testing results were documented on the Infectious Communicable Disease (ICD) form and in the lab section in each applicable record. The care for STI infections was documented and notifications of the health department were documented, when required. One female youth was identified as being pregnant, consented to the gynecological evaluation. The medical staff completed the evaluation. All seven IHCRs in the initial sample reviewed found each youth were offered HIV testing during the medical intake process. None of the youth consented to testing. The clinic manager stated all youth are screened for STIs. The clinic manager further stated, APRN or designated health authority (DHA) order STI testing, as needed. Youth are given the opportunity to request HIV testing with the HIV testing being provided on-site by certified HIV counselors. All seven interviewed youth reported they could request a 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.	

The center has a policy and procedures for youth to make sick call requests. Sick call is provided by medical staff seven days a week. When a youth wants to make a request to be seen for sick call, the youth complete a sick call form and submit to staff. The staff inputs the sick call request in the Facility Management System (FMS), which generates a notice of the sick call request to supervisors and administration for review, if medical staff are unavailable. All sick call requests are reviewed by the clinic manager who is a registered nurse (RN), within twenty-four hours. A sick call log is maintained electronically through the FMS. Youth initialed or signed the sick call log to acknowledge they received sick call care. The clinic manager explained the sick call process identifying when sick call is provided, who provides sick call, and when youth are referred to the advance practice registered nurse (APRN) or designated health authority (DHA). Seven interviewed youth stated they have never completed a sick call request. The clinic manager reported there were no sick call request in two months. Seven staff were interviewed and each stated 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 policy and procedures for first aid and episodic care. Youth requiring first aid and episodic care are escorted to the clinic when medical staff is on-site. Eighteen on-site episodic care were reviewed. The episodic care was provided by medical staff and documented in accordance with Department's requirements. An episodic care log is maintained and revealed the eighteen episodic care conditions were reviewed by medical staff.

Reviewed documentation indicated the designated health Authority (DHA) 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 transport vehicle. Reviewed documentation indicated first aid kits are checked monthly by clinical staff to ensure all required contents were present and within expiration dates. The kits have break away ties which secure the first aid kits. Documentation indicated supplies are restocked when items are used or when expired. Seven first aid kits were observed and each were fully stocked with items approved by the DHA. The center has four automated external defibrillators (AED, 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 annual compliance review team, demonstrating each AED was ready for use. Documentation indicated the AEDs were checked monthly by the clinic manager.

The center has a policy and procedures for 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. Documentation indicated one quarterly drill with staff demonstrating 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 telephone numbers are posted in master control and the clinic which are not accessible to youth. A review of twelve staff training records found all staff held current certifications for first aid, CPR, and use of an AED. Medical 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 clinic manager was able to explain the procedures related to episodic and emergency care, including 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 (IHCR) indicated there were no off-site medical care since the COVID-19 pandemic. An interview with the clinic manager indicated when a youth is transported off-site for medical care an Off-Site Summary of Care form is completed. The Off-Site Summary of Care forms and discharge paperwork are reviewed and signed by the advanced practice registered nurse (APRN) or designated health authority (DHA)

during their next visit to the center. Follow-up care is documented on Health Discharge Summary forms when the youth is 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.	

The center has a policy and procedures for youth with chronic conditions. Four of the seven youth reviewed individual healthcare records were identified with chronic conditions. One of the four youth was in the enter over ninety days. Initial evaluations and treatment plans for the chronic conditions were completed on each of the four youth. None of the youth required off-site medical care for their chronic conditions. The four youth with chronic conditions were on the alert list. Treatment orders related to the chronic conditions were clear. Each of the youth with conditions were documented on the chronic conditions list. Each 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. Written interviews completed by the clinic manager and DHA were aware of the process for evaluating and monitoring youth with chronic conditions.

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

The 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 (IHCR) were reviewed. Admission paperwork indicated four youth were prescribed medication at the time of their admission. All medications and prescriptions were verified and the DHA and psychiatrist ordered the medications to be continued. A Medication Receipt form was completed to document the receipt of the medications in each IHCR. The four IHCR records indicated all medications were verified and the designated health authority (DHA) ordered the medications to be continued.

A review of seven Medication Administration Records (MAR) 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 advance practice registered nurse, 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. Supervisors are trained to pass medication when medical staff is not on- site. Medical staff and youth initialed the MAR for each dose of medication administered. Refusals of medication are documented on the MARs and on the Department's Refusal of Care form. Monitoring for side effects are documented on MARs each time medication is administered. Weekly monitoring for side effects are documented.

The medical staff administers all medication at the center when on-site. A list of non-healthcare staff which are trained supervisors, are authorized to administer medication including 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 stated there were no youth at the center on parenteral medication during the annual compliance review period. No medication administration was observed during the week of the annual compliance review. The clinic manager explained the process for medication administration. Youth are escorted to the clinic by direct care staff, the youth approach the medication cart one youth at a time, the medical staff followed the Six Rights of Medication Administration, and question youth regarding side effects and allergies. Direct-care staff supervised youth during medication. There were no non-healthcare staff administering medication during the week of the annual compliance review to observe.

Three individual healthcare records (IHCR) were reviewed for youth who were taking psychotropic medication. The three youth were prescribed psychotropic medication at the time of their admission. The psychiatrist was contacted in each case. The psychiatrist ordered the three youth to continue their medication. The psychiatrist completed a psychiatric evaluation on each youth within a week of their admission utilizing the Department's Clinical Psychotropic Progress Note (CPPN). The psychiatrist completed a psychiatric evaluation using the CPPN on each youth within fourteen days of the referral. Documentation indicated there were no youth receiving new psychotropic medication or changes in medication dosages. A psychiatric evaluation using the CPPN was completed on each youth within fourteen days of the medication being provided 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. The clinic manager stated medication is administered to youth most times by nursing staff. The clinic manager state the only time non-healthcare staff would administer 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 is not on-site. An interview with a supervisor reported only supervisors give youth medication when medical staff is not on-site. Five of the seven interviewed youth stated nursing staff give them medication and the remaining two 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 medication 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 OTC medications 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 on 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. The clinic manager counted sharps and medications in the presence of a member of the annual compliance review team. The inventories were accurate.

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 guidelines. The comprehensive education plan shall include pre-service and in-service training for all staff. Education for youth infection control shall also be provided at the time of intake and subsequently when the need is identified.	

The center has a policy and procedures for infection and exposure control to 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, bioterror, 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.

The 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 (IHCR) 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 indicated the staff received training on universal precautions, which was provided by the clinic manager. The clinic manager indicated youth are provided infection control education as a part of the admission process. The clinic manager conducts infection control training for the staff. The exposure control plan is located in the medical unit and in master control.

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

The center has a policy and procedures for prenatal care and education. There was one pregnant youth in the center applicable for prenatal care and education during the annual compliance review period. The admission forms for the youth were completed. An initial assessment was conducted and prenatal care along with a special diet and other special accommodations were immediately ordered at admission. There was documentation of daily

monitoring of the youth's pregnancy. The youth was in the center for less than thirty consecutive days. Seven youth individual healthcare records were reviewed of which three were female. One of the youth received prenatal, obstetrical, or gynecological services. The two remaining youth did not require prenatal care services. The clinic manager stated 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.

Duval Regional Juvenile Detention Center has a policy and procedures in place on active supervision of youth. Youth and staff were observed throughout the week of the annual compliance review. The staff and youth were observed conducting daily activities such as education, meals, line movements, youth in the mods, and outside activities. Staff were visually observed conducting supervision of youth all week. Youth were observed during line movements to and from school. Staff conduct movement of youth by clearing with master control and documenting in the logbooks before escorting the group. Staff to youth ratios were within policy compliance. The staff used head counts, alpha lists, and logbooks to track daily census. Seven interviewed staff revealed there are enough staff to provide for the safety and security for the youth and staff.

5.02 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 procedures on the behavior management system (BMS). A tour of the center found the program has postings in all living areas which clearly specify appropriate and inappropriate behaviors, rules, norms, and expectations. The BMS was approved by the detention regional director. A review of the BMS found it includes rewards for positive behavior and consequences for inappropriate behavior. The center uses a three-level system for rewarding positive behavior. Level one is the most restrictive level. Only youth who exhibited

major problem behaviors or have been placed in confinement are dropped to level one. The youth will need to have three good days of behavior to move to level two. Level two provides the youth with all the basic rights, additional activities and incentives such as access to television, 9:00 p.m. bedtime, and board games. Level three provides the youth with all the basic rights plus additional privileges such as a level up party, additional telephone time, later bedtime, access to the snack store, games, movies, television, and prime seating. All youth entering the center are placed on level two. Each day youth have an opportunity to earn points. After three days youth with good behavior moves up to level three. A review of youth point cards revealed rewards and consequences were given in accordance with the BMS. The superintendent reported Detention Services uses a three-level system to track youth behavior. Regardless of the level a youth is on, all youth will have their basic rights including three meals per day plus snack, clothing, sleep, healthcare and mental health and substance abuse services, school, exercise, letter writing, telephone use a minimum of twenty minutes per week, religious programs, parent/guardian visitation, visits with juvenile probation officer, attorney or clergy, and access to bathing and hygiene. Seven staff interviews revealed the BMS consist of a point/level system. Staff interviews revealed the BMS is posted throughout the center and is included in the orientation process. Five of six interviewed youth rated the center's BMS as good. The remaining youth rated it as poor. Each of the six interviewed youth were able to explain the center's BMS. The six youth stated they are rewarded with late sleep times, movies, games, food, additional telephone time and token store. All six interviewed youth stated staff utilize the rewards the same.

5.03 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 (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.*	

The center's behavior management system (BMS) policy and procedures were reviewed. The center's BMS restricts certain types of penalties on youth who demonstrate negative behaviors. According to the policy, group punishment is not used as part of the center's BMS. Corporal punishment is not used in the center. Any allegations of corporal punishment of any youth by center staff are to be reported to the Florida Abuse Hotline and the Department's Central Communications Center (CCC). Seven staff interviews revealed only levels and points can be taken away from youth as a punishment. The seven staff reported never observing a co-worker take meals, snacks, clothing, education, or medical care from a youth as a consequence of their behavior. The staff revealed they have never observed staff encouraging youth to beat up another youth. Four youth stated they had been sent to their room for punishment. The remaining two youth stated they have not. The youth stated the door was shut and locked. The

youth were interviewed if when receiving consequences, were they fair. One interviewed youth stated yes, two stated no, and three stated they never received consequences.

5.04 Ten-Minute Checks (Critical)	Satisfactory Compliance
Staff shall visually observe youth on standard supervision at least every ten minutes while they are in their sleeping quarters, either during sleep time or at other times, such as during an illness or room restriction. *Staff conduct 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; preprinted 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 116 cameras in which all were operational. The camera recording is stored for thirty days. A tour of the center found there were no obstructions blocking the module room windows and staff were able to visually see all youth while conducting ten-minute checks. The center utilizes the Guard One System (Wand) to conduct ten-minute checks. The checks are also downloaded unto a computer. Five randomly selected dates and times were observed for ten-minute checks. On the day observed, all ten-minute checks were completed within policy compliance. Seven interviewed staff reported room checks for sleeping or non-punishment reasons are conducted every ten-minutes. The superintendent revealed the electronic wand is used to document room checks when youth are placed in a room as part of the daily schedule such as shift change, bedtime, showers, or during a rolling or a facility lockdown. The superintendent stated when a youth is placed in a room whether for sleeping or other reasons, officers conduct visual observations to ensure safety and security and notate those checks by utilizing an electronic wand system. When conducting a room check, staff pause at the door and look into the room to ensure there are no issues with the youth.

5.05 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 policy and procedures in place to track youth census and counts. Master control and all module logbooks were reviewed from the past six months to determine all census counts, youth movement, and daily tracking were documented from the beginning until the end of each shift. Formal counts were documented at the beginning and end of each shift, prior to and following routine group movements, when a population changes occurs, and following any emergency. Each count was audibly clear over the radio and observed while inside of the master control operating area during the week of the annual compliance review. Random counts were also observed and documented to account for all youth assigned to the center. Seven staff interviews revealed counts are conducted at the beginning and end of each shift. Counts are also conducted hourly, randomly, after each release or admission, any major disturbances, and any security codes such as code blue, red, or white. Staff interviews revealed emergency counts are conducted when a youth is believed to be missing, when visibility is hindered such as an electrical outrage, after major disturbance, and during emergency drills.

5.06 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 policy and procedures in place related to logbook maintenance. The center has separate written logbooks for master control, each youth module, contracted staff and visitors. Master control and all module logbooks were reviewed from the past six months. All

entries by staff were written in black or blue ink with no erasers or white out used. All errors were struck through with one line and initialed by staff. The master control logbook captured admissions, releases, emergency situations, incidents involving youth, monthly drills, facility counts, confinement, youth movement, Center Communications Center(CCC) calls, and all other information involving the center. The date, shift, and supervisor on duty were included in the heading of each page of the logbook. Youth placed on precautionary and/or secure observation were closely monitored as well as the beginning and the ending time of the precautionary and/or secure observation were documented in the logbooks as well. The center does not utilize an electronic logbook.

5.07 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 policy and procedures in place related to logbook reviews. A review of the center's logbooks for the past six months revealed the superintendent and or designee reviewed each logbook on a weekly basis. Each module logbook was reviewed daily by each shift supervisor. There was documentation of the superintendent and or designee touring each of the youth living areas at least once during each consecutive shift. There was documentation of the juvenile justice detention officers (JJDO) reviewing the logbook which is maintained in assigned living area when accepting responsibility for living area at shift change. An interview with the superintendent or designee revealed all logbooks entries are reviewed weekly for the previous seventy-two hours. Each review is documented and highlighted in a yellow marker. The superintendent also stated a supervisor reviews the master control logbook of the previous seventy-two hours and document their presence in the living area logbooks every shift. The JJDO reviews the logbook maintained in the assigned living area when accepting responsibility for the assigned living area.

5.08 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 2020-2021 Detention indicators.)*	

The center has a policy and procedures regarding key control. An inventory of each key is maintained and completed with accuracy including all required information was observed. A review of training records for three supervisors and nine juvenile justice detention officers (JJDO) confirmed each staff were properly trained on the center's key control process. The center's keys were maintained in a secure metal storage box on the wall inside of master control and also inside of the supervisor's office. The administrative staff which includes education, maintenance, nursing, mental health staff, shift supervisors, superintendent, and assistant superintendents sign-out keys inside master control. Emergency keys are stored in a separate locked cabinet inside master control. Only administration and supervisors have access to emergency keys. The JJDO keys are stored in a locked cabinet inside of the supervisor's office and issued to staff during shift briefing by the oncoming shift supervisor. All staff keys were maintained on a tamper-resistant key ring and a number is inscribed on the ring to indicate the amount of keys on the key ring. Shift supervisors document keys issued on a log and enters the information in the Department's Facility Management System (FMS). All keys are returned by the JJDO at the end of each consecutive shift. This process was observed during the week of the annual compliance review and were conducted correctly according to policy. All personal keys belonging to staff are stored in their personal lockers away from the secured area of the center and visitors turn their personal keys into the master control operator prior to entering the secured area. An interview with the maintenance staff revealed there were no instances of lost keys. An interview with the master control operator on duty revealed they were able to explain the process for restricting usage of keys such as medical, youth and staff records, and youth property locker keys. If keys were lost or missing, a diligent search is conducted, and the Department's Central Communications Center is contacted within two hours of gaining knowledge of the lost or missing keys. If keys are damaged, the superintendent and maintenance staff is notified. The superintendent interview revealed permanent keys are not issued to any staff. Seven staff were interviewed and each was able to explain the center's daily key control, damaged, and/or missing key process. Each staff stated the master control operator and the supervisors are responsible for tracking all keys. Each staff was 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. The seven staff stated youth do not have access to any keys.

5.09 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 for the sole purpose of youth transportation. Eight of the vehicles were inspected during the week of the annual compliance review. The remaining vehicle was new to the center and had not been involved in a transport. Upon completion of the inspection, 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 were signed out from master control for each transport along with the vehicle logbook, cell phone, and vehicle keys. Each vehicle was found to be locked when not in use. As part of the transportation process, staff are to check all vehicle cages before and after each transport for contraband and document the inspection in the assigned vehicle logbook. None of the fire extinguisher were current, one was last inspected in 2015, six were inspected in 2016, and one was inspected in 2018. All of the fire extinguishers received an inspection during the week of the annual compliance review. Contraband checks were not documented in the vehicle logbooks for any of the five vehicles reviewed, as required. A visual observation of a transport indicated each youth was searched before and after each transport. All of procedures were followed by staff making the transport. Maintenance documented weekly and monthly vehicle inspections for the past six months. All vehicle receives an annual maintenance inspection and were documented, as required. Each vehicle was found to be in good working condition. Six interviewed youth revealed they felt staff drive safely when transporting youth. The youth revealed they have never seen anyone place contraband in a transport vehicle.

5.10 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 policy and procedures for tool inventory and management. The policy includes guidelines for the storage of kitchen knives or other hazardous sharps as well. All maintenance tools were stored and locked away when not in use. Each tool was found marked with a distinct identification code and stored on a peg board. Facility maintenance personnel completes a weekly inspection of all tools, records the inventory on a log, and turns the inventory report into the superintendent or designee. Maintenance personnel revealed after the completion of each work project, the area is cleaned and inspected for contraband prior to allowing youth access. There were no missing tools listed on the inventory. All of the tools were listed on the inventory. Visual observation revealed the tool area was well organized, neat, and clean. Service vendors sign in and sign out when entering the center and are always accompanied by maintenance personnel when in the secured area of the center. When a vendor enters the facility with a tool bag, the tool bag is searched by the shift supervisor, and all tools are counted before and after being in a secure 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 a daily inventory log. The kitchen storage at the facility 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 interviewed staff revealed if a tool is damaged or missing, all youth movements are stopped and a thorough search of all youth, staff, and the center is conducted immediately. The

superintendent interview revealed the maintenance mechanic and administration have access to facility tools.

5.11 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 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. Six youth were interviewed and each all stated they are allowed to use mops and brooms. Six staff were interviewed and each stated youth are allowed to use mops and brooms under direct staff supervision. Youth were observed using cleaning tools through video.

5.12 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 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 inaccessible to youth. The storage shed was neat and organized. The center had an inventory of all chemicals documented by maintenance personnel and reviewed by administration staff. Safety Data Sheets (SDS) are maintained with the hazardous chemicals in a binder inside of the shed. The SDS were reviewed and contained a sheet for all chemicals present.

5.13 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 policy and procedures which addresses access to all flammable, toxic, caustic, and poisonous items. All hazardous chemicals are stored in a secured area inaccessible to youth. Youth were not visually observed using any chemicals during the week of the annual compliance review. Six interviewed youth stated they do not use any type of cleaning agents. Each of the seven interviewed staff stated youth are not allowed to clean with substances considered toxic, flammable, or poisonous.

5.14 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 policy and procedures addressing the disposal of flammable, toxic, caustic, and poisonous items. The maintenance personnel are responsible for diluting, handling, and disposing of hazardous waste materials. The center reports there were no chemical spills or disposal of flammable, toxic, caustic, or poisonous items in the past six months. If the issue arises where flammable, toxic, or caustic material items need to be disposed of; the center contacts the local fire department. A review of the Central Communications Center (CCC) incident reports within the past six months prior to the annual compliance review confirmed there were no center spills.

5.15 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 policy and procedures regarding the use of confinement under twenty-four hours. Five confinement reports under twenty-four hours were reviewed. Within each report, the ten-minute checks were conducted within compliance of policy. The confinement rooms were searched prior to the youth entering. Each youth were offered the opportunity to file a grievance. While in confinement, the youth were reviewed by the shift supervisor within the first two hours and documented 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. Each youth was counseled by the superintendent or designee prior to being released from confinement. All confinement rooms are free of obstructions and were deemed safe for youth to enter.

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. Seven staff were interviewed and each stated when a youth is placed in confinement staff complete a confinement report, conduct and document ten-minute checks in which five minute checks are conducted in the first hour), and search the confinement room. Six of the seven interviewed staff revealed youth placed in temporary confinement are provided education materials. The staff reported if Protect Action Response (PAR) is used the youth is seen by medical staff. The superintendent interview revealed the center uses the Department's Juvenile Justice Information System, SharePoint, and administration staff track the use and appropriateness of confinement. During an interview with the facility superintendent, it was stated the regional detention management reviews the use of confinements, lockdowns, and restraints monthly.

5.16 Confinement Over 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. *Confinements should not exceed twenty-four hours; however, if a youth continues to exhibit behavior which poses a risk to him or herself, staff, or others, a Confinement Review must be conducted.*	

The center has a written policy and procedures regarding the use of confinement over twenty-four hours. An interview with the superintendent revealed the center did not had any youth placed on confinement over twenty-four hours.

5.17 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 facility is prepared to manage emergency and disaster situations. The center completed three COOP drills of at least one on each shift since the last annual compliance review, including a weather drill prior to the beginning of hurricane season in May 2020. Seven staff interviews revealed staff participated in a flooding, escape, weather, fire, medical, and mock suicide drills. The superintendent interview revealed the emergency plan describes how to respond to emergency situations including fire and fire prevention/evacuation, severe weather, major disturbances, pandemics, bomb threats, taking of hostages, chemical spills, flooding, or terrorism threats or acts. The plan is readily available to staff , youth, and visitors.

5.18 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 center shall conduct and document quarterly mock escape drills.*	

The center has a policy and procedures addressing escape and escapes drills. The center has an escape prevention plan which includes all required elements. Drills were completed quarterly

on each shift as required. The drills were documented in the master control logbook. A review of seven staff training records confirm each received escape prevention training annually. 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 the signs of escape, and what to do in the event of an attempted escape or if an escape occurs, and conduct monthly escape drills.

5.19 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 procedure 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 facility's evacuation plans were located throughout the center indicating primary and secondary evacuation routes. Seven interviewed staff revealed each staff indicated fire drills takes place monthly. Four of six interviewed youth revealed they were instructed on what to do in case of a fire. Each of the fire extinguishers in the center were found to be current. None of the fire extinguisher in the center's vehicles were current; one was last inspected in 2015, six were inspected in 2016, and one was inspected in 2018. All of the fire extinguishers received an inspection during the week of the annual compliance review.