STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

PROGRAM REPORT FOR

Manatee Regional Juvenile Detention Center Re-Review

Departmnet of Juvenile Justice

State-Operated
1803 5th Street West
Bradenton, Florida 34205

Review Date(s): May 7-8, 2019

PROMOTING CONTINUOUS IMPROVEMENT AND ACCOUNTABILITY
IN JUVENILE JUSTICE PROGRAMS AND SERVICES

Rating Definitions

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

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

Review Team

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

Brenda Comadore, Office of Program Accountability, Lead Reviewer (Standard 5)
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BUREAU OF MONITORING AND QUALITY IMPROVEMENT
RE-REVIEW ADDENDUM

Program Name: Manatee Regional Juvenile Detention Center
Provider Name: State operated
Location: Manatee County / Circuit 12
Review Date(s): May 7-8, 2019

MQI Program Code: 298
Contract Number: N/A
Number of Beds: 60
Lead Reviewer Code: 172

Standard 5: Safety and Security
Detention Rating Profile

Indicator Ratings

		Original Review 09/28/18	Re-Review 05/08/19
Standard 5 - Safety and Security			
5.01	* Active Supervision of Youth	Satisfactory	Satisfactory
5.02	* Ten-Minute Checks	Failed	Limited
5.03	Census Counts and Tracking	Satisfactory	Satisfactory
5.04	Logbook Maintenance	Limited	Limited
5.05	Logbook Reviews	Failed	Satisfactory
5.06	Key Control	Failed	Satisfactory
5.07	Vehicles and Maintenance	Limited	Limited
5.08	Tool Inventory and Management	Satisfactory	Satisfactory
5.09	Kitchen Tools	Satisfactory	Limited
5.10	* Youth Access & Use of Tools, Cleaning Items	Satisfactory	Satisfactory
5.11	Inventory of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory	Satisfactory
5.12	* Access to all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory	Satisfactory
5.13	Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory	Satisfactory
5.14	Confinement Under Twenty-Four Hours	Failed	Limited
5.15	Confinement Over Twenty-Four Hours	Failed	Limited
5.16	Continuity of Operations Planning (COOP) Drills	Satisfactory	Satisfactory
5.17	Escape Drills	Failed	Satisfactory
5.18	Fire Drills	Limited	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).

Summary

Manatee Regional Juvenile Detention Center is a sixty-bed hardware-secure facility equipped to supervise detained youth in a safe, secure, and humane environment. The center is comprised of one building which houses administration, medical clinic, an intake/controlled observation area, a kitchen, dining room, classrooms, and the four living modules. The center has three living modules for male youth, B1, B2, and B3; and one living module for female youth, G1. One of the male living modules, B2, was closed at the time of the annual compliance review due to painting improvements which have been completed. They were preparing to move another male living module into this area soon, so they could begin making improvements to another module. There is a secure sally port area with entry into the intake area. The area for tool storage and the majority of chemicals maintenance area is inside a locked fenced-in area in back of the detention center.

The superintendent, assistant superintendents, and juvenile justice detention officers are responsible for ensuring the youth detained in the center are in a safe and secure environment. All staff are responsible for youth safety and the security of the center and provide twenty-four-hour active supervision of all youth directly and/or by digital video recorder (DVR) surveillance cameras. The center uses an electronic wand system to conduct checks on all youth during sleeping hours. The center has a maintenance mechanic who is responsible for ensuring all flammable, toxic, and poisonous items are inaccessible to youth, and all potentially dangerous tools used at the center are always secure.

Standard 5: Safety and Security

5.01 Active Supervision of Youth (Critical)

The center originally received a **Satisfactory Compliance rating** for this indicator during the FY 18/19 annual compliance review, conducted September 25-28, 2018. The center has written policy and procedures regarding supervision of youth. During the annual compliance review, observations confirmed staff were actively supervising youth at all times. Observations also confirmed consistent communication between staff and master control using a two-way radio to complete head counts and to receive authorization for all movement within the center. The staff were seen supervising youth on living modules, in the classrooms, during line movement, and during recreation. A review of the center's logbooks for the last six months established headcounts are conducted on a consistent basis during the beginning and ending of each shift and randomly through each shift. The logbooks are the centers main tool to keep track of how many youths are in the center. This includes documentation of all trips for youth out of the center (for court, doctors, etc.), in addition to all admissions and releases. Interviews were conducted with seven staff during the annual compliance review. All seven staff indicated youth counts are done at the beginning of the shift, and six of the seven confirmed these are also done at the end of each shift. Four of the respondents indicated counts are also done before and after school, and one stated they are done after meals. All seven of the interviewed staff were able to explain the basic procedure which would be followed if a count is not correct. All indicated all movement would stop, and an immediate recount would be conducted. A few of the respondents also indicated they would conduct another count if still not correct. If they could not rectify the count after the second attempt, the center would then call a code green (for escape) and then search the entire facility for the youth in question. All seven interviewed staff indicated there have not been enough staff here to provide for the safety and security of the youth and staff during recent months. The responses reflected they have had an increased population from other centers, too many holdovers, and a great deal of turnover. Three of the staff commented they feel like their personal safety is at risk on the living modules at times, with one staff indicating they feel they are being placed into "dangerous situations" due to staff shortages.

During the annual compliance re-review the center received a **Satisfactory Compliance rating** for this indicator. Observations of staff supervision of youth, during breaks in the common areas, line movements from modules, to halls, and to the cafeteria on day two were completed and found staff provided appropriate supervision of youth throughout the daily activities. A review of the master control logbook and staff interviews confirm resident counts are conducted throughout the day as required. The superintendent stated the center uses the daily statistical report, which tracks items such as population census, court dates, and juvenile probation officer (JPO) appointments as a method of tracking daily census. Interviews with seven staff confirm random head counts are conducted regularly and are verified with master control.

5.02 Ten Minute Checks (Critical)

The center originally received a **Failed Compliance rating** for this indicator during the FY 18/19 annual compliance review, conducted September 25-28, 2018. The center has a written policy and procedures regarding room checks when they are placed in their rooms for sleeping or other reasons. The center has cameras on each of the four currently used youth living modules,

and in other center common areas recording on a digital video recorder (DVR) system for thirty days. The ten-minute checks conducted from 8:00 p.m. until 7:00 a.m. are conducted using an electronic wand system. Staff utilize the electronic wands by tapping them on the check point sensors on the outside of each youth's room. The data from the wand is downloaded every few days to ensure no data is lost. The center utilizes visual observation reports (VOR) to document all checks completed on youth who are in their rooms, or are in confinement, during waking hours.
A youth in the center died by suicide on June 10, 2018. Due to this event, it was the unwritten expectation of the Assistant Secretary of Detention Services for staff to be completing checks on youth every five minutes. This information was confirmed through an interview with the superintendent. A review was conducted for the ten-minute checks using wand print-outs from the previous six-month period and a review of recordings from the previous thirty days. The review of wand check documentation and video review for four separate nights found the staff on G1, which is the girls living module, were completing their checks on youth every five minutes, as required by the current expectation. The staff on the other living modules for males were not completing these checks every five minutes, however, they were conducting them at least every ten-minutes during the majority of the reviewed checks. The following missed checks were found during a review of Wand Activity Reports and DVR recordings. Video review from September 7, 2018 on living module B1, from 10:57 p.m. until well beyond 12:00 a.m. found only one check was completed by a staff member relieving the assigned staff for a break. The staff assigned to the living module was observed to be watching television, with a youth on precautionary observation sleeping on a couch behind them, while no room checks were completed. A review of wand check documentation from August 13, 2018 on living module B3 found no checks were completed from 12:46 a.m. - 1:26 a.m. A review of wand check documentation from September 1, 2018 on living module B3 found no checks were completed from 3:10 a.m. - 3:30 a.m. A review of wand check documentation, and video review, from September 2, 2018 on living module B1 found no checks were completed from 1:03 a.m. - 2:59 a.m. The video review during this time period found the staff was completing a youth intake on the living module. Once this was complete, the staff was observed watching television on the living module. A review of wand check documentation from September 8, 2018 on B1 found no checks were completed from 2:00 a.m. - 5:46 p.m. The superintendent viewed this lapse in checks, and reported it was the same staff who was watching television during the September 7, 2018 review of living module B1 noted earlier. Another review of wand check documentation from September 19, 2018 on living module B1 found no room checks were completed from 1:54 a.m. - 2:10 a.m.

An interview with the field training coordinator (FTC) indicated they sent emails to the superintendent and both assistant superintendents each time they downloaded wand documentation into their computer system. An interview with the superintendent reflected he would conduct video review whenever emails were received from the FTC. The center was unable to provide any documentation to reflect fidelity checks were being done during this review period. These reviews are required to be completed every forty-eight hours at a minimum.

Random checks were also completed on VORs for all units on randomly selected days. This review found staff were completing checks on the youth within the ten-minute time frame. These VOR forms also reflected these checks were being done very close to the five-minute expectation currently in place. This was also confirmed through video review and by reviewer observation during the annual compliance review. Seven staff were interviewed to determine their understanding of how often youth need to be checked while they are in their rooms for sleep or other non-punishment reasons. Each of the staff indicated checks should be completed

every five minutes according to the policy change since the incident on June 10, 2018. One staff indicated this expectation is almost impossible, another stated they hate the frequency because it is causing problems for their feet, and another felt it has gone on too long.

During the annual compliance re-review the center received a **Limited Compliance rating** for this indicator. The center has facility operating procedures in place addressing the safety and security of the youth and the digital video recording of incidents. The center's policy indicates youth on standard supervision requires visual observations of the youth's condition while in their rooms at intervals not to exceed ten minutes.

The center has fifty-eight cameras and all cameras are operational and recording twenty-four hours a day. The camera's digital recorder stores thirty days of camera footage. An interview with the assistant superintendent indicated they conduct verification of the video portion of the ten minute accountability checks two or three times a week. The center also uses the wand system to document the ten minute accountability checks. The center maintains all wand check sheets on their computer shared drive and the checks are reviewed by the training coordinator when they are uploaded to the shared drive, and the checks are then forwarded to the superintendent for review. During the annual compliance re-review the following dates were reviewed, April 15th, 2019, April 25, 2019, May 1, 2019 and May 6, 2019, for compliance with the center's policy of ten minute checks on the youth while in their rooms. All three youth modules currently housing youth were able to be reviewed for the dates listed above. The video review confirmed room checks on April 15, 2019 and May 1, 2019 were conducted every ten minutes on the all three youth modules (B2, B3 and G1) for the reviewed time frames. The video on April 25, 2019 confirmed B2 and B3 room checks were conducted every ten minutes; however, G1 video revealed a check was conducted at 4:28 a.m. and another check was not conducted until 5:09 a.m., which indicates a forty-minute gap between checks. The video on May 6, 2019 revealed there was a two minute gap between checks on B3, with a check being conducted at 12:36 a.m. and the next check was conducted at 12:48 a.m. The video also revealed on B2 dormitory there was a check conducted late by five minutes, with the checks being conducted at 12:00 a.m. to 12:15 a.m., and then again, a twenty-minute gap from 12:38 a.m. – 12:58 a.m. The video also revealed a late check of four minutes on dormitory G1 and the time of those checks were 12:30 a.m. to 12:44 a.m.

Seven staff were interviewed about how often staff conducted visual checks on youth when they are in their rooms and six of the staff indicated ten minutes. One staff further indicated if a youth is on precautionary observation, checks are conducted every five minutes. The seventh staff indicated they did not know how often checks are conducted on youth when they are in their rooms; it should be noted the seventh interviewed staff member was the center's administrative assistant.

5.03 Census, Counts, and Tracking

The center originally received a **Satisfactory Compliance rating** for this indicator during the FY 18/19 annual compliance review, conducted September 25-28, 2018. The center has a written policy and procedures regarding census counts and tracking of youth. The center keeps track of their census by conducting formal head counts at the beginning and end of each shift, in addition to at least one other time during each shift. During the annual compliance review, a team member observed population counts conducted at various times of the day. Observations

also validated staff requesting authorization to master control prior to movement from one location to another. There was documentation in the master control logbook to reflect counts at the beginning and end of each shift, and randomly throughout each shift. Informal interviews with three staff during the review found they were aware of how many youths were with them when questioned. The seven interviewed staff indicated counts are completed at least every hour. If there is a discrepancy, they indicated all movement will stop, and an emergency count will be conducted. All seven of the interviewed staff were able to explain the basic procedure which would be followed if a count is not correct. All indicated all movement would stop, and an immediate recount would be conducted. A few of the respondents also indicated they would conduct another count if still not correct. If they could not rectify the count after the second attempt, the center would then call a code green (for escape) and then search the entire facility for the youth in question. The same seven staff were questioned about when emergency counts would be conducted in the center. Seven indicated this would be done if a youth is missing, six respondents indicated one would be done if visibility was hindered, and six indicated they would do one after a major disturbance. Additional responses were provided by two of the staff. One indicated an emergency count would be done after a camera disruption or if there is a possible miscount.

During the annual compliance re-review the center received a **Satisfactory Compliance rating** for this indicator. The center has a written policy and procedures to address census counts and tracking of youth. The center has a practice of conducting status checks at the start, end and throughout the shifts. All transports, youth movements, headcounts, and emergency counts are documented in the center's logbooks to monitor youth census. Additionally, all census changes are updated periodically in the Department's Juvenile Justice Information System (JJIS). A review of the logbooks from the past six months of master control and all three living unit modules confirmed upon any change in the center's population, routine group movements and living module counts were documented in a respective logbook. During the annual compliance re-review, team members observed population counts conducted at various times on each day; in addition, to when a code was called. Seven staff were interviewed regarding procedure for conducting counts; four staff indicated when youth are believed to be missing and when visibility is hindered; three staff indicated after a major disturbance; five staff stated when any code is called; and one staff noted when drills are conducted.

5.04 Logbook Maintenance

The center originally received a **Limited Compliance rating** for this indicator during the FY 18/19 annual compliance review, conducted September 25-28, 2018. The center has a master control logbook. This book is maintained by a master control worker, if they have one for the day. A review was conducted on the logbooks from the past six months. The logbooks contained a chronological record of events, incidents, and activities occurring in the center. Each logbook was bound with numbered pages and contained entries regarding admissions and releases, emergencies, incidents, head counts, transports, youth movement, documentation of law enforcement presence, and precautionary observation documentation to include placement information with subsequent step-downs, to include when the placement was initiated and ended. Each logbook entry consistently included the date and time of the event, names of staff and youth involved, a very brief description of the event with the initials of the person making the entry, and the date and time of the entry. There were very few entries found obliterated or removed. All applicable incidents for calls placed to the Central Communications Center and/or the Florida Abuse Hotline were found documented in the logbook. The logbook

was found to indicate head counts were conducted, and accurate information was recorded to reflect how many youths were in the physical presence of staff during the count. The center also documented all youth movement within the master control logbook. The center also gathers all pertinent information on a shift report which is maintained with the Facility Management System (FMS) within the Department's Juvenile Justice Information System (JJIS). The review of living module logbooks found all pertinent information regarding occurrences for each module being documented consistently. The center was not consistently documenting the required drill information and confinement documentation, which should include the time confinement was initiated for each youth as well as the time ended for each youth. Drill review found ten escape drills were conducted during the previous six-month period, and nine of these were not documented in the master control logbooks. Ten fire drills were also conducted during the previous six-month review period, and six of the ten were not documented in the master control logbook. Twenty-five confinement youth reports were reviewed from the past six months. Four were not documented as having been placed into confinement in the master control logbook, and eleven of the youth had no entry in the master control logbook indicating when they were released from the placement.

During the annual compliance re-review the center received a **Limited Compliance rating** for this indicator. The center has a written policy and procedures regarding logbook maintenance. The center maintains several hard covered bound and numbered page logbooks in multiple locations. A logbook is located in each of the three living modules, one at master control, one for visitors and one for maintenance/contracted staff both located in master control. The center requirement is for all activities, incidents and events be chronologically documented to include the time of the event (a.m./p.m.) with a brief description , and initialed by the staff making the entry in a corresponding logbook. During the annual compliance re-review observations confirmed separation of all seven logbooks and located in designated areas. The master control logbook primary entries capture population counts, transports, youth admission and releases, called in Department's Central Communications Center (CCC) reports, mock drills, incidents, law enforcement presence, and all other pertinent information. A review of the center's logbooks since the Outcome Based Corrective Action Plan completion in February 2019, across eight dates from February 2019 to May 2019, was completed. Two out of the seven logbooks were detached from the logbook cover. All reviewed logbook entries included the time of entry; however, a.m. and p.m. was not consistently noted on the time within the logbooks as required by the center's policy. Two events recorded with use of military time. One recorded event timeframe did not align and correspond with the timeframe entries prior and after the noted event leading into the next page. One event timeframe was incorrectly documented; one event date was incorrectly documented; one page at the top had a date documented incorrectly and three pages did not include the date at the top of the page. Documentation review confirmed entries impacting the safety and security of the center including special needs and mental health alerts were highlighted. All escape, fire and Continuity of Operations Plan (COOP) drills were documented from February 2019 to April 2019. All entries were documented in black or blue ink and included staff initials. Review of logbooks noted errors were infrequent; however, two out of four errors were not initialed by the individual voiding the crossed-out error.

5.05 Logbook Reviews

The center originally received a **Failed Compliance rating** for this indicator during the FY 18/19 annual compliance review, conducted September 25-28, 2018. The center has a policy and procedures in place regarding logbook reviews. The center's policy requires the superintendent or designee to review the master control logbook and all living module logbooks at least once a week and document their review of the logbook. The living unit logbooks had documentation reflecting consistent reviews being conducted by the superintendent or their designee. Three master control logbooks were selected for review to determine how frequently these weekly superintendent reviews were occurring for the master control logbook. The review of the logbook for the majority of June found a superintendent or designee had only conducted one review on June 26, 2018. The review of the master control logbook documentation for the eight weeks prior to the annual compliance found a review was conducted only once by the superintendent or designee during this time period. This was during the week of September 2-8, 2018. A review of nine master control and living unit logbooks was conducted. This reflected staff signed to reflect a review of the living unit logbook when reporting for duty, in addition to reviewing the logbook entries for the previous seventy-two hours. Additionally, the review found shift supervisors reviewing and signing the master control logbook when they accept responsibility for the center. A review of living unit logbooks confirmed they were visiting each unit during their shift and entering a review of each living module logbook during their shift.

During the annual compliance re-review the center received a **Satisfactory Compliance rating** for this indicator. The center has a written policy and procedures in place addressing logbook reviews by the superintendent or designee. A review of the center's logbooks since the Outcome Based Corrective Action Plan completion in January 2019, across nine dates from February 2019 to May 2019, was completed. Findings revealed throughout the five logbooks reviewed, supervisors are conducting their reviews at the beginning and ending of each shift, as required. Additionally, the superintendent and/or designee conducts a review at least weekly and documents the findings of their review.

5.06 Key Control

The center originally received a **Failed Compliance rating** for this indicator during the FY 18/19 annual compliance review, conducted September 25-28, 2018. The center has a policy and procedures regarding key control. All of the center's active keys are housed in locked cabinets located in master control. Observations found the master control has three separate locked cabinets to house staff keys. The center has one box for restricted keys, which are provided to teachers, mental health staff, medical staff, and kitchen staff. This box uses the "keeper" system, which requires staff to provide their key ring for personal keys which is inserted into the cabinet to release their set of keys for the center. At the time of the annual compliance review, this cabinet had at least two broken mechanisms for sets of keys within the cabinet. The second key box is for the personal keys turned in by direct care staff. The third locking cabinet holds the sets of keys for the juvenile justice detention officer supervisors (JJDOS) and juvenile justice detention officers (JJDO). There is also an area which is used to store all keys from visitors to the center. The master control area is secure and was observed locked at all times during the annual compliance review. Observations also found the emergency key ring for the center is stored in a small red locked box with a window in the vestibule leading to the secure area of the center. An interview was conducted with one staff who was in charge of the master control area

during the annual compliance review. The staff indicated they conduct a visual inspection of the keys in the cabinet and compare this with the current key assignment log when their shift commences. All keys are accounted for at the beginning and end of each shift. The practice is for staff to turn in their personal keys when they enter the building to master control, or for them to lock them in their personal lockers in the staff break room. If they turn their personal keys in to master control, these are placed into the personal key locker for staff. Observations during the annual compliance review found staff are provided their assignments at the shift briefing. They then go to master control to receive their assigned keys. This distribution is documented by the master control operator in the center's key logbook. The center provided a "Master Key Log" for review. This was last updated on August 16, 2018. The review of this document found seven reviewed key rings had a total of nine keys documented as unknown on the log. Each key is required to have a numbered tag or metal chit on the ring indicating the number of the key ring, as well as how many keys are on the ring. Eleven key rings were checked against the provided master key log. Two of the reviewed key rings had broken keys. They were both removed from circulation, and a work order had been submitted for each. Eight of the rings did not match the master key log; however, the number of keys matched the number marked on the stamped chit. The master key log indicated six of these rings should have had at least one more key on each ring, and two of the rings should have had two more keys on each ring. Even though the number of keys found on the key ring did not match the number stamped on the metal chit, the number of keys did match what was documented in the key inventory log. Two restricted key rings were also checked to see if they matched the inventory. One of the key rings matched while the other did not. A kitchen key ring (Kit #1) was observed to have a chit indicating there should be fifteen keys on the ring, but a count showed sixteen keys on the ring. The master key log reflected this ring should have had twenty keys on it. Further review of the master key log found there were four keys which were identified multiple times on the list. A review of the van keys found only the van identification number designated on the log. The review of these key rings found each ring also had an additional key for the anti-theft club which is kept in each of the vans. An informal interview was conducted with one of the assistant superintendents and this individual presented a key ring which was not found on the master key log. This ring had four keys on it, and there was no identification tag/chit on the ring to identify it or to indicate how many keys should be present. When this was discussed further at the daily debriefing, it was revealed his full set of permanent keys which were issued to him are typically kept in his desk, unless specific keys are needed. Informal staff interviews were conducted with three staff. Each of these staff did not have their personal keys with them. Two had turned them into master control, and the other had their personal keys in the non-secure area. The key log book kept in master control was also reviewed for compliance with the tracking of key use. All keys are issued by the master control operator. This logbook documented the date and time of issue, the name of the staff who received the key ring, and the time the key rings were returned. A review of twelve randomly selected days of key control logbook entries indicated there were 420 times keys were issued. This review found 168 of the entries were missing one or more of the following items: date, staff name, time out, key number, time in, initials in, and initials out. The center keeps their backup keys in a locked cabinet within one of the assistant superintendent offices. They have a key control log which indicates what each key in the box will do, and which hook it is kept on in the box. The center was unable to provide a master key inventory which indicates what each key on each ring will do. This is required for the center. The master key log provided for review, which was found to have multiple deficiencies as noted above, only indicates a number or code for each key on the rings. There is no master inventory in place to reflect where each key will work. Interviews with seven staff indicated the keys for medical records, youth property areas, mental health records, case management/intake records, and the kitchen are restricted. Only staff designated to work in these areas, by their position or assigned permissions, are allowed to access these areas. Their answers to interview

questions reflected an understanding of the steps which need to be followed if a key is lost or found to be missing.

During the annual compliance re-review the center received a **Satisfactory Compliance rating** for this indicator. The provider has policy and procedures in place to ensure the proper usage, storage and general security of any detention facility key is maintained in the facility and procedures to replace missing and damage keys. The review team observed the key logbook in master control and the key storage areas in master control and the conference room. The key storage in the conference room is located behind a locked door, inside a locked box with the superintendent possessing the only key. The logbook maintained a system of addressing assignment, tracking, storage, and distribution of keys. An interview with master control confirmed only staff assigned to a specific area are given keys to the same area. Master Control also confirmed they had one damaged key during the annual compliance re-review period and it was reported to the supervisor and a maintenance request form was completed immediately. Upon receipt of the maintenance request form the damaged key was replaced and the damaged key was turned in to master control, for required inventory and documented in the maintenance log. Seven staff interviews confirmed youth do not have access to any facility keys. Reviewer observations of key inventory in master control confirmed key rings matched the actual key rings in use and the proper procedures for distribution and collection of keys were being completed.

5.07 Vehicles and Maintenance

The center originally received a **Limited Compliance rating** for this indicator during the FY 18/19 annual compliance review, conducted September 25-28, 2018. The center has a policy and procedures for vehicles and maintenance. The center was able to provide annual safety inspection invoices for all ten of the center's vehicles. The center has nine vans, of which only eight are used to transport youth. Random vehicle checks during the annual compliance review found all vehicles were kept secure. Observations conducted on a transport found staff were ensuring youth were wearing seatbelts for the transport to court. Staff were also observed wearing their seatbelts when they left for the trip. Four available vans were inspected during the annual compliance review. Each of the vans were found to contain an emergency roadside kit, jumper cables, a biohazard spill bag, and the appropriate number of seat belts. The center policy requires staff to sign out a first aid kit for each trip. This keeps the contents from breaking down due to the extreme temperatures in Florida. Each of the inspected vans were also found to have a fire extinguisher which was inspected during 2018. Each van key rings also had a tool which was both a window punch and a seat belt cutter. The center's policy requires the maintenance mechanic to complete weekly and monthly inspections on each vehicle. A review of documentation found the weekly inspections were completed for the past six-months, with no exceptions. The center was not able to provide any evidence reflecting the maintenance mechanic was completing the required monthly inspection of vehicles during this review period. The center provided documentation reflecting the maintenance mechanic was completing daily vehicle inspections on a vehicle maintenance check list. The center's policy indicates daily inspections are to be done by transport staff and should indicate they have searched the vans for contraband, ensure there is enough gas, verify seatbelts are working, test the security screen, confirm vehicle folder has needed info, ensure they have a cell phone. This information is required to be documented in the van logbook. A review of van logbooks found staff were not documenting inspections in the van logbooks as required, even though observations during the review confirmed the required contraband checks were being conducted. The documentation in the van logbooks found very limited information to reflect pre-trip information is being completed and documented. The van logs were reviewed for four vans for their trips taken for August and

September 2018. The trip logs indicated ninety-three trips were taken. Only eighteen of the trips were documented in the van logbooks, and only ten log book entries reflected a pre-trip inspection check was completed. The reviewer did observe a few instances when a pre-trip inspection was documented in the master control log book rather than the van log book where required, but when this occurred, the documentation related only to one of several vans transporting youth on the date entered in the log.

During the annual compliance re-review the center received a **Limited Compliance rating** for this indicator. The center has a policy and procedures addressing transportation and vehicle maintenance. The center has eight vans used to transport youth and one car used only by staff. Two of the eight vans were off-site during the annual compliance re-review week for scheduled maintenance. All vehicles had documentation of a completed annual inspection. Each of the six on-site vans were observed by a review team member; one of which was observed leaving the center to transport youth to court. Prior to the transport staff checked the van and each youth. This check and search was called into master control and documented in the logbook. All vehicles were secured upon inspection. Each vehicle had a first aid kit which is stored in intake and placed in vehicles upon transport. Additionally, each vehicle had a fire extinguisher, working seatbelts, a window punch and seat belt cutters; with one exception. One van had an expired fire extinguisher. All vehicles were in good working condition with minor exceptions: one of the back doors did not open on a second van, the passenger door didn't open from the outside in the third van and the fourth van had graffiti written by a youth in marker.

The weekly vehicle checklists were checked for January 2019 to May 14, 2019. One checklist is to be completed each week for all vehicles. Seven of the eight vans weekly checks were not documented on the weekly vehicle checklist form. The January checklists indicates a weekly check was completed for each of the eight vehicles in accordance with the center's policy and procedure. The February, March and April checklists show one van was checked each week and the remaining seven van checklists show no checks were conducted.

Trip logs were reviewed for February 1, 2019 to April 30, 2019. A minor amount of log entries was missing items such as: a time in or out and/or a mileage in or out. Trip logs were compared to the center's pre-trip vehicle checklists and found fifteen of the fifty-five trips documented on the trip log in February did not have a corresponding pre-trip checklist in addition to twenty-four of the fifty-three trips in March and fourteen of the forty-three in April.

5.08 Tool Inventory and Management

The center originally received a **Satisfactory Compliance rating** for this indicator during the FY 18/19 annual compliance review, conducted September 25-28, 2018. The center has a policy and procedures regarding tool inventory and management. The center ensures all tools and equipment related to maintenance are properly maintained, stored, and inventoried. Inspections of tool control areas are conducted monthly, and the results of these inspections are submitted to the superintendent or designee for their review. Tools are stored in a locked room which is inside a locked fenced-in area on the back of the detention center. This area is locked when not in use, and no youth have access to any tool, nor the area. This area is off-limits to detention staff as well, with only the maintenance mechanic and center administrators having authorized access to this area. Interviews with administrative staff indicated any broken or defective tools would be removed for repair or replacement. This would be immediately reported to the superintendent with an incident report also being completed. Immediately following repairs or

replacement of a tool, they are returned to the appropriate storage area and properly secured. The center's tools were inspected during the annual compliance review and all were found to be marked with an identification code identifying the tool as Department of Juvenile Justice property. There were no tools found which were not recorded on the center's inventory.

During the annual compliance re-review the center received a **Satisfactory Compliance rating** for this indicator. The center has policy and procedures in place to ensure all tools and equipment related to maintenance are properly stored, inventoried, and maintained. A visual observation of the tool shed was conducted. Tools were stored in a locked shed, inside full-length cabinets. The tools were found to be properly identified as Department of Juvenile Justice property and in a designated place. One tool, a bolt cutter, was identified as Manatee Regional Juvenile Detention Center property and one tool was missing from the tool cabinet. According to procedure a tool disposal, replacement and repair form was completed and located in the facilities maintenance logbook for the missing tool, indicating it was damaged. The Chief of Detention Services reported completion of the form is standard practice for replacing missing or damaged tools. The center maintains a perpetual inventory of tools, reviewed and signed off monthly by the chief of Detention Services and the superintendent.

5.09 Kitchen Tools

The center originally received a **Satisfactory Compliance rating** for this indicator during the FY 18/19 annual compliance review, conducted September 25-28, 2018. The center has a policy and procedures regarding control and inventory of kitchen tools. All kitchen tools are maintained in a locked box in the back hallway of the kitchen. No youth have access to the kitchen at any time. An observation of the center's kitchen areas was conducted during the annual compliance review. A physical count was conducted to compare the actual kitchen tools with the inventory during the review, and all knives were accounted for. The tools were visible on a shadow peg board system through the window of the locked cabinet. Kitchen staff sign out a knife on a log when they need to use one. The kitchen service manager or another food service worker in their absence conducts inspections and counts of the knives at the beginning and ending of each day. An interview with kitchen staff confirmed youth were not permitted in the kitchen area, and it is the center's facility operating procedure to report any lost or damaged kitchen tools immediately to the superintendent or supervisor. They also reported having no broken or missing knives or other kitchen tools during this review period.

During the annual compliance re-review the center received a **Limited Compliance rating** for this indicator. The center has a policy for tools and sensitive items which includes procedures for the inventory and maintenance of kitchen tools. The policy indicates "an itemized inventory must be completed of all culinary equipment including kitchen knives and other hazardous sharps upon reporting for duty. All equipment shall be accounted for prior to the departure of the kitchen staff". A review of documentation reveals the kitchen staff only inventory kitchen knives each day (before and after shift). This inventory is documented on a knife check out sheet. A check of these knives was completed every day for the last six months with one exception; no check was documented on March 22, 2019. The kitchen manager provided the last utensil inventory form which was last completed in July 2018. The reviewer checked each of the kitchen tools and equipment, with the kitchen manager and assistant detention center superintendent, to complete a comparison of equipment with the master inventories and there were several items which did not match the inventory. The number of items on inventory for in-use and in storage were off in several utensils. The discrepancy was mainly due to an overage of utensils. As an example of the overage the center had three spatulas, one large spoon, one large metal solid ladle, one vegetable peeler, one pair of tongs, two slotted spoons with holes

and three meat thermometers. Additionally, at least two utensils on the center's utensil inventory sheet indicate there are none of those utensils in use or in storage; however, this is not the case. The center indicates several of the items were left at the center after their most recent barbeque. The policy indicates kitchen knives and other hazardous kitchen sharps shall be stored in a locked cabinet, drawer or toolbox which contains the inventory; however, the review team would consider meat thermometer's a hazardous kitchen sharp and should be marked with an identifying number, secured in a locked box/area when not in use, and inventoried daily. During a facility tour, one of the thermometers was kept in a basket near the food line and could be accessible to youth. The staff immediately moved this item to a more secure location. According to the kitchen manager, there have been zero reports of broken or missing tools since the last annual compliance review. Additionally, the center kitchen staff indicates staff are required to complete a kitchen sharps inventory form monthly; however, only an inventory for May 2019 was provided to the review team. The form only has a list of items pre-typed on the form and staff handwrites the date at the top of the form. There is no signature of person taking inventory or an indication of what their findings are upon the inventory. The policy indicates youth never have access to the kitchen or kitchen tools and interviews with seven staff and seven youth validate this practice.

5.10 Youth Access and Use of Tools, Cleaning Items (Critical)

The center originally received a **Satisfactory Compliance rating** for this indicator during the FY 18/19 annual compliance review, conducted September 25-28, 2018. The center has a policy and procedures regarding youth access to and use of tools and cleaning Items. The policy prohibits youth from handling or having access to any hazardous materials. Interviews with food service and administrative staff confirmed youth do not have access to the areas where tools or toxic items are stored. Youth are only permitted to use mops/brooms and scrub brushes. Observations of cleanup during the annual compliance review found youth cleaning under direct staff supervision. Staff was observed dispensing the cleaning solutions for youth and kept control of cleaning agents at all times. All seven interviewed staff indicated youth are allowed to use mops and brooms, while four of the seven of the respondents indicated the youth can also use scrub brushes. All seven staff indicated they will spray chemicals and then the youth will clean and will wipe areas down. Five of the seven interviewed youth indicated they have assisted in cleaning while in the center. Each indicated they can use mops and brooms to help clean. All five also indicated staff spray the chemical, and the youth clean the area and wipe it off. The other two youth have not assisted in cleaning while in the center.

During the annual compliance re-review the center received a **Satisfactory Compliance rating** for this indicator.
The center has policy and procedures in place to prevent youth access and usage to any tools, including kitchen and medical equipment. Seven staff and seven youth interviews confirmed youth are only allowed to use common cleaning items such as mops, brooms and other household items under the supervision of direct care staff.

5.11 Inventory of all Flammable, Toxic, Caustic, and Poisonous Items

The center originally received a **Satisfactory Compliance rating** for this indicator during the FY 18/19 annual compliance review, conducted September 25-28, 2018. The center has a written policy and procedures to address the inventory of flammable, toxic, caustic, and poisonous items. A review of the inventory of flammable, toxic, caustic, and poisonous items was found to be accurate. Cleaning chemicals are stored in a locked cabinet inside a locked fenced-in area

behind the detention center in a locked shed. The flammable items are kept in three easily identifiable yellow flammable item cabinets. Safety Data Sheets (SDS) for all flammable, toxic, caustic, and poisonous items were as maintained in a large binder. The SDS binders are maintained near the chemicals, and are accessible, if needed, for reference. Chemical inventory and storage is maintained by maintenance staff, and access to this shed is limited according to the center administration staff and the maintenance mechanic. The chemical storage shed was organized and free from clutter. These areas are inaccessible to youth.

During the annual compliance re-review the center received a **Satisfactory Compliance rating** for this indicator. The center has a policy and procedures to address the use, storage, disposal and inventory of chemicals; including poisonous, flammable and toxic materials. The kitchen maintains an inventory of five chemicals frequently used. These chemicals are kept in a storage room outside of the building behind the kitchen. A binder of SDS are located in all areas of the kitchen and in the storage room, where chemicals are kept. The remainder of chemicals were secured outside in a separate caged in area. Chemicals were stored in several metal cabinets within the caged area. These cabinets were marked as containing flammable/hazardous materials and all cabinets were secured upon inventory and observation of the annual compliance review team. Monthly inventory sheets for chemicals in both areas were reviewed and all chemicals were accounted for. Upon observations of the maintenance tool shed, review team members noticed several gallons of paint, paint thinner and paint primer being stored. The center could not provide an inventory of these items and no SDS sheets were observed in the area where these items are stored; however, the center's response was the paint, paint thinner and primer, discovered in the tool storage shed, were items belonging to the regional maintenance team. Parts of the facility had been primed (main hallway) and one module was completely painted, as part of a project being led by the regional maintenance team. For reasons beyond the center's control, the regional maintenance team needed to be pulled from the painting project at this center but kept their supplies in the shed for when they return. The facility does not keep an inventory of materials which are not specifically purchased by the center or do not belong to them. These items were clearly stored in an area separate from where the facility's chemicals and caustics are being stored. During a tour of the center, an open container of charcoal lighter fluid was seen sitting on a chair outside the back door of the kitchen. The center staff indicated it did not belong to the center and was recently brought in by staff for a barbeque the center had. When the reviewer observed the kitchen's storage area on day two the lighter fluid was still on-site.

5.12 Access to all Flammable, Toxic, Caustic, and Poisonous Items

The center originally received a **Satisfactory Compliance rating** for this indicator during the FY 18/19 annual compliance review, conducted September 25-28, 2018. The center has a policy and procedures regarding access to any flammable, toxic, caustic, and poisonous items. The policy prohibits youth from handling or having access to any flammable, toxic, caustic, and poisonous items. All flammable, toxic, caustic, and poisonous items are stored in locked cabinets inside a locked fenced-in area behind the detention center and in a locked shed. Key access to the shed and storage cabinets is restricted to maintenance and administrative staff only. The maintenance shed, fenced-in area, and storage cabinets were observed locked at all times during the annual compliance review. Five of the seven surveyed youth indicated they have assisted in cleaning while in the center. These youths stated the staff will spray the chemical, and the youth will clean the area and wipe it off. The other two interviewed youth indicated they have not assisted in cleaning while in the center.

During the annual compliance re-review the center received a **Satisfactory Compliance rating** for this indicator. The center has policy and procedures in place prohibiting youth from using, handling or cleaning up of dangerous or hazardous chemicals or responding to chemical spills. Youth are not permitted to handle, dispose or clean bio-hazardous waste. All flammable, toxic, caustic, and poisonous items are stored in locked cabinets inside a locked fenced-in area behind the detention center and in a locked shed. Key access to the shed and storage cabinets is restricted to maintenance and administrative staff only. The maintenance shed, fenced-in area, and storage cabinets were observed locked at all times during the annual compliance review and all youth are prohibited access. Seven staff and seven youth interviews confirmed youth are not allowed access to toxic or poisonous chemicals.

5.13 Disposal of all Flammable, Toxic, Caustic, and Poisonous Items

The center originally received a **Satisfactory Compliance rating** for this indicator during the FY 18/19 annual compliance review, conducted September 25-28, 2018. The center has a policy and procedures regarding the disposal of all flammable, toxic, caustic, and poisonous items. An interview with the maintenance staff confirmed their knowledge of the procedure for disposal of all flammable, toxic, caustic, and poisonous items. They indicated most chemicals are completely used up, and do not require disposal. The maintenance staff reported no chemicals required disposal during this reporting period. The center has a contract with EnviroLight and Disposal, Inc. to dispose of all flammable, toxic, caustic, and poisonous items, when applicable. The center does gather grease which is accumulated from the dishes and trays washed in the center. This is picked up on a quarterly basis. This was confirmed through a review of contractor receipts from this reporting period.

During the annual compliance re-review the center received a **Satisfactory Compliance rating** for this indicator. The center has a policy and procedures which indicates the maintenance mechanic or other trained staff who have the proper safety equipment in accordance with Occupational Safety and Health Administration (OSHA) standards will be responsible for the disposal of chemicals. The center's procedures indicate disposal of all hazardous waste shall be by one of the following methods: compaction, evaporation, flushed, or incineration

Hazardous liquid waste shall be disposed of in accordance with the manufacturers' safety data sheet. Observations confirmed biohazard spill kits are strategically placed throughout the facility and the red biohazard red bags are placed in each first aid kit. The center's superintendent reports they have not had a chemical spill nor has there been a need to dispose of chemicals since the last annual compliance review.

5.14 Confinement Under Twenty-Four Hours

The center originally received a **Failed Compliance rating** for this indicator during the FY 18/19 annual compliance review, conducted September 25-28, 2018. The center has a policy and procedures regarding confinements of youth under twenty-four hours. The center had 201 confinements during the previous six months, and seventeen were selected to review for compliance with this indicator. The review of confinements confirmed staff are consistently

documenting an incident report in the Facility Management System (FMS) within the one-hour timeframe after an incident. The center has three confinement cells in the isolation hallway. They also use cells in the living modules if they need more. The reviewed documentation reflected female youth are placed in their own cell when placed in disciplinary confinement. All seventeen reviewed confinement reports reflected the staff searched the room prior to placing the youth, as required. Eight of the sixteen applicable confinement reports had no documentation to show a juvenile justice detention officer supervisor (JJDOS) completed a review for fairness and appropriateness within the two-hour requirement. Seven of these had an entry by a JJDOS; however, these did not address the fairness or appropriateness of the placement itself. Seven of the sixteen applicable reviewed reports had at least one of the required three-hour checks by a juvenile justice detention officer supervisor (JJDOS) conducted outside the three-hour requirement. The center's facility operating procedures (FOP) requires these checks include a reason for continued confinement. Factors for justification include severity of rule violation, past disciplinary history, and behavior while in confinement. These must be clearly documented in the confinement report. The review found appropriate justification was not documented in at least one three-hour review for three of the fourteen applicable youth. These reviews indicated the youth was either sitting calmly or was just resting during waking hours. All seven interviewed staff indicated they complete a report and complete ten-minute checks when youth are placed in confinement. Only five of the respondents indicated they would search the room prior to placing the youth in confinement. One of the other staff indicated they will search the confinement room once the youth is released from confinement or relocated to their own room for confinement, since they are sometimes confined in their own rooms. The other respondent related they do not search youth rooms prior to confinement because room searches are done daily, and the room should have already been checked for the day.

Logbook review on the morning of September 27, 2018 found two youth were being held in the isolation hallway. Observations by the review team confirmed the youth were being held in these confinement rooms. A review of confinement reports found both youth were released from confinement the previous afternoon on September 26, 2018. However, there were no new confinement reports documenting why the youth were in confinement on September 27, 2018. Video review confirmed the two youth were in confinement from at least 9:00 a.m. on September 27, 2018 until the evening. Provided visual observation report (VOR) logs found each of the youth were let out during the day for meals or to help clean; however, both were placed back in their cell after the activity was complete. The center staff could not provide any documentation to support why the youth were placed back into the cells. The superintendent indicated one of these youths had shown aggression towards others and does not want to be in population, but this was not documented anywhere. The center also indicated they felt the supervisor from the morning just forgot to enter the two youth into FMS before they had to leave for a family emergency. No explanation could be provided as to why the supervisor who took over did not enter a report when they tried to enter their three-hour checks into the system. FMS was reviewed on October 4, 2018, and this confinement incident was still not reflected in FMS for either youth. Video review and VOR documentation did confirm staff were checking these youth every five minutes while in this placement.

During the annual compliance re-review the center received a **Limited Compliance rating** for this indicator. The center has facility operating procedures (FOP) in place addressing the confinement of youth. The FOP indicates prior to placing a youth in confinement the room shall be checked for potential hazards. The FOP further indicates all confinements shall be approved by a supervisor, the initial confinement will be reviewed by the supervisor for fairness and appropriateness within two hours of the confinement; then the supervisor shall review the

confinement every three hours and document the reason for continued confinement. The FOP also indicated if a youth is to remain in confinement over eight hours the superintendent or designee shall be notified of the reason the youth was maintained in confinement. A review of seven youth confinement reports under twenty-four hours were reviewed for compliance. All seven reports contained documentation the confinement room was searched prior to the placement of the youth into the room. All confinement reports were completed by the juvenile justice detention officer (JJDO) within one hour of the confinement and submitted to the juvenile justice detention officer supervisor (JJDOS) for review. All reports contained a JJDOS review of the confinement for fairness and appropriateness within two hours of the confinement. All reports contained JJDOS reviews every three hours, with one exception. One JJDOS check on one of the confinements was documented one minute late. Six of the seven reports contained information about the youth's behaviors or reason for continued confinement documented in the JJDOS three-hour reviews. The seventh report contained three JJDOS reviews starting from 8:30 a.m. to 2:30 p.m. which indicated confinement continued and did not document the behaviors of the youth or a reason why the youth was maintained in confinement. All confinements were reviewed within forty-eight hours by the superintendent or assistant superintendent. Six confinement reports indicated the youth was in confinement over eight hours and there was documentation the superintendent or designee approved three of the youth's confinements could exceed eight hours. The remaining three youth confinement reports did not contain documentation the superintendent approved the youth's stay in confinement for more than eight hours. Five of the youth were placed into confinement during school hours and notification was made to the school staff the youth was in confinement. An interview with the lead teacher confirmed the detention center staff notifies the school staff when a youth is placed in confinement. The lead teacher further advised when a youth is in confinement they are offered scholastic magazines and worksheets; however, most of the youth are not amenable to accepting the materials to work on while in confinement.

An interview with seven staff indicated five knew they had to complete a confinement report when a youth is placed into confinement. Six of the staff knew ten-minute visual checks are to be conducted on the youth when they are in confinement. Four of the interviewed staff indicated the confinement room needs to be searched prior to placing the youth in the room. Additional comments made by the seven interviewed staff about placing a youth in confinement are as follows: the youth needs to be searched; place a visual observation record on the door; notify the supervisor; counsel the youth; give the youth meals and showers; sometimes remove the youth's shoes and sweaters; inform the youth of their rights and the right to make an abuse call; and enter the confinement in the logbook. A review of the center's three confinement rooms indicated the room windows and cameras are free of obstructions and the rooms had no non-fixed items. A review of the confinement reports and visual observation reports for the youth in confinement confirmed the youth were provided meals and hygiene. The center's three confinement rooms are maintained in an isolation hallway away from the general population of the center and the youth in the confinement rooms do not have contact with the other youth in the center.

5.15 Confinement Over Twenty-Four Hours

The center originally received a **Failed Compliance rating** for this indicator during the FY 18/19 annual compliance review, conducted September 25-28, 2018. The center has a policy and procedures regarding confinements of youth over twenty-four hours. A review of the confinements for the past six months found seventy-one confinements in which youth were confined for over twenty-four hours. The average time spent in confinement for these youths

averaged a little over fifty-four hours. Seven of these confinements were selected to review for compliance with this indicator. A review of the seven confinements confirmed staff consistently documenting an incident report in the Facility Management System (FMS) within the one-hour timeframe after an incident. The center has three confinement cells in the isolation hallway. They also use cells in the living modules if they need more. The reviewed documentation reflected female youth are placed in their own cell when placed in disciplinary confinement. All seven reviewed confinement reports reflected the requirement of the staff searching the room prior to placing the youth. Five of the seven reviewed confinement reports reflected completion of the review for fairness and appropriateness within the two-hour requirement. Two had supervisory reviews documented within two hours of the placement, but they did not address the fairness or appropriateness of the placement itself. Three of the seven reviewed reports had at least one of the required three-hour checks by a juvenile justice detention officer supervisor (JJDOS) conducted outside the three-hour requirement. One of these youths had five of their three-hour JJDOS checks done outside of the timeframe, with one lapse being more than five hours. Another reviewed youth stayed in confinement for ninety hours according to the list of confinements from FMS. Their placement began on August 3, 2018. The center stated this was an error, however, they could not provide any documentation reflecting when the youth was released from confinement. His last documented JJDOS check was August 5, 2018 at 6:00 a.m. The report reflected a nursing check being completed on the youth the following morning at 10:00 a.m., even though the center indicated the youth had been released. Confinements for more than seventy-two hours require a hearing. This was not conducted for this youth. The third youth with deficiencies was missing checks on July 28, 2018 from 8:09 p.m. through 7:29 a.m., and on July 29, 2018 from 10:00 p.m. through 5:01 a.m. the next morning. The center's facility operating procedure (FOP) requires the checks to include a reason for continued confinement. Factors for justification include severity of rule violation, past disciplinary history, and behavior while in confinement. These were consistently being documented in the reviewed confinement reports. The FOP requires extensions beyond eight hours in confinement to be approved by the regional director or designee. Documentation indicating extension beyond eight-hours was only provided for two of the seven youth. The FOP also requires e-mails to be sent to the regional director to extend confinement beyond twenty-four hours, and every twenty-four hours, thereafter. The center was able to provide evidence reflecting an extension beyond twenty-four hours for the initial period for five of the seven youth. Three of the reviewed youth were maintained in confinement beyond forty-eight hours, and one beyond seventy-two hours. No extension requests were provided to show an additional request for an extension from the regional office for any of these youths. The FOP also states, "Seven of seven youth placed temporarily in confinement shall be afforded the same services as youth in the general population." This is to include participation in education and opportunities to have large muscle exercise, among other things. No documentation regarding notification to school personnel was documented in confinement reports, and there was nothing to indicate they were provided any assignments while confined. In addition to the lack of documentation regarding education in the confinement reports, the center had no process in place to follow in the event a youth is confined during school hours. Only two of the seven reports reflected youth were offered large muscle exercise during the time spent in confinement.

During the annual compliance re-review the center received a **Limited Compliance rating** for this indicator. The center has facility operating procedures (FOP) addressing confinement of the youth. The FOP has all the same steps as under twenty-four hour confinement; however, there are additional steps which must be taken to maintain a youth in confinement over twenty-four hours. If the center needs to extend the confinement over twenty-four hours they need to seek permission from the detention regional director, or designee, who in turn will notify the detention assistant secretary. The notification must be done every twenty-four hours. The policy further

indicates no confinement will exceed seventy-two hours. The policy also indicates a licensed mental health professional shall review the status of any youth in confinement every twenty-four hours. A review of seven youth confinement reports over twenty-four hours were reviewed for compliance. All the reports contained documentation the confinement rooms were searched prior to the youth's placement in the room. All reports contained documentation each confinement was approved by the superintendent or designee for placement over eight hours. Six of the seven reports contained documentation each of the confinements were approved by the regional director for placement over twenty-four hours. The center was unable to provide documentation the regional director had approved the seventh youth's confinement over twenty-four hours. Three of the seven reports contained juvenile justice detention officer supervisor reviews of the confinement for appropriateness every three hours. Two of the remaining four reports each had a missing three-hour supervisory review because the Department's Juvenile Justice Information System (JJIS) was not operational, and the supervisor could not enter their reviews into the system. One of the two remaining reports contained a supervisory review which was conducted late by fourteen minutes, and then there was a missing three hour review between 10:19 a.m. through 3:00 p.m., when the youth was released from confinement. The last report had one supervisory review done five minutes late, another review thirty minutes late and then no supervisory review documented between 10:20 a.m. through 3:00 p.m. When the supervisors conducted their three hour reviews of the reports they documented the need for continued confinement based on the youth's behaviors, discipline history or due the severity of the infraction. There was documentation in three of the seven reviewed reports a mental health professional reviewed the status of the youth every twenty-four hours. The remaining four reports did not have any indication a mental health professional reviewed the youth's status while they were in confinement and there was no mental health review documented on the report itself or on any of the youth's visual observation reports. During the debriefing process, the center advised the team the JJIS system was down during two the twenty-four hour timeframes when mental health should have documented their review of each youth on the confinement report; however, the mental health professional did not document their review of the youth's status on anything and there was no way to validate if mental health professional had conducted a status review with the two youth. None of the seven reviewed confinements exceeded three days.

5.16 Continuity of Operations Planning (COOP) Drills

The center originally received a **Satisfactory Compliance rating** for this indicator during the FY 18/19 annual compliance review, conducted September 25-28, 2018. The center has a policy and procedures regarding a Continuity of Operations Plan (COOP). Copies of the COOP are maintained in the master control area. A review of drill documentation confirmed the center conducted COOP drills in April and May of 2018. Each of these drills were focused on the center being prepared in the event of a hurricane. The reviewed drill documentation included a synopsis of what happened, reviews by supervisory staff, a completed checklist of the steps to follow in an emergency, and signatures of all participants. No corrective actions were suggested on either of the drills. Three of the seven interviewed staff indicated they had participated in a weather drill during the past six months.

During the annual compliance re-review the center received a **Satisfactory Compliance rating** for this indicator. The center has a written policy and procedures in place pertaining to a Continuity of Operations Plan (COOP). The center requires implementation of COOP drills at least twice a year, once before the start of hurricane season on June 1st. A documentation

review of the center's COOP drills revealed completion of drills in January and April 2019. Each drill included a written scenario and an attachment of staff sign in sheets for each staff participating, and a signature by all supervisory staff indicating the drill was reviewed. There were no corrective actions recommended on either of the drills. One drill did not have the signature of the instructor conducting the drill; one drill documented scenario response about the drill indicated the presence of medical staff checking youth medication and kitchen supplies; however, the sign-in sheet did not reflect attendance of any medical staff. The center facility trainer verbally notified the review team the documented response event was human error as it was the shift supervisor who checked on the medication and kitchen supplies. The center acknowledged all exceptions found. A review of the center logbook, confirmed documentation of drills as required. Seven staff were interviewed, four indicated they participated in a weather drill during the past six months; six staff reported participating in a suicide drill; and all seven staff stated they participated in fire drills during the past six months.

5.17 Escape Drills

The center originally received a **Failed Compliance rating** for this indicator during the FY 18/19 annual compliance review, conducted September 25-28, 2018. The center has a policy and procedures in place to address escape drills. A review of escape drill documentation found the center completed escape drills on each of the two shifts from April through September of 2018. Nine of the ten escape drills were not documented in the master control logbook. Six of the ten escape drill reports did not have any signature pages attached to reflect who participated in each of the drills, and six of the ten drills were not signed by the person conducting the drill and were not reviewed by a supervisor. The center's policy also requires all staff to be provided escape prevention training annually. A review of seven staff training records found five completed this training in 2017. Three of the seven interviewed staff indicated they had participated in an escape drill during the past six months.

During the annual compliance re-review the center received a **Satisfactory Compliance rating** for this indicator. The center has a written policy and procedures in place to address escape drills. The center has an escape prevention plan to ensure all staff are trained in an escape prevention and response. The plan requires staff to be attentive, practice appropriate levels of youth supervision, and remain alert for an immediate response. The center is required to conduct escape drills quarterly. A review of escape drills for the last quarter since the Outcome Based Corrective Action Plan completion in January 2019, indicates in February 2019, there was a completion of two escape drills on each of the two shifts. One escape drill did not have the signature of the instructor conducting the drill. A review of the center's logbook, confirmed both drills were documented in the master control logbook. A review of seven staff training records for the year 2018 revealed all completed a training on escape prevention. Seven staff were interviewed, in which three indicated participation in an escape drill within the past six months. The remaining four staff did not state, in the interview, participation in an escape drill.

5.18 Fire Drills

The center originally received a **Limited Compliance rating** for this indicator during the FY 18/19 annual compliance review, conducted September 25-28, 2018. The center has a policy and procedures in place to address fire drills. The policy requires the facility conduct a fire drill every month on every shift. A review of documentation from the last six months found fire drills

were completed on each of the two shifts from April 2018 through September of 2018. Documentation of the drills included the date and time conducted, the scenario of the drill, and any additional needed follow-up. The review found two drills were missing a signature page for the staff who attended the drill, and two of the drills were not reviewed by supervisory staff. A review of the center's logbooks found only four of the ten reviewed drills were documented in the master control logbooks, as required. The center's Continuity of Operations Plan (COOP) has incorporated a fire prevention and safety plan to ensure the safety of youth and staff. Documentation was provided for an annual inspection by the State Fire Marshal on May 10, 2018. No major fire safety violations were found during the inspection. Five of the seven interviewed staff indicated they had participated in a fire drill during the past six months. Five of the seven interviewed staff also indicated fire drills are conducted monthly. The other two staff stated fire drills are not conducted monthly. Seven youth were asked if they had been instructed on what to do in the case of a fire, and five indicated they had been. The other two youth did not remember receiving this instruction during their stay.

During the annual compliance re-review the center received a **Satisfactory Compliance rating** for this indicator. The center has a written policy and procedures in place to address conducting fire drills. The center's fire prevention plan is incorporated in the Continuity of Operations Plan (COOP). During the annual compliance re-review, a center tour was conducted, which observations confirmed postings of fire evacuation routes and egress plans throughout the facility. The center provided the annual inspection from the State Fire Marshal, which was completed on May 10, 2018, with no violations found. A review of the center's fire mock drill binder included all the documented unannounced drills conducted within the past six months from November 2018 to April 2019. Findings revealed there were no missed drills and twelve drills were conducted on all two shifts at least once monthly. Nine of the twelve drills documentation was completed according to procedure. However of the remaining three drill documentation; one drill sign-in sheet was dated incorrectly, one drill sign-in sheet did not have the instructor's signature, and one drill sign-in sheet did not have the instructor's signature, date or location of drill noted. A review of the center's logbooks for fire drills, during the past six months, revealed ten drills were documented. Two drills conducted in November 2018, were not documented in the master control logbook. Seven staff were interviewed and six indicated participation in a fire drill within the past six months. The remaining one staff did not indicate, during the interview, participation in a fire drill.

Program Name: Manatee Regional Juvenile Detention Center
Provider Name: State operated(DJJ)
Location: Manatee County / Circuit 12
Review Date(s): May 7-8, 2019

MQI Program Code: 298
Contract Number: N/A
Number of Beds: 60
Lead Reviewer Code: 172

Overall Rating Summary

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

Limited Ratings	Failed Ratings
5.02 * Ten-Minute Checks	
5.04 Logbook Maintenance	
5.07 Vehicles and Maintenance	
5.09 Kitchen Tools	
5.14 Confinement Under Twenty-Four Hours	
5.15 Confinement Over Twenty-Four Hours	