STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

# BUREAU OF MONITORING AND QUALITY IMPROVEMENT

## PROGRAM REPORT FOR

## St. Lucie Regional Juvenile Detention Center

***Department of Juvenile Justice***

**(State-Operated)**

**1301 Bell Avenue**

**Fort Pierce, Florida 34982**

***Review Date(s): September 11-14, 2018***

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:

Christine Calvert-Joyner, Office of Program Accountability, Lead Reviewer (Standard 3)
Teves Bush, Office of Program Accountability, Regional Monitor (Standard 5)
Paula Friedrich, Office of Program Accountability, Regional Monitor (Standard 4)
Tonya Gittens, Office of Program Accountability, Regional Monitor (Standard 1)
Jenny Hickox, DJJ Probation, Circuit 19, Senior Juvenile Probation Officer (Standard 2)
Peter Keelan, Office of Education, South Region, Education Coordinator (Standard 2)
Mamine Saintil, Palm Beach Regional Detention Center, Superintendent (Standard 2)

Program Name: St. Lucie Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: St. Lucie County / Circuit 19
Review Date(s): September 11-14, 2018

MQI Program Code: 225
Contract Number: N/A
Number of Beds: 50
Lead Reviewer Code: 163

# Methodology

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

## Persons Interviewed

- ☒ Program Director
- ☒ DJJ Monitor
- ☒ DHA or designee
- ☒ DMHCA or designee
- ____ # Case Managers
- **3** # Clinical Staff
- **1** # Food Service Personnel
- **2** # Healthcare Staff
- **1** # Maintenance Personnel
- **3** # Program Supervisors
- **1** # Other (listed by title): **Lead Teacher**

## Documents Reviewed

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

## Surveys

- **7** # Youth
- **7** # Direct Care Staff
- ____ # Other: ____

## Observations During Review

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

## Comments

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

# Standard 1: Management Accountability
# Detention Rating Profile

## Indicator Ratings

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

* The Department has identified certain key critical indicators. These indicators represent critical areas that require immediate attention if a program operates below Department standards. A program must therefore achieve at least a Satisfactory Compliance rating in each of these indicators. Failure to do so will result in a program alert form being completed and distributed to the appropriate program area (detention, residential, probation).

# Standard 2: Youth Management
# Detention Rating Profile

## Indicator Ratings

| Standard 2 - Assessment and Performance Plan | | |
|---|---|---|
| 2.01 | Admission | Satisfactory |
| 2.02 | Orientation | Satisfactory |
| 2.03 | Classification | Satisfactory |
| 2.04 | Classification of Gang Members | Satisfactory |
| 2.05 | Notification of JPO Circuit Gang Rep | Satisfactory |
| 2.06 | Admission of Youth Personal Property | Satisfactory |
| 2.07 | Storage of Youth Personal Property | Satisfactory |
| 2.08 | Release | Satisfactory |
| 2.09 | Release of Youth Personal Property | Satisfactory |
| 2.10 | Release of Meds, Aftercare Instructions | Satisfactory |
| 2.11 | Review of Youth in Secure Detention and Home Detention | Satisfactory |
| 2.12 | Daily Activity Schedule | Satisfactory |
| 2.13 | Adherence to Daily Schedule | Satisfactory |
| 2.14 | Educational Access | Satisfactory |
| 2.15 | Career Education | Satisfactory |
| 2.16 | Behavior Management System | Satisfactory |
| 2.17 | * Unauthorized Use of Punishment | Satisfactory |
| 2.18 | Grievances | Satisfactory |
| 2.19 | Trauma-Informed Care | Satisfactory |

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

## Indicator Ratings

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

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# Standard 4: Health Services
# Detention Rating Profile

## Indicator Ratings

| Standard 4 - Health Services | | |
|---|---|---|
| 4.01 | * Designated Health Authority/Designee | Satisfactory |
| 4.02 | Facility Operating Procedures | Satisfactory |
| 4.03 | Authority for Evaluation and Treatment | Satisfactory |
| 4.04 | Parental Notification | Satisfactory |
| 4.05 | Notification - Clinical Psychotropic Progress Note | Satisfactory |
| 4.06 | Immunizations | Satisfactory |
| 4.07 | Healthcare Admission Screening Form | Satisfactory |
| 4.08 | Medical Alerts | Limited |
| 4.09 | Suicide Risk Screening Instrument | Satisfactory |
| 4.10 | Youth Orientation to Healthcare Services | Satisfactory |
| 4.11 | DHA/Designee Admission Notification | Limited |
| 4.12 | Healthcare Admission Rescreening | Satisfactory |
| 4.13 | Health Related History | Satisfactory |
| 4.14 | Comprehensive Physical Assessment | Satisfactory |
| 4.15 | Female-Specific Screening/Examination | Satisfactory |
| 4.16 | Tuberculosis Screening | Satisfactory |
| 4.17 | Sexually Transmitted Infection Screening | Satisfactory |
| 4.18 | HIV Testing | Failed |
| 4.19 | Sick Call Process - Requests/Complaints | Satisfactory |
| 4.20 | Sick Call Process - Visits/Encounters | Satisfactory |
| 4.21 | Restricted Housing | Failed |
| 4.22 | Episodic/First Aid Care | Satisfactory |
| 4.23 | Emergency Care | Satisfactory |
| 4.24 | Off-Site Care/Referrals | Satisfactory |
| 4.25 | Chronic Conditions/Periodic Evaluations | Satisfactory |
| 4.26 | Medication Management - Verification | Satisfactory |
| 4.27 | Medication Management - Orders/Prescriptions | Satisfactory |
| 4.28 | Medication Management - Storage | Satisfactory |
| 4.29 | Medication and Sharps Inventory | Satisfactory |
| 4.30 | Medication Management - Controlled Medications | Satisfactory |
| 4.31 | Medication Administration Record | Satisfactory |
| 4.32 | Medication Administration By Licensed Staff | Satisfactory |
| 4.33 | Medications Provided By Non-Licensed Staff | Satisfactory |
| 4.34 | Psychotropic Medication Monitoring | Satisfactory |
| 4.35 | Infection Control - Surveillance, Screening, and Management | Satisfactory |
| 4.36 | Infection Control - Education | Satisfactory |
| 4.37 | Infection Control - Exposure Control Plan | Satisfactory |
| 4.38 | Prenatal Care - Physical Care of Pregnant Youth | Satisfactory |
| 4.39 | Prenatal Care - Nutrition and Education of Youth | Satisfactory |
| 4.40 | Prenatal Staff Education | Satisfactory |

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# Standard 5: Safety and Security
# Detention Rating Profile

## Indicator Ratings

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

* The Department has identified certain key critical indicators. These indicators represent critical areas that require immediate attention if a program operates below Department standards. A program must therefore achieve at least a Satisfactory Compliance rating in each of these indicators. Failure to do so will result in a program alert form being completed and distributed to the appropriate program area (detention, residential, probation).

## Strengths and Innovative Approaches

- Since the last annual compliance review the center has a volunteer coming in monthly to conduct arts and crafts with the female youth.

- The center has two soft rooms decorated by youth and staff to transform the center into a more trauma-informed care environment. The center has also added youth and staff art work displayed throughout the center and an awards/inspiration bulletin board maintained by the education department. The soft room near master control was repainted in April 2018 by a juvenile justice detention officer and female youth.

- The center has a newly implemented student of the week program. Each week, two youth are selected based on classroom participation and performance. Each youth selected for student of the week receives a certificate, picture taken, and their choice of a Slurpee or snack. Each certificate is given to the youth's parents/guardians, and the youth's picture is displayed in the main hallway at the center.

- The center has designated a staff member as a "behavior management champion" whom holds monthly meetings with youth in an effort to improve the behavior management system.

- The center participates in the south region employee of the month program. If selected, staff receive a fifty-dollar gift certificate.

- In January 2018, the center began holding bi-weekly reward meals for youth on level three status. This has improved youth behavior and gives youth an additional reason to keep their level status.

- The center holds visitation three times a week and additional visitations on holidays. Special visitation is also conducted regularly to strengthen families and give the youth opportunities to connect with family members while detained. Special visitation scheduling accommodates working parent/guardian schedules, families with transportation issues, grandparent guardians who do not drive at night. The center also allows youth with children the opportunity to visit their child during special visitation scheduling.

- Since January 2018, one of the faith-based volunteers teaches "Gracious Living" monthly. The class teaches table manners, place setting, utensil use, and proper dinner table etiquette.

- Each living module has a large white-board displaying each youth's behavior management system level. This allows youth to view and track their progress. Levels are updated on "C" shift and can be viewed by youth each morning.

- The center has begun a weekly "Bingo Friday's" event. This event is available to youth with positive behaviors on level three status and is led by the mental health staff.

# Standard 1: Management Accountability

## Overview

St. Lucie Regional Juvenile Detention center is a state-owned detention facility, operated by the Department of Juvenile Justice, located in Fort Pierce, Florida. The center is located within walking distance of the Juvenile Assessment Center (JAC), and the juvenile intake unit and serves youth throughout the four counties within Circuit 19. The center houses fifty beds for both male and female youth who are detained pending adjudication, disposition, or placement in a residential commitment program. Youth are provided services which include booking and orientation, behavior management, safety and emergency procedures, transportation, mental health, and healthcare services. The center's educational services are provided by the St. Lucie County School Board. The mental health and healthcare services are provided through the contracted provider, Maxim Healthcare Services, Inc. The center's management team includes the superintendent, two assistant superintendents, an administrative assistant, juvenile justice detention officer supervisors (JJDOS), juvenile justice detention officers II (JJDO II), and juvenile justice detention officers (JJDO I). At the time of the annual compliance review, the center had four vacancies, which includes: one juvenile justice detention officer I, one maintenance mechanic, one medical clerk, and one food service staff. 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.

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

The center maintains a written policy and procedures in place regarding background screening. A review of nine newly hired staff and three new volunteers documented the center received a background screening check from the Department's Background Screening Unit (BSU)/Clearinghouse before staff hire dates and volunteer start dates. The center's Annual Affidavit of Compliance with Level 2 Screening Standards was submitted and completed on January 18, 2018, meeting the annual requirement. The Annual Affidavit of Compliance with Level 2 Screening Standards for school board teachers was submitted to the BSU/Clearinghouse on January 30, 2018.

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

The center maintains a written policy and procedures regarding five-year background rescreening. The center had four staff and one volunteer applicable for having a five-year rescreening completed. A review of five staff and volunteer documented each staff/volunteer had a background screening check completed within ten days of their anniversary date or service date, from the Department's Background Screening Unit (BSU)/Clearinghouse. The center also conducts a driver's license check on all staff monthly through the Department of Highway Safety and Motor Vehicles. If there are any reports of negative findings staff are not allowed to operate any of the Department's state vehicles.

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

The center maintains a policy and procedures regarding staff code of conduct. A review of seven staff personnel records documented each staff signed a code of conduct. The code of conduct addressed officer professionalism, poor performance, negligence, conduct unbecoming of a public employee, misconduct, and prohibition of any form of abuse, profanity, threats, harassment, intimidation, horseplay, and/or personal relationships with youth. Three of the seven reviewed records documented two staff receiving a written reprimand and one receiving a verbal reprimand. Each staff was able to return to their assigned duty. A review of two additional staff records found staff receiving commendations in the form of employee of the month. An interview with the superintendent stated the center's code of conduct prohibits any form of abuse, threats, or intimidation. Staff are required to conduct themselves in a manner not causing embarrassment to the work place. Staff are role models for the youth and should

maintain a professional relationship always. Each of the seven interviewed staff acknowledged receiving a copy of the handbook and a copy was observed placed in each staff record. If staff are found in violation through physical abuse, threats, or the use of profanity while performing their duties, the staff will face disciplinary actions. The center maintains copies of all disciplinary actions of staff. Seven staff were interviewed, and three staff stated they have never observed their co-worker using profanity when speaking to youth. Two staff stated they observed staff use profanity once. One staff stated they were not sure what was taking place at the time, but they heard a staff member use profanity. Another staff stated the staff using profanity no longer works at the center. Two reported they observed staff occasionally use profanity when speaking with youth. The first staff stated when another staff may be trying to get the youth in line and they are not paying attention, the staff will use profanity. Another staff stated it may be in the heat of the moment. It was further explained when staff is trying to gain control and profanity may come out. None of the staff reported they have ever observed a co-worker using threats or intimidation when interacting with youth. Seven staff were interviewed regarding the center's working conditions and five staff reported the working conditions are fair at the center, one staff stated the working conditions are very good, and one stated poor. The staff did not want to go into details on why working conditions were reportedly poor. Seven youth were interviewed regarding staff interactions with youth and six youth stated staff are respectful when talking with them. One youth stated staff are not respectful youth. The youth further stated when she asks for paper staff will not give it to her, but when another youth ask for paper they will get it. Seven youth were interviewed regarding the staff using profanity. Six youth stated they have never heard staff use curse words when speaking with youth, and one youth stated staff curse at other youth often. The youth declined to offer details or specifics on staff cursing at youth. All seven youth also stated they have never heard staff threaten youth.

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

The center maintains a policy and procedures regarding incident reporting to the Department's Central Communications Center (CCC). Within the last six months the center had thirty-one CCC reportable incidents. A review of five CCC reports documented each call being placed to the CCC within the required two hours of the caller gaining knowledge of the incident. All five incidents were shown to be documented in the center's logbook. Observations during the annual compliance review week showed there were no internal incidents or grievances which needed to be reported to CCC. An interview with the superintendent stated all reportable incidents must be called into the CCC within two hours of the incident or two hours after gaining knowledge of the incident. Detention center and contracted staff are mandatory reporters and must report all forms of abuse or harassment. All youth detained have a right to report any form of abuse or harassment. Seven youth were interviewed, and each stated they have never been stopped from calling the Florida Abuse Hotline and/or CCC. Seven staff were able to explain the process for allowing youth to call the Florida Abuse Hotline and/or the CCC.

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

The center maintains a written policy and procedures regarding Protective Action Response (PAR). In the past six months the center had thirty-one PAR reports. A review of seven PAR reports documented six reports were completed by the end of each staff member's workday. One PAR report found two of the four staff involved did not complete their portion of the report by end of the workday. Each staff did complete their portion of the report the following day. None of the PAR reports indicated a PAR medical evaluation was needed after the post-PAR interview was conducted. Each PAR documented a post-PAR interview was completed. All PAR incidents were documented in the Department's Juvenile Justice Information System (JJIS). All seven PAR reports had documentation of a review completed by a supervisor or a PAR instructor to determine if use of force was consistent with the Department's policy within seventy-two hours as required. The center's PAR rate during the annual compliance review period was 2.67, which is below the statewide detention PAR rate of 9.29. All seven interviewed staff stated staff try to talk to youth prior to using physical restraints. An interview with the superintendent stated after each physical intervention, level three response, a PAR report must be completed in JJIS. The shift supervisor is required to review and complete the post-PAR interview questions with the youth within thirty minutes. A certified PAR instructor or supervisor must review each report. The center's administrators must review the report to ensure compliance. The center's administrators are responsible for monitoring all PAR reports in JJIS and complete reviews within seventy-two hours. Any misuse of PAR must be immediately reported to the Department's Central Communications Center (CCC). The center reported no incidents where a youth alleged abuse or the CCC was contacted due to improper PAR usage since the last annual compliance review.

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

The center maintains a written policy and procedures regarding pre-service training. A review of seven staff training records for pre-service training documented five staff completed their training in the required 180 days of hire. Two staff are currently in phase one and are within the required time frame, awaiting phase two training. Phase two training consists of attending the Department's training academy. Seven reviewed records documented staff completed the required training before having contact with youth. Required training prior to youth contact includes Protective Action Response (PAR), cardiopulmonary resuscitation (CPR), first aid, mental health services, substance abuse services, suicide recognition and intervention, safety and security, Prison Rape Elimination Act (PREA), human trafficking, and detention operations. All completed training was documented in the Department's Learning Management System (SkillPro). The center's in-service and pre-service plan was signed by the assistant secretary and forwarded to the center on January 19, 2018.

| 1.07 In-Service Training | Satisfactory Compliance |
|---|---|
| *All detention staff completes twenty-four hours of in-service training, including mandatory topics specified in Florida Administrative Code, each calendar year, effective the year after pre-service/certification training.*<br><br>*Supervisory staff completes eight hours of training (as part of the twenty-four hours of in-service training) in the areas specified in Florida Administrative Code.* | |

The center maintains a written policy and procedures regarding in-service training. Seven reviewed training records documented each staff exceeded the twenty-four-hour annual training requirement. One of seven reviewed training records showed the staff was missing the required trauma informed care, two hours of online suicide prevention training, and ethics training. Seven records documented Protective Action Response (PAR), cardiopulmonary resuscitation (CPR), first aid, and automated external defibrillator (AED), Prison Rape Elimination Act (PREA), sexual harassment, the Department's safety training, and necessary certifications were current and up-to-date. Three supervisor training records were reviewed and were applicable for having the required eight hours of supervisor training completed. One of the three supervisor records documented having no supervisor training. Most of the reviewed in-service training was documented in the Department's Learning Management System (SkillPro). There were a few trainings observed which were not documented in SkillPro, such as one staff's AED training, and all staff emergency response trainings. The training coordinator stated the center is not required to document drills into the Department's SkillPro system. The center uses drills as the training to cover emergency response. An interview with the superintendent reported all staff are required to complete in-service training in SkillPro. It was further explained, the in-service training incudes CPR, first aid, AED, PAR, PREA, facility operating procedures (FOPs), sexual harassment, suicide prevention, and the Department's safety training.

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

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

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

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

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

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

The center maintains a written policy and procedures regarding alerts. The center's alerts are logged in the Department's Juvenile Justice Information System (JJIS). Required alerts are entered by medical staff, mental health staff, juvenile justice detention officer supervisors, and/or juvenile justice detention officers. A review of the center's alerts showed alerts included the name and title of person entering the alert, along with the alert type. The center's alerts are discussed during each shift briefing and printed daily by each shift supervisor. Alert copies are provided to each staff during shift briefings. A review of alerts showed alerts were downgraded and/or removed by medical staff, mental health staff, and juvenile justice detention officer supervisors when applicable. An interview with seven staff documented staff are informed of alerts through the center's logbooks, shift briefings, alert forms, JJIS, and the alert board maintained in master control.

# Standard 2: Assessment and Performance Plan

| Overview |
|---|

The center is located within walking distance of the Juvenile Assessment Center (JAC), and the juvenile intake unit. All youth transported to the detention center are screened and classified by a juvenile justice detention officer (JJDO) in accordance to their individual level of risk. Admission includes screening for any significant medical, mental health, substance abuse, allergies, critical, and/or special needs. All screening, alert, and intake information is entered into the Facility Management System (FMS) and in the Department's Juvenile Justice Information System (JJIS). The center determines all youth risk factors when assigning safe and secure group and room placement. Orientation of the center is held in conjunction with the admission paperwork and includes parent/guardian telephone contact and the explanation of the orientation brochure. The brochure topics include important staff, center services, rules, procedures, and the behavior management system. The admission and orientation are concluded with securing youth property, and meal offerings. The detention center displays grievance and sick call forms in each living module for easy access by the youth. The center conducts detention review meetings weekly for all youth in secure detention and on home detention. The School Board of St. Lucie County provides course offerings to include career education and needed exceptional education services.

| 2.01 Admission | Satisfactory Compliance |
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*All youth are admitted to the program in accordance with Florida Administrative Code through a process, at a minimum, addressing the following:*

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

*Any youth identified as at risk of suicide shall be placed on Precautionary Observation until evaluated by the licensed mental health provider.*

The center maintains a written policy and procedures to ensure the proper screening, evaluation and documentation is provided for each youth admitted into the detention center. The St. Lucie Juvenile Assessment Center (JAC) and the St. Lucie Detention Center are co-located in the same building. Seven youth records were reviewed. One record did not include an arrest report due to the youth being detained on a contempt charge. A contempt charge court order does not require an arrest affidavit. The appropriate order was located in the record. The remaining six arrest affidavits were in the youth's records as required. All seven records reviewed contained the Detention Risk Assessment (DRAI) and Suicide Risk Screening Instrument (SRSI). All seven records included documentation youth were searched by same sex staff and received

medical, mental health, and substance abuse screenings upon admission. All seven records reflected youth were offered telephone calls. Six records documented youth made a telephone call to their parent/guardian and one refused. The refusal was documented on the Secure Detention Admission Wizard. All seven records documented each youth was offered something to eat during admission. An observation of a youth admission was made during the annual compliance review. The youth was offered a phone call to his parent/guardian but refused. The refusal was documented on the Secure Detention Admission Wizard. The youth was searched by same sex staff, was offered a shower, and dressed in the standard detention attire. The youth watched the Prison Rape Elimination Act (PREA) video and after it was over, staff answered the youth's admission questions. A picture of the youth was taken and uploaded into the Department's Juvenile Justice Information System (JJIS). The youth was screened to identify medical, mental health and substance abuse needs and placed on precautionary observation. The youth was assigned to the day room due to it being the youth's first time in detention and the youth was also given a hot meal.

| **2.02 Orientation** | **Satisfactory Compliance** |
|---|---|
| *Program orientation process shall occur within twenty-four hours of a youth being admitted into detention and documented according to Facility Operating Procedures. During the orientation process, youth must be advised, both verbally and in writing, at a minimum, the following:*<br>*1. Facility rules and regulations;*<br>*2. Grievance procedures;*<br>*3. Visitation;*<br>*4. Telephone calls;*<br>*5. Available medical, mental health and substance abuse services and how to access them;*<br>*6. How to access the Florida Abuse Hotline;*<br>*7. Expectations for behavior and related consequences;*<br>*8. Possible new law violations for destruction of property; and*<br>*9. Youth rights.* | |

The center maintains a written policy and procedures to advise youth of center rules and regulations, expectations for behavior and related consequences for failing to meet those expectations and youth rights within twenty-four hours of a youth being admitted into detention. Seven youth records were reviewed and each included orientation documents which were completed within twenty-four hours of admission. All seven records documented orientation was explained verbally by the staff and youth were given written information. Each youth signed the orientation packet acknowledging they received the packet. Each packet included information regarding rules and regulations, youth rights, visitation policies, telephone call policies, grievance procedures, access to medical treatment, mental health and substance abuse services, access to the Florida Abuse Hotline, the Department's Central Communications Center (CCC) and behavior related consequences. The packet identified behavior related consequences as level drops, privilege restriction, room confinement, and new law violations. The Department's resident contract on rules and regulations was located in all seven youth records. Seven youth were interviewed and all acknowledged the center rules and regulations, daily schedule, education services, visitation, abuse reporting, and behavior management system was explained upon admission. A youth admission was observed during the annual compliance review, but an orientation was not observed. The youth was interviewed and reported receiving orientation prior to the admission paperwork. The center does not utilize and an orientation video.

| 2.03 Classification | Satisfactory Compliance |
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*All youth admitted to the detention center shall be classified to provide the highest level of safety and security. Considerations shall include, at a minimum:*

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

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

The center maintains a written policy and procedures to ensure all youth admitted to the detention center are classified by the admitting officer to provide the highest level of safety and security. Seven youth records were reviewed and all included documentation of consideration of potential safety and security concerns prior to group and room assignment. Considerations included the youth's sex, height, weight, age, level of aggressiveness, mental illness, intellectual abilities, physical disabilities, history of violent behavior, gang affiliation, criminal behavior, history of sexual offenses, medical status, suspected or identified suicide risk, and security and escape risk. Each reviewed youth classification form identified any special needs and included all the required elements. All youth were assessed using the Vulnerability to Victimization Sexually Aggressive Behavior (VSAB) assessment, Secure Detention Admission Wizard, juvenile offense history, active alerts, and the Suicide Risk Screening Instrument (SRSI). Three of the seven reviewed records showed youth were placed in single occupancy dorms due to sexually aggressive behavior or victim of sexual abuse and vulnerability to victimization. One youth was placed in the day room due to his young age and first time in detention. Another youth was placed in the day room, on constant supervision, due to the SRSI results. The remining two records showed both youth were appropriate for unrestricted classifications. Each reviewed youth record documented appropriate classification alerts were entered into the Department's Juvenile Justice Information System (JJIS). An observation was conducted of the classification process during the annual compliance review. Staff reviewed the Secure Detention Admission Wizard, VSAB, SRSI, alerts, face sheet, and current offenses.

| 2.04 Classification of Gang Members | Satisfactory Compliance |
|---|---|
| *All newly admitted youth are screened to determine if he or she is a criminal street gang member or is affiliated with any criminal street gang.*<br><br>*Each facility shall identify a staff person to serve as a gang representative who shall review identified youth for suspected gang involvement or gang activity.* | |

The center maintains a written policy and procedures to ensure screening of all youth for possible gang involvement or an affiliation with any type of street gang. Seven records were reviewed, and all documented youth were screened to determine gang membership or gang affiliation upon admission. Two of the seven records showed youth admitted to gang involvement or affiliation during intake. Both records showed the youth were previously identified as gang affiliated. Each record showed an alert was present in the Department's Juvenile Justice Information System.

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

The center has a gang representative to communicate suspected gang activity. The center's gang representative is responsible for notifying the juvenile probation officer (JPO) representative and superintendent regarding any indication of gang activity by electronic mail. The center has designated a shift supervisor and the assistant superintendent share information with the circuit liaison. None of the seven reviewed records were applicable for a new gang member identification. Two additional records were available and provided by the center. Each included a gang identification form and a corresponding electronic mail message to the gang liaison. The probation reform specialist for Circuit 19 serves as the liaison. The circuit gang liaison is responsible for notifying law enforcement. Gang alerts are discussed weekly at the center's detention review meetings with juvenile probation officer supervisors, detention staff, school board representatives, and social service agencies. An interview with the circuit gang liaison reported they also attend meetings with the St. Lucie County Restoring the Village Youth Initiative. The Restoring the Village Youth Initiative serves as the circuit's gang prevention initiative. Community outreach workers working with the families also attend these meetings where gang issues are discussed. An interview with the assistant superintendent verified the process.

| 2.06 Admission of Youth Personal Property | Satisfactory Compliance |
|---|---|
| *The program takes possession of each youth's personal property during admission. In the presence of each youth, staff inventories all personal property in the youth's possession and records each surrendered item on the Property Receipt Form.* | |

The center maintains a written policy and procedures to ensure youth's personal property is maintained securely and returned to them in a timely manner upon their release.
Seven reviewed records contained a property receipt. Each receipt documented the youth and staff name and signatures, letter of acknowledgement of unclaimed property form, and a property receipt for the youth's personal property. The center places personal property such as clothing and foot wear in a brown bag in a secured locker. Five of the reviewed records documented valuable property. All valuable property is placed in a clear tamper-proof bag, logged into the logbook with date, time, youth's name, Department identification number, name of the officer securing the property, and the officer's initials. The center's practice is to place the clear bag into the drop safe. Observations during the annual compliance review showed two of the seven records only had clothing logged and did not require valuable property storage. One youth refused to sign the property receipt form and the youth's refusal was documented on the form. The assistant superintendent demonstrated the process of handling youth's valuable and personal property during the annual compliance review. The center also documents all safe entries in a logbook. The safe logbook was reviewed, and entries were present for each youth with valuable property. Each of the seven interviewed youth reported staff checked their personal property upon admission, and youth signed a form stating their personal property was correct. An interview with the superintendent reflected upon admission, all youth property is inventoried and stored in a tamper-proof property bag and both youth and staff sign, date, acknowledge all the items listed are inside the bag. The shift supervisor removes the property from the intake area and takes the property to master control. The property is then logged by the master control operator and dropped inside the initial safe located inside master control. A copy of the property receipt is placed in the youth's record.

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

The center maintains a written policy and procedures to ensure youth's personal property is maintained securely and returned to them in a timely manner upon their release. The center safeguards each youth's personal property until it can be returned to the youth and/or parent/guardian. Observations of youth's personal property during the annual compliance review showed non-valuable property, such as clothing and shoes are, placed in a brown bag and stapled shut. The youth reviews the information and signs the receipt form. The youth's personal property is placed in an assigned locker and secured. Observations showed valuable property is placed in clear tamper-proof plastic bags, signed by youth and staff, dated, and logged by the master-control operator. The valuable property is then dropped in the initial drop safe located inside master control, under camera surveillance. A copy of the property receipt is placed in the youth record. The center administrators then remove the property, placing it in a storage safe located in the sunshine room, which is also under video surveillance. The items will remain there until the youth is released or property is released to parent/guardian. A review of the Department's Central Communications Center reports for the past six months did not show any reported incidents regarding youth property. An interview with the center's superintendent validated the center's property storage practice.

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

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

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

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

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

*The releasing officer shall verify the identification of the youth.*

The center maintains a written policy and procedures to ensure all releases from detention occur promptly and accurately. Seven records were reviewed, and three records were applicable for release procedures. All three records documented the on-duty supervisor reviewed all release paper-work prior to the youth's release. One youth was released to the statewide transportation hub for his residential commitment program. A copy of the photo identification of the staff who took over supervision of the youth was placed in the youth record. One youth was released on home detention with electronic monitoring to his parents/guardians. A copy of the parent/guardian's identification was placed in the record, and the youth and parent/guardian were notified in writing of youth's next court date. The parent/guardian signed the property receipt report acknowledging receipt of the youth's property. Observed documentation showed all required parties signed all applicable forms. The date of admission and the date of termination was documented in the youth record and the Department's Juvenile Justice Information Center (JJIS). The third youth was transferred to another detention center due to behavior issues, pending placement in a high-risk program. The youth's record contained a photocopy of staff assuming supervision identification, and the Department's Release Wizard form was completed and signed. An observation of a youth's release process was conducted during the annual compliance review. Detention staff and the supervisor identified the correct youth, detention and court orders were reviewed by the supervisor. The reason for release was the expiration of detention time, and this was verified by the court order. The supervisor called the nurse to make sure youth was not being released with any medication. The parent's photo identification was copied for youth's record. The parent/guardian and youth were given notice of youth's court date in writing. The personal and valuable property were released to youth's parent/guardian and the youth was released back to his parent/guardian in his own clothes. The Department's Release Wizard was completed, and the release information was updated in JJIS. The Department's Central Communications Center (CCC) reports were reviewed for the past six months and there was one reported negligent release at the center. The CCC report was taken, investigated, and corrective action was put in place.

| 2.09 Release of Youth Personal Property | Satisfactory Compliance |
|---|---|
| *Upon the youth's release from detention and retrieval of personal property, the releasing officer, the youth, and the youth's parent or legal guardian shall review and sign the Property Receipt Form and account for all of the youth's personal property.* | |

The center maintains a written policy and procedures to ensure youth's personal property is maintained securely and returned to them in a timely manner upon their release. The policy outlines each youth and their parent/guardian are required to sign the property receipt acknowledging receipt of youth's personal property. Seven records were reviewed and only two records were applicable for release of valuable property. An additional record was chosen for review. All three closed records showed youth and parent/guardian signed the property receipt acknowledging receipt of each youth's personal property. An interview with the assistant superintendent explained unclaimed property is disposed of after thirty days. This practice is explained to each youth through the signed property letter of acknowledgement and is given to each youth upon admission. The center makes every effort to return the property. The center's unclaimed property is donated to Safe Space. Safe Space is a local charity for domestic violence victims. All donations are logged on a disposed property form with an attached record of donation. The superintendent interview also confirmed this process. Examples of property disposal paperwork, logs, and receipts were received during the annual compliance review. An on-site observation of a youth's release showed the center's policy and procedures were followed.

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

The center maintains a written policy and procedures regarding release of youth taking prescription medications. Seven records were reviewed and only one was applicable for release of prescription medications. Two additional youth records were chosen for review. All three reviewed records showed youth were released to an appropriate person with a copy of a photo identification. Each record contained a receipt of medication, signed by the parent/guardian or receiving Department staff, the type of medication, strength, dosage, quantity, and any pending medical appointments. An observation of a release during the annual compliance review confirmed the staff telephone the medical staff during the release to determine if a youth is prescribed medication.

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

The center maintains a written policy and procedures for weekly detention reviews for youth securely detained, placed on home detention or electronic monitoring, to ensure proper management of youth and the sharing of information. During the annual compliance review, an observation of a detention review meeting was conducted. All parties were present from all required departments. Staff in attendance included mental health staff, medical staff, education staff, juvenile probation officer supervisor, and superintendent. The center reviews all securely detained youth, home detention youth, alerts, and circuit waiting lists. Waiting lists include all

youth currently in adult jail. A review is also conducted of any medical and mental health updates during weekly detention review meetings. Reviewed documentation for the past six months of detention review meetings confirmed the center's practice and all regular attendees. An interview with the center's superintendent reported the meeting is chaired by the center's detention review specialist. Attendees of detention review include representatives from medical, mental health, education, the circuit's public defender's office, juvenile probation officers and supervisors, assistant chief probation officer, chief probation officer, and the commitment manager.

| 2.12 Daily Activity Schedule | Satisfactory Compliance |
|---|---|
| *Youth are provided the opportunity to participate in constructive activities that will benefit the youth and the program. The Superintendent or Designee develops a daily activity schedule, which is posted in each living area and outlines the days and times for each youth activity.* | |

The center maintains a written policy and procedures which outlines daily activities schedules. Youth are provided the opportunity to participate in constructive activities benefiting the youth and the center. The center's superintendent develops a daily activity schedule, which is posted in each living area and outlines the days and times for each youth activity. Observations during the annual compliance review revealed schedules are posted throughout the center and in each living module. Posted schedules include recreation, education, visitation, hygiene, times for meals, gender-specific programming, life skills, and restorative justice programming. Seven interviewed staff confirmed the daily schedule includes gender-specific groups. Life skills and restorative justice sessions are led by mental health staff, volunteers, and center staff. Youth are also allowed to complete community service hours through a t-shirt program and greeting card program hosted at the center. The center also hosts talent shows with the youth to maintain their good behavior. Seven interviewed youth reported the center has a posted daily activity schedule.

| 2.13 Adherence to Daily Schedule | Satisfactory Compliance |
|---|---|
| *Facility staff shall adhere to the daily activity schedules. Documentation of all activities shall be made in all applicable logs.*<br><br>*The on-duty supervisor must approve any significant changes in the activity schedule and shall document the reason for the change(s) in the shift report.*<br><br>*Any cancellation of visitation shall be approved by the superintendent.* | |

The center maintains a written policy and procedures which outlines adherence to a daily schedule. The daily activity schedule, logbooks and movements were observed during the annual compliance review. Reviewed documents indicated the center is adhering to the activity schedule. Reviewed sign-in sheets from groups led by mental health, volunteers and staff showed the groups are occurring and logbooks clearly indicated when and where groups are held. Changes to the schedule are relayed to staff by the supervisor and require approval from administration. Any cancellation of visitation must be approved by the superintendent. Seven youth were interviewed and six stated the daily schedule is followed. One youth stated they do not let youth out of their room after showers. Seven staff where interviewed and all reported the daily schedule is followed. Observations during the annual compliance review revealed schedules are posted in the center and in each living modules and the schedule was followed,

as posted. A random selection of logbooks for the past six months was reviewed and reflected there were no deviations from the daily schedule.

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

The center offers an education component operating on a year-round basis. An interview with the lead educator and the information through multiple center logbooks showed the center's educational program is in session six hours a day Monday through Friday. Educational programing is offered weekly for a total of 250 days a year. The skills addressed and developed in the education program is supported by academic courses which are monitored by the School Board of St. Lucie County. The education staff works closely with the center's behavior management system and has a bulletin board on display in the center's main hallway. The board displays awards and encouraging statements for youth to view. All youth enrolled in the educational program can earn course credit for participation and completion of the education component course offerings. There were no on-site observations during the annual compliance review to suggest the educational experience was unduly interrupted or suspended for any length of time. The education department is equipped with a computer lab with twelve computers used for entry testing and state testing. The teachers utilize scholastic magazine, course specific and real world current events, magazines, and a hip-hop based Language Arts program as supplemental teaching aids. The education department also offers an in-house library system, allowing youth to check in and check out reading materials. Each youth requiring exceptional education services is afforded access to individualized education planning and review, paraprofessional support, small group and individualized instruction, a speech and language therapist, and access to the school board's psychologist. Additional exceptional education services include access to a behavior analyst, occupational therapist, physical therapist, and vision/mobility specialist.

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

The center defines career education based upon the age of the youth, assessed educational abilities and goals of the youth to be served and, the typical length of stay and custody characteristics at the center. The center offers Type 1 career education. This classification denotes the center offers coursework which centers on "soft skill" which include exploring and researching career choices, and the instruction of life skills. Additional career instruction includes communication and decision-making skills. The center utilizes ARISE and Career Choices for their career education curriculum.

| 2.16 Behavior Management System | Satisfactory Compliance |
|---|---|
| *The program provides a system of rewards, privileges, and consequences to encourage youth to fulfill the program's expectations.*<br><br>*Each facility shall implement and maintain a behavior management system to meet the needs of the youth and the facility. The system shall be approved by the regional director and shall include rewards for positive behavior and consequences for inappropriate behavior.*<br><br>*The behavioral norms and expectations for youth shall be posted in all living areas and shall clearly specify appropriate and inappropriate behaviors.* | |

The center maintains a written policy and procedures to provide a uniform behavior management system (BMS) offering a predictable set of rewards, privileges and consequences for behavior. The center provides a system of rewards, privileges, and consequences to encourage youth to fulfill the center's expectations. The system includes rewards for positive behavior and consequences for inappropriate behavior. The behavioral norms and expectations for youth are posted in all living areas and clearly specify appropriate and inappropriate behaviors. Youth are informed of the BMS upon admission through an orientation. The BMS consists of three levels. Each youth enters as a level two, when admitted, and then their level moves up or down, depending on their behavior. Youth on level three have the privilege of participating in weekly incentives such as pizza parties and ice cream socials. The youth are also rewarded weekly by school officials for their good behavior and educational improvements. Inappropriate behavior is documented in the logbook and an incident report is completed for any youth receiving a reduction in their level. Youth levels are updated nightly on "C" shift, and upon waking, youth can view their status and able to ask questions, if needed. Each module has a white board tracking all youth levels. The center uses a point sheet to document youth positive and negative behaviors. Point sheets are reviewed by administration staff weekly. Seven staff were interviewed regarding their perceived effectiveness of the BMS. Three staff reported they feel the BMS is effective. Four of the staff stated the system is not effective due to youth demonstrating negative behavior after they receive a reward. Seven youth were interviewed, and six youth stated the system is good. One youth stated the system is poor. The youth reporting the system is poor stated their level has been dropped without previous knowledge. Seven youth were interviewed regarding whether they believed consequences for negative behavior was fair at the center. Three youth reported the consequences received were fair, two stated consequences were not fair, and two reported they have never received any consequences. The two youth reporting consequences were not fair stated staff were quick to drop a level and did not provide sufficient warning. Seven interviewed staff reported the youth are spoken to about their behavior and the level of consequences. Also, staff reported discussing alternative acceptable behavior and calling supervisors to counsel with the youth. Seven staff were interviewed regarding the frequency in which they are receiving BMS related feedback from supervisors. Two of the interviewed staff reported receiving feedback from administration on a weekly basis, five reported to receiving feedback as needed. An interview with the center superintendent supported the center's practice and policy regarding the BMS.

| 2.17 Unauthorized Use of Punishment (Critical) | Satisfactory Compliance |
|---|---|

*The center's behavior management system restricts certain types of penalties on youth who demonstrate negative behaviors.*

*Group punishment shall not be used as a part of the facility's behavior management plan. However, corrective action taken with a group of youth is appropriate when the behavior of a group jeopardizes safety or security, and this should not be confused with group punishment.*

*Corporal punishment shall not be used in detention facilities. All allegations of corporal punishment of any youth by facility staff shall be reported to the Florida Abuse Hotline, pursuant to Chapter 39, F.S., and the Central Communications Center.*

*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 maintains a written policy and procedures prohibiting group and corporal punishment of youth. Youth are not allowed to discipline other youth at the center. Seven youth were interviewed, and each reported youth are not allowed to discipline other youth, nor have they observed staff tell other youth to discipline other youth. Seven staff were interviewed, and all reported use of corporal punishment is not authorized, nor have they witnessed other staff members tell any youth to punish another youth. The center's policy clearly states the use of group punishment and corporal punishment is not allowed. The center's behavior management system (BMS) limits certain types of penalties for youth who demonstrate negative behavior. The center's BMS uses a level system which ranges from level one to level three. Seven youth were interviewed and five indicated they received consequences which involved losing points or their level. Two youth stated they never received consequences. Youth were also interviewed regarding their perceived fairness of the BMS. Two youth stated they thought consequences were fair and three stated consequences were not fair. The youth stating consequences were unfair did verbalize staff were not consistent or did not warn them prior to implementing a level drop. Seven interviewed staff indicated they have never witnessed intimidation, humiliation, or unauthorized use of punishment at the center. A review of the last six months of incident reports was completed and there were no observed incidents indicating unauthorized use of punishment.

| 2.18 Grievances | Satisfactory Compliance |
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*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 maintains a written policy and procedures to ensure each youth has the right to file a grievance and ensure all youth are treated fairly, respectfully, without discrimination, and their rights are protected. The grievance process is posted in each living unit and explained to each

youth during the admission and orientation process. The first step in the grievance process is the informal phase which is completed by detention staff whereby the youth and staff attempt to resolve the youth's complaint. If the staff is unable to resolve the issue, the written grievance will be submitted to the supervisor, beginning the formal grievance process. Next, the appeal phase requires a response from the superintendent or designee. The grievance forms are located on each living area and accessible to all youth at the center. Seven staff were interviewed, and all were able to explain the grievance process. All staff stated they have not seen co-workers take meals, snacks, clothing, and/or denied youth education access or medical care. Seven youth were interviewed, and one stated the grievance process is not fair and the other six reported having never filed a grievance. The youth reporting the grievance process was not fair refused to offer additional information. The center has had seven grievances filed in the last six months. A review of five grievances showed four were resolved during the informal phase. One grievance was not resolved due to the youth leaving the center. The unresolved grievance was filed for a probation complaint. Documentation showed it was forwarded to the circuit's chief probation officer by the center superintendent. An interview with the center superintendent explained all youth have the right to file a grievance if they feel their rights have been violated. Formal grievances are documented in the center logbook and forwarded to the shift supervisor. If the youth is not satisfied with the outcome provided by the shift supervisor, they may appeal to the superintendent or designee. All grievance hard copies are uploaded into the Department's Juvenile Justice Information System.

| **2.19 Trauma-Informed Care** | **Satisfactory Compliance** |
|---|---|
| *The facility is incorporating trauma-informed practice into current operations to deliver services and to provide care to youth in custody, acknowledging the role that violence and victimization play in the lives of most of the youth entering the facility.*<br><br>*Trauma-informed practice has many characteristics, which include the following:*<br><br>• *A recognition of the high prevalence of trauma*<br>• *Assessment for traumatic histories and symptoms*<br>• *Recognition of culture and practices that may be re-traumatizing*<br>• *Collaboration of caregivers*<br>• *Training of staff to improve trauma knowledge and sensitivity*<br>• *Increased staff understanding of the function of behavior (rage, self-injury, etc.) as an expression of trauma*<br>• *Use of objective and neutral language (avoids labeling of youth)* | |

The center has a policy and procedures which addresses trauma informed care. Seven reviewed youth records showed each youth admitted to the center received a trauma risk assessment upon intake. Center staff receive training in trauma informed care as part of their pre-service and in-service curriculum. A review of seven staff in-service training records showed six received the required trauma informed care training. The center continues to improve the appearance of the facility by painting the walls bright colors and adding several murals to the walls. The superintendent explained the center is moving away from posters and completing paintings to soften the hallways. The center currently has two soft rooms for the youth to utilize. The walls are covered with inspirational and positive quotes and drawings completed by the youth and staff. An interview with the superintendent explained officers are trained to identify warning signs and triggers related to trauma. The center also works closely with mental health staff and youth families while youth are in detention as a trauma informed practice.

# Standard 3: Mental Health and Substance Abuse Services

## Overview

The St. Lucie Regional Juvenile Detention Center maintains a contract with Maxim Healthcare Services, Inc. to provide mental health and substance abuse services. Maxim Healthcare Services, Inc. subcontracts with Camelot Community Care, Inc., to provide comprehensive mental health, substance abuse, and psychiatric services to youth at the center. The center has a full-time licensed clinical social worker (LCSW), who serves as the designated mental health clinician authority (DMHCA). The DMHCA is responsible for overseeing all mental health services at the center and is on call twenty-four hours a day, seven days a week. The center has two non-licensed bachelor's level mental health staff working under the direct supervision of the DMHCA. Clinical services are available seven days a week. The center has a comprehensive plan for the delivery of mental health treatment services, a suicide prevention plan, a crisis intervention plan, and an emergency care plan. 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. The center conducts mini-treatment team meetings, on a weekly basis, for applicable youth receiving services. The center utilizes New Horizons of the Treasure Coast in Fort Pierce, Florida for Baker Act crisis stabilization and for Marchman Acts.

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

The center maintains a written policy and procedures to ensure there is a single licensed mental health professional identified as the designated mental health clinician authority (DMHCA), who is responsible for the coordination and implementation of mental health and substance abuse services. A review of the job description and contract, and interview with the DMHCA supported the center's DMHCA is responsible and accountable for ensuring coordination and implementation of mental health and substance abuse services. The DMHCA is a licensed clinical social worker who holds a clear and active license in the State of Florida. The center's DMHCA is on-site forty hours a week and is on call twenty-four-hours a day.

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

The center maintains a written policy and procedures to ensure mental health services and substance abuse services are provided by individuals with appropriate qualifications. The center's staffing is in accordance with the contract and Florida Administrative Code 63N. The

DMHCA is a licensed clinical social worker and the psychiatrist is a medical doctor. Each license were clear and active in the State of Florida.

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

The center maintains a written policy and procedures to ensure mental health services and substance abuse services are provided by individuals with appropriate qualifications. The designated mental health clinician authority (DMHCA) ensures the center's clinical staff are working under direct supervision and are providing services they are qualified based on education, training, and experience. Verifications of training and experience for three bachelor's-level mental health staff showed each was qualified based on education verification, initial training, and work experience. The center's staffing requirement is for two bachelor's-level staff; however, one staff went on maternity leave since the last annual compliance review and required a substitute staff. The substitute staff possessed a bachelor's level degree and documentation of fifty-two hours of required pre-service training. Each bachelor's-level staff possesses a degree from an accredited university or college in the field of counseling, social work, psychology, or related human services field. The two permanent non-licensed staff had two years clinical experience assessing, counseling, and treating youth with serious emotional disturbances or substance abuse problems. Each reviewed mental health clinical staff record documented receipt of twenty hours training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. Each reviewed training included administration of, at a minimum, five Assessments of Suicide Risk (ASR) or crisis assessments conducted on-site in the physical presence of a licensed mental health professional. Reviewed training records showed each of the non-licensed mental health clinical staff persons work under the direct supervision of a licensed mental health professional and receive a minimum of one hour a week of on-site face-to-face direct supervision by the licensed DMHCA. Documented direct supervision showed each non-licensed staff providing services received clinical supervision for at least one hour during each week they provided services. Camelot Community Care does not have a Chapter 397 license to provide outpatient substance abuse services. An interview with the DMHCA reported she is responsible for providing substance abuse services to youth at the center. The DMHCA is responsible for providing direct clinical supervision and for reviewing each ASR and follow-up ASR, crisis assessment and follow-up crisis assessment completed by the non-licensed mental health clinical staff person within twenty-four hours of the referral for assessment. Additionally, all ASRs, follow-up ASRs, crisis assessments or follow-up crisis assessments completed by the non-licensed mental health clinical staff must be signed by the DMHCA the next scheduled time she is on-site.

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

The center maintains a written policy and procedures ensuring the mental health and substance abuse needs of the youth are identified through a comprehensive screening process. The mental health and substance abuse needs of youth are identified ensuring referrals are made when youth have identified mental health and/or substance abuse needs or are identified as a possible suicide risk. The center's superintendent has established procedures for a thorough review of preliminary screening conducted which was signed by the superintendent and the designated mental health clinician authority (DMHCA) on August 15, 2018. Seven reviewed youth records were each applicable for a Positive Achievement Change Tool (PACT), Suicide Risk Screening Instrument (SRSI), and Massachusetts Youth Screening Inventory – Second Version (MAYSI-2), completed by probation screening staff. Each documented completion and review of these instruments was conducted by detention staff. In addition, each record documented an SRSI completed at intake, using the Department's Juvenile Justice Information System (JJIS), and each SRSI documented mental health staff completed the required section within twenty-four hours including recommendations in the screening results section. Six youth records were applicable for youth having positive SRSI responses and were appropriately placed on suicide precautions. All six contained a completed referral and documented the need for an Assessment of Suicide Risk (ASR). Each screening was completed by trained staff. Six reviewed records showed on the PACT, MAYSI-2, and/or SRSI the need for further assessment was indicated, and each contained the appropriate referral. An interview with the superintendent explained upon admission, all screening paperwork copies are provided to the mental health and superintendent designee notifying them of suicide precautions and referrals for additional assessment. Four youth records were applicable for the PACT report indicating further assessment due to suicide indicators and were subsequently placed on suicide precautions. Six PACT assessments indicated a need for comprehensive assessment and appropriate notifications and referrals were made. Two youth records whose MAYSI-2 screening indicated suicide risk were placed on suicide precautions. Three PACT assessments indicated a need for a comprehensive assessment and appropriate notifications and referrals were made.

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

The center maintains a written policy and procedures ensuring youth who are identified through preliminary screening, during intake and admission, as having mental health and/or substance abuse issues or needs are referred for a further in-depth mental health and/or substance abuse evaluation. All youth referred for further assessment upon admission screening are referred to the Drug Abuse Treatment Association (DATA). DATA is responsible for conducting the Treatment Accountability for Safer Communities (TASC) assessment and case management

model. The model is designed to decrease juvenile delinquency by identifying individuals with substance use and mental health problems and placing them in appropriate services. Any youth who are identified through the center's screening process as having a potential substance use and/or mental health problems are referred to the TASC program for further assessment. The TASC staff complete the Substance Abuse and Mental Health assessment and generate a comprehensive report and recommendations. Seven reviewed youth records showed each was referred to the community provider for additional assessment upon admission. Two records were applicable for a fourteen-day update on the evaluation status and both found the referral was ordered and/or scheduled. Five reviewed records showed the comprehensive evaluation was completed within thirty days, while two records have not yet reached the thirty-day due date. Each completed comprehensive assessment was completed by the community provider.

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

The center maintains a written policy and procedures ensuring mental health and substance abuse treatment planning focuses on providing mental health treatment and/or substance abuse treatment, which will reduce or alleviate the youth's symptoms of mental disorder or substance abuse impairment and enable the youth to function adequately. Each youth determined to need mental health treatment, including treatment with psychotropic medication, or substance abuse treatment while in a detention center, must be assigned to a mini-treatment team. Seven youth records were reviewed and five showed the youth required treatment while at the center. Each of the five applicable records documented an assignment to a mini-treatment team. The center's mini-treatment team is comprised of education, mental health, medical, direct care, and administrative staff. Three youth requiring mental health services and two youth requiring substance abuse services were receiving individual, family, or group counseling according to the frequency of the plan. All seven records reflected an active Authority for Evaluation and Treatment (AET) form on record. The three youth requiring substance abuse services did have a substance abuse consent form on record. All clinical treatment notes are documented on Department's form MHSA 018. Mental health and substance abuse groups are offered at the center. The center also offers psychoeducational or life skills groups using the ARISE curriculum. Three youth were applicable for participation in substance abuse groups and corresponding sign-in sheets showed fifteen or fewer participants. Group sign-in sheets showed thirteen substance abuse groups have been held at the center in the last six months. All sign-in sheets documented facilitation by the licensed clinical social worker (LCSW) and fewer than fifteen participants. The LCSW uses motivational interviewing (MI) and the adolescent community reinforcement approach (ACRA) for substance abuse treatment groups. Two youth were applicable for participation in mental health group therapy and sign-in sheets for corresponding groups showed ten or fewer participants. Group sign-in sheets showed twenty-eight mental health groups have been held at the center in the last six months. All sign-in sheets documented facilitation by mental health staff. Twelve documented more than ten participants. The center's designated mental health clinician authority (DMHCA) explained the

psychoeducational groups using the ARISE curriculum were not considered mental health treatment, despite being recorded on a mental health sign-in sheet. It was further explained by the DMHCA and lead teacher the ARISE groups were co-led by educational and mental health staff and served as a life-skills curriculum. Youth selected for participation in ARISE groups were selected based on their behavior management system level, not mental health needs. The center reported they will use a different sign in sheet and/or group name to differentiate the treatment and life-skills groups in the future. Seven youth were interviewed asking them to rate the mental health and substance abuse services at the center. Two youth reported not receiving services, two rated services as good, and three rated services as very good.

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

The center maintains a written policy and procedures ensuring mental health and substance abuse treatment planning focuses on providing mental health treatment and/or substance abuse treatment which will reduce or alleviate the youth's symptoms of mental disorder or substance abuse impairment and enable the youth to function adequately. The center's designated mental health clinician authority (DMHCA), and mental health clinical staff are responsible for ensuring the development and review of an initial and/or individualized mental health and substance abuse treatment plans for each youth receiving mental health and substance abuse treatment in the center. Seven youth records were reviewed and six showed they were applicable for requiring a treatment plan. Three of the seven were applicable for and documented an initial treatment plan in place within seven days of admission. All of the three initial treatment plans were developed on the Department's form MHSA 015, and contained the reason for referral, initial diagnostics and statistical manual-five (DSM-5) diagnosis, initial treatment methods, initial treatment goals, psychiatric services, and applicable medication and monitoring frequency. Each initial plan included mental health signatures, DMHCA signature within ten days, youth signature, and signature of mini-treatment team members. Three of the seven reviewed records were applicable for an individualized treatment plan. Each of the three records contained an individualized plan developed by the thirty-first day of admission and was signed by the DMHCA within ten days, as required. Three individualized treatment plans were reviewed and contained the DSM-5 diagnosis, treatment focused symptoms, treatment goals, and youth strengths, abilities, preferences, and needs. Only one record was applicable for psychiatric services to include medication and monitoring frequency, pharmacological interventions and an additional two were requested and provided. Each of the three individualized plans outlined pharmacological interventions, frequency, and dosage as necessary. All reviewed progress notes supported youth are receiving treatment services as prescribed. All reviewed individual treatment plans were signed and dated by youth, mental health professional, treatment team members, and parent/guardian when possible. Three reviewed records were applicable for a mental health/substance abuse (MH/SA) discharge summary. Each was documented on Department's form MHSA 011, completed upon the youth's transition and/or discharge, and was provided to youth, parent/guardian and juvenile probation officer. A review of three individual

treatment plans reflected each were reviewed every thirty days, as required. One youth was applicable for three reviews and a total of five reviews showed none where applicable for modifications and/or updates to goals or services. Each reviewed treatment and discharge plan review was signed by the clinical staff, youth, and licensed mental health professional. A mini-treatment team was observed during the annual compliance review which confirmed the center's participants and practice.

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

The center maintains a written policy and procedures ensuring psychiatric services are provided to youth in need. Psychiatric services at the center include psychiatric evaluation, psychiatric consultation, medication management, and medical supportive counseling. Psychiatric services are provided to youth with a Diagnostic and Statistical Manual-5 (DSM-5) mental disorder and each youth receiving psychotropic medication as set forth in Rule 63N-1, Florida Administrative Code. Seven youth records were reviewed and one was applicable for a psychiatric interview and two additional records were requested and received. All three reviewed records documented an initial psychiatric interview included reason for the referral, history, mental status exam, DSM-5 diagnosis, treatment recommendations, applicable prescribed medication, explanation of the need of psychotropic medications, and frequency of medication monitoring. Each in-depth psychiatric evaluation was completed within thirty days of referral and/or admission. Each in-depth evaluation included the reasons and factors leading to referral, development history, history of psychiatric illness, mental status exam, identification of family environmental factors, DSM-5 diagnosis, treatment recommendations, prescribed medication and frequency of monitoring, explanation of the need for psychiatric medications, most recent applicable lab results, and signature of practitioner. Reviewed progress notes and the Department's Clinical Psychotropic Progress Note (CPPN) determined the two applicable youth admitted with psychotropic medications were seen within fourteen days of admission by a psychiatrist. Each record contained documentation of page three of the CPPN, although it was not required due to no changes made to prescriptions. One record was applicable for an updated psychiatric evaluation and two were applicable for a new evaluation. A monthly CPPN was completed for two youth applicable for continued psychotropic medication every thirty days as required, while the third evaluation did not reflect medication was prescribed. Two records applicable for medication were written and the evaluation included identifying data, DSM-5 diagnosis, target symptoms of each medication, description of the effect of medication on target symptom, medication range, medication frequency, side effects, youth's adherence to medication regime, signature of psychiatrist, and date of signature. Two records were applicable and documented monthly Tardive Dyskinesia monitoring by the psychiatrist. An Authority for Evaluation and Treatment (AET) was observed in all seven reviewed records. No reviewed records were applicable for page three of CPPN where youth had a change or started medications requiring parent/guardian consent. An interview with the center's medical staff reported there have been no incidences where the psychiatrist has stopped, or changed psychiatric medications requiring parent/guardian consent since the last annual review and attributed this to the psychiatrist's conservative methods. No youth records were applicable for foster care consents. One youth was eighteen and documentation showed signature on the appropriate consents.

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

The center follows a suicide prevention plan to safely assess and protect youth with elevated risk of suicide in the least restrictive means possible, in accordance with Rule 63N-1, Florida Administrative Code. The center's suicide prevention plan includes identification and assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and review process. The plan was revised and approved by the superintendent and designated mental health clinician authority (DMHCA) on August 15, 2018. The plan included the identification and assessment of at-risk youth for suicide, suicide risk alert, levels of supervision, suicide precautions, referrals, notification and communication, immediate staff response, use of extra precautions, review process, and emergency contact numbers. The plan is maintained in the center's medical office, master control, and on the center's computer system and is accessible to all staff.

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

The center follows a suicide prevention plan to safely assess and protect youth with elevated risk of suicide in the least restrictive means possible, in accordance with Rule 63N-1, Florida Administrative Code. The center has an established review process for every serious suicide attempt or serious self-inflicted injury requiring hospitalization or medical attention, and a mortality review for a completed suicide. The multidisciplinary review includes circumstances surrounding the event, center procedures relevant to the incident, all relevant training received by involved staff, pertinent medical and mental health services involving the victim, possible precipitating factors, recommendations for changes in policy, training, physical plant, medical or mental health services, and/or operational procedures. Seven youth records were reviewed and six were applicable for suicide risk procedures while at the center. Each documented an alert initiated in the Department's Juvenile Justice Information System (JJIS), suicide risk assessment referral made, and an Assessment of Suicide Risk (ASR) completed and documented in real time. Each reviewed precautionary observation (PO) log included documentation of safe housing areas. One record was applicable for parent/guardian notification completed due to youth being released on PO prior to the completion of an ASR and all appropriate documentation was present. A review of five ASRs showed documented consultation with designated mental health clinician authority (DMHCA) and superintendent or designee's immediate notification of suicide risk. Each reviewed ASR was completed within twenty-four hours and documented a conference held prior to changing supervision level.

Reviewed records showed four youth were stepped to standard supervision, and one was stepped to close supervision following the ASR completion. Four ASR's documented completion by non-licensed staff who received ASR training and were signed by the licensed DMHCA within twenty-four hours. One ASR was completed by the DMHCA. Each reviewed ASR result included recommendations for supervision and follow up. Results or outcomes of each ASR's noted change of supervision level were included in the center's logbook for each of the five ASR's completed. All five JJIS alerts were removed when youth's supervision level was down-graded. No reviewed records were applicable for secure observation. An interview with the assistant superintendent, and review of a provided sample, showed the center's practice is to complete health status checklists prior to youth placement in secure observation. No records were applicable for parent/guardian notification of suicide risk based on the ASR results. The center has a procedure in place to notify the juvenile probation officer (JPO) and parent/guardian of suicide risk as indicated by the ASR. Two additional youth records reviewed showed the completion of crisis assessments where an ASR was warranted. One record documented a mental health referral entered into JJIS June 24, 2018 by the center's mental health staff stating, "Youth made statements to mental health indicating he had thoughts of self-harm. Youth denies current intent and/or plan. Mental health will follow up with youth within twenty-four hours". No alert was initiated. The youth was not placed on suicide risk and a crisis assessment was completed the following day with a recommendation for standard supervision. The second record reflected a crisis assessment was completed on April 1, 2018 due to "Youth presents quiet and isolates from other youth. Youth's JPO reported this youth parents/guardians reported possible suicidal ideation prior to admission". No alert was initiated, and a crisis assessment was completed. An interview with the DMHCA reported an ASR was completed a few days prior. The center's policy states if the youth's behavior or statements indicate possible suicide risk, the youth must receive an ASR instead of a crisis assessment. An interview with the superintendent reported secure observation is utilized for youth who are on precautionary observation, whose behavior is inappropriate or threatening to the population, and at no time would the center ever place a potentially suicidal youth in a room.

Seven youth were interviewed regarding being placed on suicide precautions while at the center. Six youth reported never being placed on suicide precautions while at the center. The one youth who reported being on suicide precautions stated staff watched them the entire time, while they were on suicide watch.

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

The center maintains a written policy and procedures ensuring the staff assigned to monitor each youth on suicide precautions must maintain one-to-one supervision or constant supervision and document their observations of the youth's behavior on the Department's Suicide Precautions Observation Log. Reviewed Suicide Precaution Observation Logs documented staff observations of youth's behavior, and not to exceed thirty-minute intervals. When warning signs were observed, notification of the center's superintendent designee and mental health clinical staff was observed documented on each Suicide Precaution Observation Log. A review of the Suicide Precaution Observation Logs found they documented safe housing areas, were reviewed and signed by each shift supervisor, and signed by mental health clinical

staff daily. Five youth were interviewed, and each reported never being left alone while on suicide precautions.

| 3.12 Suicide Prevention Training [Detention Staff] (Critical) | Satisfactory Compliance |
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| *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 maintains a written policy and procedures ensuring all staff will receive at least six hours of suicide prevention and implementation of suicide precautions training annually. The mental health clinical staff will assist in training staff on suicide prevention, including verbal and behavioral cues which indicate a suicide risk, throughout the year. A review of the three non-licensed mental health staff records found each had completed more than the minimum six hours of suicide training required. Observations during the center tour validated the contents of the center's two suicide kits included the knife-for-life, wire cutters, and needle nose pliers. The center maintains one suicide response kit in master control and the other in the shift supervisor's office outside of the male living module. Seven staff were interviewed regarding the location of the center's suicide response kit. All seven staff reported the suicide kit was located in master control. Six staff reported a kit was also available in the shift supervisor's office. Five staff also reported a kit was available in the medical office. A review of the center's mock suicide drills showed drills are completed monthly on each shift. Drills are reviewed during shift briefings, at monthly management meetings, during monthly center-wide meetings, and on display and review in the staff break room. Each reviewed mock drill included actions taken by staff, methods for contacting other center staff, and provisions for life saving measures.

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

The center maintains a written policy and procedures ensuring the center responds to youth in crisis in the least restrictive means possible to protect the safety of the youth and others while maintaining control and safety of the center. The center maintains a crisis intervention plan which was revised and approved by the superintendent and designated mental health clinician authority (DMHCA) on August 15, 2018. The crisis intervention plan includes procedures for notification and alert system, means of referral, communication, supervision, and documentation and review. The plan is maintained in the center's medical office, master control, and on the center's computer system, accessible to all staff.

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

The center maintains a written emergency care plan outlining mental health and substance abuse emergency procedures and ensure youth who are believed to be an imminent danger to themselves or others, due to mental illness or substance abuse impairment, receive emergency mental health or substance abuse services. The emergency care plan was revised and approved by the superintendent and designated mental health clinician authority (DMHCA) on August 15, 2018. The plan detailed emergency procedures inclusive of immediate staff response, notification and communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment under Chapter 394 Florida Statute, Baker Act, transportation for emergency mental health evaluation and treatment under Chapter 397 Florida Statute, Marchman Act, return from emergency mental health or substance abuse services, documentation, training and mock drills, and review. The center utilizes New Horizons of the Treasure Coast in Fort Pierce, Florida, for Baker Act crisis stabilization and for Marchman Acts. The plan is maintained in the center's medical office, master control, and on the center's computer system, accessible to all staff.

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

The center maintains a written policy and procedures ensuring the detention center responds to youth in crisis in the least restrictive means possible to protect the safety of the youth and others while maintaining control and safety of the center. One record was applicable for the completion of a crisis assessment where a youth was demonstrating acute psychological distress since the last annual compliance review. The reviewed record contained the reason for assessment, mental status examination and interview, determination of danger to self and/or others, initial clinical impression, supervision recommendations, treatment recommendations, and recommendations for follow-up or further evaluation. The notification to parent/guardian was not applicable due to the youth being eighteen years old. The Department's Juvenile Justice Information System (JJIS) was updated with the applicable alert. The completed crisis assessment was reviewed and electronically signed by the superintendent or designee. The crisis assessment recommendation was for close supervision. The record showed a follow-up mental status examination was completed by the licensed mental health staff prior to placing the youth on standard supervision.

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

The center maintains a written policy and procedures ensuring staff must immediately respond to youth presenting an imminent danger to self or others, due to mental illness or substance abuse impairment, to protect the youth and others from harm. An interview conducted with the designated mental health authority clinician authority (DMHCA) indicated the center had one applicable youth requiring Baker Act procedures since the last annual compliance review. The youth was transported by detention staff to the Baker Act receiving facility with the Certificate of Professional Initiating Involuntary Examination completed by the DMHCA. The DMHCA completed the required form and proceeded to send the youth to New Horizons of the Treasure Coast in Fort Pierce, Florida. Documentation reflected the youth was on precautionary observation prior to and following the Baker Act. A mental status examination, assessment, and conference were held prior to the discontinuation of suicide precautions, as required. The center's superintendent designee called the incident into the Department's Central Communications Center and the event was non-reportable. There was no documentation to support the center completed an incident report regarding the reviewed Baker Act. No records were applicable for Marchman Act proceedings since the last annual compliance review.

# Standard 4: Health Services

## Overview

St. Lucie Regional Juvenile Detention Center's healthcare services are provided through a contract with Maxim Healthcare Services Inc., which stipulates a State of Florida licensed physician is to serve as the center's designated health authority (DHA). The DHA is responsible for overall medical services, including the review and approval of the center's operating procedures and protocols. The DHA is required to be on-site one and one-half hours a week. Maxim Healthcare Services, Inc. provides on-call services twenty-four hours a day, seven days a week. The contract also provides for an advanced registered nurse practitioner (ARNP) to be on-site at least five hours a week, a full-time registered nurse (RN), a full-time licensed practical nurse (LPN), and a full-time records clerk. At the time of the annual compliance review, the records clerk position was vacant. The center's medical clinic maintains nursing coverage Monday through Friday, from 7:00 a.m. through 8:30 p.m., and on weekends, from 7:30 a.m. through 4:00 p.m. Medications are procured though Diamond Pharmacy Services. In emergent cases, medications may be obtained through the local Jackson Pharmacy. The center holds a current Modified Class II Institutional Pharmacy Permit. The St. Lucie County Health Department provides testing for sexually transmitted infections and on-site human immunodeficiency virus (HIV) testing. HIV pre-test and post-test counseling was provided by the former medical records clerk, who was certified as a HIV counselor, and is currently provided by the St. Lucie County Health Department.

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

The center maintains an executed contract for medical services with Maxim Healthcare Services, Inc. whose licensed physician completed specialized training in pediatrics and serves as the center's designated health authority (DHA). Additionally, the center has a licensed advanced registered nurse practitioner (ARNP), who had current collaborative practice protocols. The protocols were signed and approved by the DHA on September 6, 2017. The DHA is available twenty-four hours a day, seven days a week by telephone and electronic mail. The DHA is responsible for the center's overall medical services, review and approval of facility operating procedures, and nursing and non-healthcare staff protocols. Maxim arranges for alternate coverage when the DHA is on vacation or is on scheduled leave from the center. Reviewed sign-in logs for the six months prior to the annual compliance review, as well as interviews with the DHA and ARNP, confirmed this practice. The contract requires the DHA to be on-site for a minimum of one and one-half hours a week. However, while providing coverage for the DHA who was on vacation, the covering physician was on-site on July 4, 2018 for only one hour and on July 11, 2018 for only one hour. The DHA is generally on-site at least once a week for two hours, as evidenced by the center's sign-in logs. Additional documentation showed neither the DHA or any other doctor signed into the center during the week of July 15, 2018 through July 21, 2018. The healthcare staff explained the doctor had a schedule conflict with his outside practice during the week.

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

The center maintains a written health-related facility operating procedures (FOP) and protocols. All health related FOPs were last revised and signed by the designated health authority (DHA) and the detention center superintendent on August 15, 2018. Reviewed healthcare documentation reflected the current DHA signed and approved protocols for the advanced registered nurse practitioner (ARNP), nursing staff, and non-healthcare staff on September 5, 2018. Each nurse acknowledged their review of the center's medical policies by their signature on August 15, 2018. The center did not hire or contract for any new healthcare staff since the last annual compliance review. The center includes a pro re nata (PRN) licensed practical nurse (LPN) on the staff roster as a current contracted medical staff. An interview with the center's assistant superintendent and the registered nurse, revealed the PRN nurse has not worked in the center since the last annual compliance review; therefore, has not signed the current nursing protocols.

| 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 maintains a written policy and procedures regarding the authorization of treatment for all youth. Seven Individual Health Care Records (IHCR) were reviewed for the Authority for Evaluation and Treatment (AET) forms. Seven IHCRs included original current signed AETs. Six AETs were signed by the parent/guardian and one was signed by a youth who is eighteen years of age.

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

The center maintains a written policy and procedures to inform the parent/guardian of significant changes in the youth's condition and obtain consent when new medications and treatments are prescribed. Seven reviewed Individual Health Care Records (IHCR) revealed two were applicable for requiring parental notification. An interview with the center's healthcare staff revealed there were no other records applicable for requiring parental notification. One IHCR was applicable for parental notification related to a decrease in medication dosage, and the second was applicable for notification related to over-the-counter medications not covered by the Authority for Evaluation and Treatment (AET) form, due to the prescription of a new medication, and the provision of off-site, non-routine dental care. In each instance, documentation indicated the parent/guardian was notified either by way of telephone or certified letter. Mail receipts and notices were maintained in each youth's respective records.

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

Seven reviewed Individual Health Care Records (IHCR) revealed one was applicable for a youth admitted to the center while receiving prescribed psychotropic medication requiring parent/guardian notification to obtain consent for the prescription of a new psychotropic medication, or the discontinuance or adjustment of the psychotropic medication. The center's operating procedure and nursing protocols require the use of the Clinical Psychotropic Progress Note (CPPN) form as part of the parental notification. Reviewed documentation validated a parental notification was made by way of postal mail, utilizing the Acknowledgement of Receipt of CPPN form, in the single applicable instance when the psychotropic medication dosage was changed. An interview with the healthcare staff indicated it is the contracted psychiatrist's practice not to initiate psychotropic medications at the center due to the youth's limited length of stay in the center. Two additional IHCRs were requested for review to meet the minimum required sample size. However, the healthcare staff indicated the center did not have any additional records applicable for requiring the use of the Clinical Psychotropic Progress Note (CPPN) form in the past year.

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

The center maintains a written policy and procedures to obtain each youth's immunization history, status, and verify them to meet state and Department requirements. Review of seven Individual Health Care Records (IHCR) confirmed each youth's immunization history and status was verified as up-to-date. The center's practice is to use the Florida Shots electronic database in conjunction with records from the St. Lucie County Health Department, to obtain immunization records. Immunization records are then printed and maintained in the respective youth's IHCR. The center did not have any instances of a parent/guardian not consenting to necessary vaccines, due to medical or religious reasons, since the last annual compliance review. The center does not administer vaccines on-site. When necessary, youth are referred to the St. Lucie County Health Department or their primary healthcare physician for vaccines.

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

The center maintains a written policy and procedures to ensure youth are screened upon admission and readmission for healthcare concerns which may require a referral for further assessments by healthcare staff. An interview with the center superintendent indicated it is the center's practice for the intake officer to conduct the entry screening to determine whether the youth has any health concerns at the time of admission and the youth is seen by the licensed

nurse within twenty-four hours of admission. Seven Individual Health Care Records (IHCR) were reviewed for healthcare admission screening. Each IHCR reviewed included documentation to support youth were screened for medical and mental health concerns upon admission. Each healthcare admission screening was conducted by a juvenile justice detention officer (JJDO) and was reviewed by a licensed registered nurse (RN) within twenty-four hours of each youth's admission. Each completed Admission Wizard in the Department's Juvenile Justice Information System (JJIS) documented the practice.

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

The center maintains a written policy and procedures to alert staff of medical issues which may affect the security and safety of the youth in the center. The center utilizes the Department's Juvenile Justice Information System (JJIS) Facility Management System (FMS) to document medical alerts. An interview with the center superintendent and reviewed documentation indicated the center's practice is for the juvenile justice detention officer (JJDO) to enter youth alerts during intake and all youth with chronic conditions are to be placed on the alert list in JJIS. An interview with the center's nursing staff and reviewed documentation validated it is the center's practice to review the medical and mental health screening to verify the alert list daily to ensure its accuracy. Reviewed documentation validated the center utilizes the JJIS alert system as their internal medical alert system. The alerts include each youth's name, Department identification number, alert type, alert notes, and the start and end dates of the alert. Seven center staff were interviewed, and all indicated they receive youth alert information by utilizing the alert report. Five staff additionally stated they learn of youth alerts during the shift briefings. Three staff also use the alert board in master control, and two also review the alert information in the center's logbook. A review of seven Individual Health Care Records (IHCR) revealed five were applicable for medical alerts. A comparison of JJIS alerts with the IHCRs validated two of the five youth were identified with the appropriate medical alerts entered into the system. However, three youth applicable for medical alerts did not have their alerts included in JJIS. The alerts omitted from JJIS were related to notations on the medical and mental health admission screening. One youth was missing alerts for an allergy to peanuts and chocolate, as well as a recent head injury inclusive of stiches. Two youth were missing an alert for medication side effects for their prescribed medication. In reviewing the printed daily alerts, it was observed four youth currently in population had open alerts which included specific diagnosis information, which is not allowed by the Health Insurance Portability and Accountability Act of 1996 (HIPPA). An additional alert, created by another center prior to the youth's arrival at the center, also included a specific medical diagnosis. An interview with Maxim staff indicated their reluctance to close or update alerts created previously by other detention centers. An interview with the Department's Office of Health Services staff, indicated the alerts should have been updated to remove the diagnosis or closed. If the alert is still applicable to the youth, a new appropriate alert without mention of diagnosis should have been opened in its place. Seven records were reviewed and four were applicable for youth placed on medical grade three through five. None of the four youth records showed an alert placed for elevated medical grade status.

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

The center maintains a written policy and procedures to ensure a Suicide Risk Screening Instrument (SRSI) is completed for each youth within twenty-four hours of admission and filed in the youth's Individual Health Care Records (IHCR). Seven reviewed IHCR revealed each youth had a current SRSI completed during the youth admission process. Each SRSI was completed within twenty-four hours of admission. All seven were completed by mental health staff under the supervision of a licensed mental health clinician. Each SRSI was maintained in the youth's mental health record.

| 4.10 Youth Orientation to Healthcare Services [Contract Provider] | Satisfactory Compliance |
|---|---|
| *All youth are to be oriented to the general process of healthcare delivery services at the facility.* | |

The center maintains a written policy and procedures to ensure each youth admitted to the center receives a healthcare orientation within twenty-four hours of admission. A review of seven Individual Health Care Records (IHCR) revealed each youth was oriented to the center's healthcare services and was provided a youth orientation packet. Each packet was inclusive of all required elements and orientation occurred within twenty-four hours of admission into the center. Each youth signed and dated the bottom of each orientation page and the signed pages were maintained in the center's medical services access binder.

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

The center maintains a written policy and procedures requiring the designated health authority (DHA) to be notified immediately when an admitted youth requires emergency medical care. A review of seven Individual Health Care Records (IHCR) revealed none were applicable for admission requiring emergency care. An interview with the healthcare staff revealed there were no youth admitted to the center requiring emergency care since the last annual compliance review. Seven records were reviewed and four were identified as youth having a chronic condition. One youth was also applicable for admission while prescribed psychotropic medication. The center's practice is to document the notification to the DHA in a DHA notification binder. Four reviewed IHCRs identified the youth as having a chronic condition which requires notification to the DHA within twelve hours of admission, but no later than noon on the day following admission. The reviewed documentation indicated the DHA was notified outside of the required time frames in three of the four applicable youth admissions. Additionally, notification to the DHA for the one youth admitted while prescribed psychotropic medication did not occur within twenty-four hours of admission as required by Rule 63M, Florida Administrative Code.

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

The center had a policy and procedures in place to address the completion of a new detention medical and mental health admission screening form, upon a youth's return or re-admission to the center. A review of seven Individual Health Care Records (IHCR) revealed none were applicable for rescreening after a change in physical custody after admission to the center. Three additional IHCRs were requested in order to achieve the minimum required sample size. However, the center had no youth with a loss of custody since the last annual compliance review. The center did have one youth who was Baker Acted after admission to the center. However, the center released the youth upon his transfer to the Baker Act facility.

| 4.13 Health-Related History [Contract Provider] | Satisfactory Compliance |
|---|---|
| *The standard Department Health-Related History (HRH) form shall be completed for all youth admitted into the physical custody of a DJJ facility.* | |

The center maintains a written policy and procedures ensuring the Health-Related History (HRH) is completed by nursing staff, no later than seven calendar days following the date of admission for each youth. A review of seven Individual Health Care Records (IHCR) revealed six included a new HRH and one included an updated HRH. Each was completed by a licensed nurse within seven days of admission. All seven HRHs were reviewed and signed by either the designated health authority (DHA) or the advanced registered nurse practitioner (ARNP) prior to or at the same time the Comprehensive Physical Assessment (CPA) was completed.

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

The center maintains a written policy and procedures regarding the completion of the Comprehensive Physical Assessment (CPA) for each youth admitted into the center. A review of seven Individual Health Care Records (IHCR) verified each included a current CPA completed within seven calendar days of admission. All reviewed CPAs were fully completed and clearly reflected each youth's assessed medical grade. Each was signed by the designated health authority (DHA) or the advanced registered nurse practitioner (ARNP). One youth signed the CPA acknowledging his refusal of a portion of the examination. "Deferred by medical doctor (MD)" or "Deferred to primary care physician (PCP)" was clearly indicated on all seven reviewed CPAs. The Department's Problem List was observed to be updated, as required, in each of the reviewed IHCR.

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

The center has a written policy and procedures addressing the completion of gender-specific screening. Two of seven reviewed Individual Health Care Records (IHCR) were applicable for gender-specific screening and examination. Therefore, one additional applicable IHCR was requested and reviewed in order to achieve the minimum required sample size. Females admitted to the center requesting a gynecological examination are referred to the female ARNP and/or off-site to the county health department. Documentation revealed the three applicable youth each received a qualitative urine pregnancy screening after providing a verbal consent. Two of the three applicable youth consented for gynecological examination or service and received services at the county health department. There were eight female youth on-site at the time of the annual compliance review and two female youth were interviewed. Both youth reported not needing or wanting gynecological services.

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

The center maintains a written policy and procedures outlining all youth are required to be screened for tuberculosis (TB). Seven Individual Health Care Records (IHCR) were reviewed. Five IHCRs included at least one verified tuberculosis screening documented on the infectious and Communicable Diseases Form and the Comprehensive Physical Assessment (CPA). Documentation confirmed the two remaining youth were each provided a Tier I Tuberculosis (TB) screening within seventy-two hours of admission. Each reviewed medical progress note, detention Admission Wizard documentation, and Comprehensive Physical Assessment (CPA), reflected neither of the screened youth required further assessment. All tests results were maintained in the IHCR.

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

The center maintains a written policy and procedures regarding the completion of the sexually transmitted infection (STI) screening. A review of seven Individual Health Care Record (IHCR) reflected three applicable youth were screened by the advanced registered nurse practitioner (ARNP) for sexually transmitted infections (STI). The screening results were documented on the Department's Infectious and Communicable Disease (ICD) form. Reviewed documentation supported no youth were out of the Department's custody for thirty or more days and subsequently, no rescreening's were required.

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

The center maintains a written policy and procedures to ensure each youth admitted to the detention center has the opportunity for education, prevention, and treatment of the human immunodeficiency virus (HIV). Each youth is offered pre-test and post-test counseling in addition to the testing for the presence of HIV. Seven youth were interviewed and all seven reported being able to request a HIV test. The center's current practice is for youth consenting to HIV testing to be referred for testing on-site at the center by the county health department. An interview with the center's registered nurse (RN) indicated the local Health Department comes on-site monthly to conduct HIV testing. Consent forms maintained in seven Individual Health Care Records (IHCR) reflected only two youth requested testing for HIV and four declined consent for HIV testing. The record for one youth included an HIV consent form which the youth signed but did not complete to indicate whether he consented or declined consent for testing. An interview with the youth clarified the youth wished to be tested for HIV at the time of his admission and still wished to be tested. However, the youth had not yet been tested at the time of the annual compliance review. Therefore, an additional record for a youth applicable for consenting to HIV testing was requested to achieve the minimum required sample size. The record for a pregnant youth documented she declined consent for HIV testing at the center as she wanted to have the testing completed by her own obstetrician during her scheduled off-site care visit. An interview with the healthcare staff revealed the youth completed HIV testing off-site; however, a copy of the consent for testing completed by the outside provider was not included in the youth's IHCR as required. Healthcare staff reported they would obtain a copy of the consent for testing from the youth's obstetrician and would enter information into the youth's health education record to reflect no pre-test counseling was provided to the youth at the center on August 22, 2018. The reviewed records for four youth who declined consent for HIV testing also documented completion of HIV pre-test counseling on their dates of admission. However, none of the four records documented post-test counseling or confidential test results. An interview with the healthcare staff clarified it is the center's practice, at the direction of the health department, to notate completion of HIV pre-test counseling on each youth's health education record on each youth's date of admission. The interview with the registered nurse also indicated pre-counseling testing was provided at the center; however, it was not provided by the health department, but rather by the medical clerk, who was certified to do so, prior to her departure from the position on August 27, 2018. The Department's Office of Health Services was interviewed regarding the local health department education offered at the program. It was explained the local health department was conducting general sexually transmitted infection (STI) education in a group setting, not individual HIV pre-test and post-test counseling with each youth. Rule 63M-2.052 stipulates HIV test results must be sealed in an envelope marked "confidential" and filed in the IHCR. The IHCRs for all three youth tested for HIV included test results which were not sealed in an envelope. All three youth healthcare records documented the youth's HIV test results in a non-confidential manner on the Department's Infectious and Communicable Disease form (HS018). Dates of HIV testing and results were indicated by the center's registered nurse on the Infectious and Communicable Disease Forms (HS018). The three reviewed records reflected testing was completed on March 26, June 15, and August 21, 2018. One of the records also documented the youth's HIV test results in the chronological progress notes and also contained an unsealed peel and stick envelope marked "confidential".

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

The center maintains a written policy and procedures, approved nursing protocols, and non-healthcare protocols for the provision of sick call. Each youth is oriented to the sick call process during their admission to the center. Sick call requests are initiated when a youth notifies the juvenile justice detention officer (JJDO) of a medical complaint. The JJDO is to enter the information into the Department's Juvenile Justice Information System (JJIS) Facility Management System, which electronically alerts the nursing staff of the youth's sick call request. A review of seven Individual Health Care Records (IHRC) indicated four youth submitted a total of nine sick call requests. Each sick call request documented the youth was seen by the nurse either the same day their request was made, or within twenty-four hours of the request. Seven youth were interviewed, and each reported they can be seen by a nurse either immediately after a sick call request was made or within twenty-four hours of the request. Four of the interviewed youth had submitted sick call requests and each confirmed the nurse conducts sick call. One youth presented with the same complaint three or more times in a two-week period and the healthcare staff preemptively referred the youth to the advanced registered nurse practitioner (ARNP) after only his second complaint of a toothache. There were no instances in which the ARNP could not determine the nature and/or severity of the youth's medical condition. Seven youth were interviewed regarding the medical care provided at the center and two youth indicated they had not received medical services at the center. Two youth rated the medical services received as very good, one rated the services as fair, and two rated the medical care as poor. Neither youth provided any explanation as to why they rated the medical services as poor.

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

The center maintains a policy and procedures to ensure all youth have access to regularly scheduled hours for sick call care. A review of seven youth records reflected four youth had submitted a total of ten sick call requests. In each instance, when a youth was seen by the licensed practical nurse (LPN), the records included documentation to reflect the Individual Health Care Records (IHCR) were subsequently reviewed by a registered nurse. The sick call forms recorded vital sign information, the treatment administered, and any necessary follow-up care. Upon completion of the medical visit, the Sick Call Index was updated in eight of ten instances, as required. The center's practice is to document each youth's sick call on the hand written Sick Call Referral Log and have the youth initial the log upon arrival at sick call. Documentation revealed eight of ten sick call requests were included on the sick call log and the youth initialed the sick call log in five of the ten reviewed instances. Seven interviewed youth reported being seen by medical staff either immediately or within twenty-four hours, after submitting a sick call request. Sick call was observed during the annual compliance review week, which confirmed the center's practice of seeing the youth privately in the medical clinic, having the youth identify himself and initial the sick call log. The youth was examined by the registered nurse and treatment was provided while a detention officer stood just outside the medical clinic door. The hours posted on the medical clinic door indicate sick call is held from 9:00 a.m. to 11:00 a.m. Monday through Sunday, as well as 4:00 p.m. to 5:00 p.m. Monday through Friday. However, the center's posted activity schedule indicated the hours for sick call

were from 7:00 a.m. to 7:55 a.m. and there were no afternoon sick call hours included. The activity schedule was revised during the annual compliance review to reflect the correct morning sick call hours as well as the afternoon sick call on weekdays and the revised schedule was posted throughout the center. Seven youth were interviewed with four youth indicating the nurse conducts sick call while the remaining three youth reported they had not submitted a sick call request.

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

The center maintains a written policy and procedures ensuring all youth in the program will be able to access healthcare staff while in restricted housing/confinement. Since the last annual compliance review, the center had thirty-five instances of youth who remained in restricted housing/confinement for more than twenty-four hours and 445 instances of youth who remained in restricted housing/confinement for less than twenty-four hours. The center had one youth placed in restricted housing on two occasions for medical issues since the last annual compliance review. Nursing staff are required by policy to make a daily visit to youth in confinement and document the visit for each youth in the chronological progress notes of the Individual Health Care Record (IHCR). An interview with the center's registered nurse explained the center's practice is to visit youth in confinement once during each shift, which she usually does upon her arrival to the center each morning. Additionally, the visits are documented in the confinement report in the Department's Juvenile Justice Information System (JJIS) Facility Management System (FMS). The facility medical services policy for restrictive housing within the youth orientation and access to healthcare services requires nursing staff to make a daily visit to youth in restricted housing/confinement. Seven records for confinements over twenty-four hours were randomly selected for review. Each of the seven reviewed confinements ranged in length from fifty-eight hours to seventy-one hours. Five of seven confinement reports failed to document any visit by healthcare staff to the youth over the course of their confinement. One youth was visited by the licensed practical nurse (LPN) twice during the youth's fifty-eight hour, twelve-minute stay in confinement. Another youth was seen by the licensed practical nurse (LPN) in the medical clinic once during the youth's seventy-one-hour, thirty-five-minute stay in confinement. None of the reviewed confinements had youth requiring administration of prescribed medication during their confinement. The youth were placed in restrictive housing for confinement purposes. None of the youth were on prescribed medication at the time they were confined. One youth was on pro re nata (PRN) inhaler for asthma.

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

The center maintains a policy and procedures regarding the practice of episodic first aid, inclusive of emergency situations. Seven Individual Health Care Records (IHCR) were reviewed and three were found to be applicable for youth requiring episodic care. Each of the applicable instances had healthcare provided by nursing staff who documented the date, time, nature of the injury, and treatment rendered. In one of the three instances, the youth was referred for off-site care and received instructions and plans for follow-up care. The center also maintains procedures to ensure first aid kits and supplies are approved by the designated health authority (DHA). Each first aid kit is inspected monthly, replenished by the registered nurse at least monthly, and each time a first aid kit is opened the snap tag seal is broken. Stocking of each

first aid kit is documented on the inventory sheet attached to the kit. Nineteen first aid kits, sealed with secure snap tags, are strategically located throughout the center, and kits are checked out to each vehicle when staff transport youth. Inspection of first aid kit contents indicated the attached inventory sheets listed all items contained within. The center does not store any first aid kits in vehicles to avoid deteriorating first aid kit items when exposed to heat. First aid kit checklists documented the monthly inspection of each of the center's nineteen first aid kits were completed each month since the last annual compliance review, with the exception of three first aid kits which did not have a documented inspection in the month of August 2018.

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

The center maintains a written policy and procedures for the provision of emergency care. Reviewed staff training documentation confirmed staff are certified in first aid and basic cardiopulmonary resuscitation (CPR) with automated external defibrillator (AED). The center maintains two AEDs, one in master control and one in the medical office. Inspection of the batteries and pads on each AED confirmed they were all current. The batteries in both machines expire in August 2020 and the pads in both machines expire in March 2020. Reviewed records revealed both the batteries and pads were replaced on August 20, 2018. The machine was powered on and off by the nurse during the annual compliance review. The center conducts monthly medical drills, on all three shifts, and the medical drills were documented in the center's master control logbook. The drills varied from situation to situation while recording the date, time of drill, persons involved, nature of the emergency, duration of event, and type of equipment used. Drill documentation noted the use of an AED as part of the drill at least once each quarter on each shift. The center had a list of emergency contact information posted for ready access to all staff, which was observed during the tour of the center during this annual compliance review. Training records reflected non-healthcare supervisory staff have up-to-date training for the use of EpiPen Auto-Injector, which was provided by the center's registered nurse. Seven staff were interviewed, and each confirmed they are able to call 9-1-1 if it is necessary.

| **4.24 Off-Site Care/Referrals [Contract Provider]** | **Satisfactory Compliance** |
|---|---|
| *The facility shall provide for timely referrals and coordination of medical services to an off-site healthcare provider (emergent and non-emergent), and document such services, as required by the Department.* | |

The center maintains a written policy and procedures to provide timely referrals and coordination of medical services for youth requiring off-site care. Reviewed documentation confirmed the center provides for timely referrals and coordination of off-site healthcare medical services. A review of seven Individual Health Care Records (IHCR) found three were applicable for receipt of off-site medical care. The medical staff maintains an episodic care log. The three reviewed instances of off-site care were not included on the log as each was a pre-scheduled medical appointment which were not emergent in nature. The Department's Summary of Off-Site Care Consultation form was completed, as required, for each instance. Each of the three Off-Site Care Consultation forms was placed in the respective youth's IHCR, along with the medical facility's discharge and follow-up documentation. A review of each youth's medical progress notes reflected the medical staff were monitoring the youth's condition and provided follow-up care, as needed. The designated health authority (DHA) was informed and reviewed

the medical facility's discharge paperwork. One of the three applicable youth required a follow-up off-site appointment and the IHCR documented referrals were tracked, and the youth received appropriate, timely follow-up care. Seven interviewed youth reported being able to see the doctor when needed. Parental notification for off-site care was required and documented for only one of the three applicable parents/guardians as one youth was age eighteen, and the other received off-site care at an appointment scheduled by the parent/guardian.

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

The center maintains a written policy and procedures for the provision of treatment for youth identified as having a chronic medical condition. Seven Individual Health Care Records (IHCR) were reviewed and four were found to be applicable as youth identified with a chronic medical condition and/or taking prescribed medications. All five youth were assigned a medical grade two or higher. Four of the five youth identified with a chronic condition or receiving prescription medication were listed on the center's internal alert system. Each applicable youth was screened during the admission process for any medical condition requiring periodic evaluations and follow-up care, which was documented in the progress notes. The youth's medical progress notes reflected each youth was medically evaluated and procedures were in place for those youth detained longer than thirty days to receive periodic evaluations.

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

The center maintains a written policy and procedures to ensure prescribed medication is accepted only from a licensed pharmacy. Seven reviewed Individual Health Care Records (IHCR) indicated four youth were prescribed medication at the time of their admission to the detention center. Reviewed documentation supported the medication was verified by the medical staff, an order was obtained from the designated health authority (DHA) and each youth continued their medications. The center maintains a written policy and procedures for non-healthcare staff to verify medications for admitted youth with medication in the absence of a licensed nurse.

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

The center maintains a written policy and procedures ensuring all medications prescribed for youth have a current, valid order and are given pursuant to a current prescription or practitioner order. Reviewed documentation indicated youth who were admitted to the center while taking prescribed medication were continued on their medication, once each prescription was verified, the designated health authority (DHA) or psychiatrist was notified, and an order provided by the DHA or psychiatrist for the medication to be continued. When a youth is admitted while taking psychotropic medications, the psychiatrist orders the youth to continue the medication regimen, pending a psychiatric evaluation. The Individual Health Care Records (IHCR) of four youth admitted while taking medication validated each youth was continued on their prescribed

medication by a physician's order. A review of the initial Medication Administration Record (MAR) for each youth also supported the continuation of the youth's medications. One of the seven reviewed youth was prescribed a new pro re nata (PRN) medication by the DHA subsequent to their admission, which also matched the youth's MAR.

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

The center maintains a written policy and procedures ensuring all medication is stored and secured in designated areas in compliance with federal, state and industry standards. The medical clinic was observed and found to be well organized, with no loose equipment or unsecured medication. All medication was properly stored in and neatly organized and secured cabinets or the locked medication cart. The medical clinic maintains a locked refrigerator exclusively for medications requiring refrigeration. The center does not store any over-the counter (OTC) medications in any location other than the medical clinic. Non-healthcare staff have limited access to medication and only have access when trained licensed medical staff are not on-site. The center maintains a written policy and procedures for the destruction and disposal of expired or discontinued medications, which are disposed of by the registered consultant pharmacist on-site each month utilizing Rx Destroyer™ medication disposal product.

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

The center maintains a written policy and procedures requiring the storage of discarded needles, syringes or any device capable of puncturing or lacerating the skin in puncture-resistant red bio-hazardous containers located in the medical clinic. Written policy and procedures also stipulate the medical unit's responsibility for sealing, labeling and disposal of any bio-hazardous materials. The center maintains an inventory for all medications and medical equipment classified as sharps. Reviewed documentation revealed the inventories were conducted, as required. The center maintains perpetual inventories for over-the-counter (OTC) medications as well. A sample review of inventories for OTC medications, prescribed medications, and sharps validated the reviewed inventories were accurate. An interview with the registered nurse validated the center had a method for detecting and responding to any inventory discrepancies.

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

The center maintains a written policy and procedures requiring storage of all controlled substances in a secure storage area, in a locked box, in the locked medication cart, and behind the locked door of the medical clinic when the clinic is not staffed. The center conducts shift-to-shift inventories for controlled substances. The controlled substances are procured through a state contracted pharmacy, with an alternate local pharmacy used in the case of emergency. At the time of the annual compliance review, there were two youth prescribed a controlled medication. Documentation showed a third shift to first shift count of controlled medications is

conducted by the registered nurse with the off-going shift supervisor each day prior to the beginning of morning medication pass.

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

The center maintains a written policy and procedures ensuring a Medication Administration Record (MAR) is maintained for each youth who has a current, valid medication order. The center utilizes the Department's MAR to record medication administration to youth. Seven Individual Health Care Records (IHCR) were reviewed and five were applicable for medications. Each reviewed MAR included the youth's name, Department identification number, date of birth, medical grade, dosage of the medication, possible side effect information, and dates the medication was initiated and discontinuation. A small photograph of each youth is printed on the top of each MAR and the center additionally maintains a larger photograph of each youth on top of each youth's MAR forms in the current MAR binder for ease of identification. Each youth and staff administering the medication both initialed the MAR to document when medication was administered.

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

The center maintains a written policy and procedures outlining the method for the safe administration of medications. During healthcare staff hours, medications are administered by licensed healthcare staff. The medication administration process by licensed healthcare staff was observed during the annual compliance review. The applicable youth were brought to the clinic by a juvenile justice detention officer (JJDO) for the administration of medication. The nurse administered the medication in an organized process while the JJDO maintained supervision of the youth by standing just outside the medical clinic in the hallway. The medical working space was observed clean and organized, with all medical equipment and medication secured. The medication pass process was observed in the center's clinic. Each youth was called one at a time, by name, to the medical cart, which was placed in the doorway to the medical clinic. Observation was made of one medication pass during which the youth was not asked to state their name; however, the nurse utilized the photograph of each youth on the MAR to confirm each youth's identity. During the observed medication pass, the nurse did not verbally verify each youth's name, date of birth, or ask each youth for the name of the medication they were prescribed. Observations showed the nurse did not question any youth as to the relevant side effects and/or allergies. The nurse stated she verified the five rights of medication administration using each youth's Medication Administration Record (MAR). The medication was provided to the youth and the nurse confirmed the youth swallowed the medication by inspecting the youth's open mouth. The nurse and the youth both initialed the MAR. One youth was observed refusing medication and the refusal was documented on the MAR. At the completion of medication pass, an informal interview with each of the two youth was conducted. One youth did not know what the three medications were administered to him during the medication pass and the second interviewed youth responded he did not know the potential side effects of his medications. Seven youth were interviewed and two confirmed receiving their medication from a nurse, while five reported not taking medication at the center.

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

The center maintains a written policy and procedures outlining the process for non-healthcare staff to assist youth with self-administering oral prescription medications and over-the-counter (OTC) medication, when licensed healthcare staff are not on-site. Shift supervisors, trained by the center's registered nurse, provide oversight of youth taking medication. The center maintains an up-to-date roster of staff authorized to assist youth with the self-administration of medication, which is posted in the medical clinic. Each staff was identified by name and title, and the date each staff was trained was included on the roster. The process for non-licensed healthcare staff assisting in medication administration was not observed during the annual compliance review. A review of medication records revealed the nursing staff administer the majority of medications. According to the healthcare staff, identified detention staff administer medications on the weekends or during overnights as ordered by the physician, when necessary, although no such instances were observed within the reviewed records. One applicable instance of a youth refusing medication was observed and the refusal was documented on the Medication Administration Record (MAR) and initialed by the youth. Seven youth were interviewed and asked to identify all staff who administered medication to them. Two youth reported receiving their medication from the nurse. Five youth reported they did not take medication at the center. None of the seven interviewed staff reported administering medication to youth.

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

The center maintains a written policy and procedures ensuring the monitoring of psychotropic medication and youth safety. Seven reviewed Individual Health Care Records (IHCR) revealed two youth were on prescribed psychotropic medication upon admission. An additional IHCR was requested and reviewed. The medication each youth was receiving prior to admission was continued until the psychiatrist conducted an initial diagnostic psychiatric interview, which was conducted within fourteen days of each applicable youth's admission. Reviewed documentation reflected each youth had a documented psychiatric referral. Youth receiving psychotropic medications receive ongoing medication monitoring every thirty days by the contracted psychiatrist. The interviewed licensed practical nurse (LPN) verified there are no standing orders for psychotropic medications.

| 4.35 Infection Control – Surveillance, Screening, and Management [Contract Provider] | Satisfactory Compliance |
|---|---|
| *The facility shall have implemented Infection Control procedures including prevention, containment, treatment, and reporting requirements related to infectious diseases, as per OSHA federal regulations and the Centers for Disease Control and Prevention (CDC) guidelines.* | |

The center maintains a written policy and procedures stipulating the responsibility of the superintendent for the development of site-specific plan addressing exposure to blood-borne pathogens. The center maintains an infection control plan, which was last updated, reviewed, and signed by the designated health authority (DHA) and the detention center superintendent on July 5, 2018. The plan outlines a process for post-exposure evaluation for staff who experience a needle stick, common infections, food borne illnesses, and other exposure precautions, as required by the Department and the Occupational Safety and Health Administration (OSHA). The center did not experience any contagious disease related incidents requiring notification to the local health department, the Center for Disease Control and Prevention (CDC), and/or to the Department's Central Communications Center (CCC) since the last annual compliance review. Staff are provided a Hepatitis B immunization, at their request. The center maintains protective equipment in each first aid kit, in master control, and the medical clinic for staff use during a possible infectious and/or exposure situation.

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

The center maintains a written policy and procedures for providing infection control education to both youth and staff. Seven Individual Health Care Records (IHCR) were reviewed and each evidenced completion of infection control education within seven days of admission, including hand washing techniques, universal precautions, prevention of and transmission of communicable diseases, vaccinations, and the Center for Disease Control and Prevention (CDC) guidelines for infection control. A review of seven pre-service and seven in-service staff training records, validated each staff completed training on the center's infection control and exposure plan.

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

The center maintains an exposure control plan to address procedures for control, inventory, storage, and disposal of contaminated materials. The center also maintains a written policy and procedures requiring the storage of discarded needles, syringes or any device capable of puncturing or lacerating the skin in puncture-resistant red bio-hazardous containers located in the medical clinic. Written policy and procedures stipulate the medical unit's responsibility for sealing, labeling, and disposal of any bio-hazardous materials. The plan was signed on August 15, 2018, by the detention center superintendent and the designated health authority (DHA). The plan was written in accordance with the Department of Labor and Occupational Safety and Health Administration (OSHA) requirements, to include risk assessment and methods of

compliance. The center has not had any incidents involving a contagious disease requiring the hospitalization or quarantine of at least ten percent of the total population of youth or staff, since the last annual compliance review. A review of seven pre-service and in-service staff training records, validated confirmed each staff received training on the center's exposure control plan.

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

The center maintains a written policy and procedures for providing education and prenatal care for pregnant youth. The center had one pregnant youth in population during this annual compliance review. Documentation reflected prenatal care was initiated upon admission, and the designated health authority (DHA) was notified. The youth was seen, daily, by a licensed medical staff and information is recorded in the medical progress notes. An interview with the registered nurse indicated the center utilizes Florida Community Health Centers, Inc. for provision of obstetrical care for pregnant youth while in the center. The center had seven other pregnant females since the last annual compliance review. None of their records were maintained at the center as they had all been discharged. Two of the seven interviewed youth were female, and both indicated they either did not need or want prenatal, obstetrical or gynecological services at the center.

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

The center maintains a written policy and procedures for providing healthcare education to pregnant youth. The youth are provided with brochure titled, "health pregnancy-pregnancy overview" containing information about each stage of pregnancy and post-pregnancy. The brochure was also inclusive of cautions and hazards on smoking, use of drugs, and sexually transmitted infections. The center had one pregnant female in population during this annual compliance review and her Individual Health Care Records (IHCR) included nursing progress notes to reflect she was seen in the medical clinic daily, where her weight and other vital signs were recorded. The center had seven other pregnant females since the last annual compliance review; however, none of their records were maintained at the center as they had all been discharged. An interview with the center's nursing staff indicated the healthcare records for the seven youth were sent to each youth's residential commitment program.

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

The center maintains a written policy and procedures ensuring all non-healthcare staff involved in the supervision or treatment of pregnant youth shall receive appropriate education. Reviewed staff training records, inclusive of seven pre-service and in-service training records, reflected

each non-healthcare staff completed training on pregnancy for monitoring, observation, and emergency care, which included the signs and symptoms of miscarriage.

# Standard 5: Safety and Security

## Overview

The St. Lucie Regional Juvenile Detention Center provides safety and security for all youth admitted into the center. All activity within the center is documented in the master control logbook. The center also maintains logbooks for each living module. Two-way radios are used to communicate with master control regarding any issues with the center and ensure accurate supervision and head counts of youth. Direct-care staff are responsible for active supervision, custody, and care of the youth. Youth headcounts are conducted at the beginning and end of each shift. These headcounts are documented in the master control logbook and each living module logbook. Detention center keys, including restricted keys, are stored in master control in a locked cabinet and are issued by master control staff. The center maintains a perpetual inventory of maintenance tools, kitchen tools, and chemicals used in the center which are stored in a secure area with no youth access and limited staff access. The center has a total of five vehicles used to transport youth. All vehicles used to transport youth are inspected annually by a certified professional mechanic. All inspected vehicles contained the required safety equipment including an up-to-date fire extinguisher, approved first aid kit, window punch, seatbelt cutter, and operable seatbelts. The center utilized confinement as a temporary response to youth during violent behavior which threatens immediate harm to youth or others. Youth in confinement have no contact with other youth in the center; however, are afforded the same living conditions as those youth in general population. The center has an approved Continuity of Operations Plan (COOP) which outlies the procedures for emergency and safety drills. The center also has procedures in place to address escape situations. A follow-up was conducted during the annual compliance review regarding the Office of the Inspector General's (OIG) center survey completed on March 7, 2018. A review of the OIG identified deficiencies was conducted. There was no graffiti observed in the center, youth rooms were neat and free from debris, and the toilets in module "F" were operable. It is to be noted there are five rooms being used as storage in module "F". The center has a total of fifty-six surveillance cameras. Each camera displayed a clear image, and all were in operation. Observation of the perimeter gate indicated the gap in the gate near the basketball court was corrected. However, it was reported the repair has not been approved by headquarters.

| 5.01 Active Supervision of Youth (Critical) | Satisfactory Compliance |
|---|---|

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

*Youth are in sight of at least one Juvenile Justice Detention Officer (JJDO) at all times (with the exception of sleeping hours or time secured in rooms).*

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

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

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

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

The center maintains a written policy and procedures to ensure youth are actively supervised by staff. Staff communicate by way of two-way radio with master control any issues pertaining to the center and youth supervision. The center utilizes a roster generated in the Department's Juvenile Justice Information System (JJIS) and white erasable board to track the daily census of youth. The census is updated, as needed, when youth are admitted and/or released from the center. The center has a daily, weekend, and holiday schedule. The schedule includes activities which incorporate structured and free time for youth. Observations of the schedules indicated they were posted in each of the living modules. A review of the daily census verified each youth in the center was listed on the census. During the annual compliance review, all staff were aware of the location of youth in their supervision at all times, were in sight and sound of youth, and were responsible for the care of youth. During the annual compliance review, staff were observed supervising youth during transport, school, lunch, line movement, and cleaning detail. Each observation indicated staff were aware of the number of youth being supervised, were in sight and sound of youth, and requested permission from master control prior to any youth movement. Seven staff were interviewed regarding whether or not they thought there were enough staff to provide for the safety and security of the staff and youth at the center. Three staff responded yes and four staff responded no. The staff responding no explained there is a lot of staff shortage at the center, shifts have been short with people leaving, the center is short staffed, and there's no enough male staff. Seven staff were interviewed regarding when the center conducts youth counts. All seven staff reported counts occur at the beginning and ending of each shift. Five staff reported counts occur before and after school and five staff reported counts also occur before and after meals. Seven staff were interviewed regarding steps taken to reconcile incorrect counts. Three staff reported a supervisor would be contacted and physically walk through to recount. One staff reported a supervisor would be notified. Two staff reported all movement would be stopped. Four staff reported when a count could not be reconciled an escape code will be called.

| 5.02 Ten-Minute Checks (Critical) | Satisfactory Compliance |
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| *Staff shall visually observe youth on standard supervision at least every ten minutes while they are in their sleeping quarters, either during sleep time or at other times, such as during an illness or room restriction.*<br><br>*Staff conducts observations in a manner ensuring the safety and security of each youth and documents real-time observation manually or electronically. Documentation must include the actual time of each visual observation and initials of the staff conducting the check; pre-printed times are not acceptable.*<br><br>*There shall be no obstructions (e.g., clothing, memos, pictures) over windows and areas where direct line of sight is needed.*<br><br>*If an officer, in the course of completing visual observation, is unable to see the youth or any part of the youth's body, the officer shall, with the assistance of another officer, open the door to verify the youth's presence.* | |

The center maintains a written policy and procedures to ensure ten-minute checks are conducted when youth are in their rooms for sleeping or other reasons. The center has a total of fifty-six operable cameras with a recording capacity of thirty days. When conducting room checks, staff must pause at the door and look into the room to ensure there are no issues with the youth. The center utilizes Silver Guard which is an electronic system to document room checks. Observation of ten-minute room checks on five different modules, from two different shifts, and six different days and times along with the corresponding ten-minute log indicated checks were being conducted every ten-minutes, or less, and in real time. Staff was observed pausing at each room to observe the youth. Seven staff were interviewed regarding the frequency of room checks for non-suicidal youth. Each of the seven staff reported checks are conducted every ten minutes. An interview with the superintendent reported secure room checks are completed by officers every ten minutes for those youth on standard supervision. The center uses the Silver Guard wand system for night checks and Visual Observation Report (VOR) logs for shift change.

| 5.03 Census, Counts, and Tracking | Satisfactory Compliance |
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*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 maintains a written policy and procedures to ensure headcounts are conducted as required. Staff must know the exact number and location of all youth under their supervision at all times. Census counts are taken, called into master control, and documented in the center's master control and living module logbooks. No youth movement is to be conducted until master control confirms the counts, reconciles the count, and authorizes center activity to resume. A review of the master control logbooks for the past six months verified headcounts are documented at the beginning and end of each shift, following any emergency situations, prior to and after youth movement, whenever a population change occurs, and randomly on each shift. Random interviewed staff, during the annual compliance review, verified they knew how many youth were being supervised without physically conducting a count. Seven staff were interviewed regarding when the center conducts youth counts. All seven staff reported counts occur at the beginning and the ending of each shift. Five staff reported counts occur before and after school and five staff reported counts also occur before and after meals. Staff were also interviewed regarding when the center conducts emergency counts. All seven staff reported an emergency count is conducted when a youth is believed to be missing. Six reported an emergency count is also conducted when visibility is hindered, such as an electrical outage. Five staff also reported an emergency count would be conducted after a major disturbance.

| 5.04 Logbook Maintenance | Satisfactory Compliance |
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*The program maintains a chronological record of events, incidents, and activities in logbooks maintained at master control and in each living area in accordance with Florida Administrative Code. Each logbook is a bound book with numbered pages. If electronic logbook software is used by the facility, it is password-protected and configured to prevent entries from being deleted or altered after they are saved.*

*At a minimum, each logbook entry includes the date and time of the event, the names of staff and youth involved, a brief description of the event, the initials of the person making the entry, and the date and time of the entry. Logbook entries are made in black or blue ink, with no erasures or whiteout areas. No logbook entries are obliterated or removed; errors are struck through with a single line and initialed by the person correcting the error.*

*Log entries regarding Medical, Special Needs, and Mental Health alerts, or other issues impacting facility safety and security shall be highlighted.*

The center maintains a written policy and procedures to ensure the maintenance of logbooks. The center has separate logbooks for master control and each living module. A review of each logbook found they were bound with numbered pages. A review of logbooks for the past six months for each living module and master control verified all entries were legible and written in ink. Entries included the date and time of the event, name of the staff and youth involved, a brief description of the event, initials of the person making the entry, and the date and time of the entry. Observations showed staff were not consistent with correcting errors. Some entries were scratched out, written over, and some were struck through without being initialed. Logbooks showed any medical, special needs, and/or mental health alerts impacting the safety and security of the center are entered and highlighted. Further review of the master control logbooks included documented emergency situations, incidents, fire and escape drills, population counts at the beginning and ending of each shift, group movements, admissions and releases, and presence of law enforcement. Reviewed logbooks also included names of youth placed in confinement or on/off precautionary or secure observation and included start and stop times for each occurrence.

| 5.05 Logbook Reviews | Satisfactory Compliance |
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*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 maintains a written policy and procedures regarding logbook reviews. The superintendent or designee reviews the logbooks on a weekly basis. The juvenile justice detention officer supervisor (JJDOS) reviews the logbooks when the shift is accepted. The juvenile justice detention officer (JJDO) reviews the logbooks each shift to document awareness of current relevant situations in the center. The master control and living unit logbooks for the

past six months were reviewed and verified the JJDOS from each shift documented a review of the master control logbook prior to accepting the shift. A review of the living module logbooks verified the JJDO coming on-duty documents a review of the logbook. An interview with the center's superintendent reported shift supervisors are required to review the logbooks each shift. Additionally, the superintendent or designee is required to review all logbooks weekly and document any discrepancies and/or concerns. A review of the center's logbooks verified the practice.

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

The center maintains a written policy and procedures to maintain and inventory center keys. Center keys are maintained on a tamper-resistant ring with a brass tag identifying the ring number and the number of keys on the ring. Center keys, including restricted keys, are stored in master control in a locked key box accessible by the master control operator, supervisors and administrative staff. Emergency keys providing egress through exterior doors are stored in master control and the supervisor's office. A key inventory is maintained on each center key. The inventory identifies the ring number, number of keys on the ring, the capacity of the keys, and the staff assigned to the keys. Keys are distributed by way of the master control operator. Staff are issued a numbered key peg which identifies what keys they are permitted to possess while on duty. When staff enter the center, personal keys are placed in a locked key box located in the lobby prior to entering the secure area of the center. Staff report to master control and must sign the key logbook with the date, time, staff name and initials of staff issuing the keys. Staff provide the master control operator with their numbered key peg and are issued the corresponding keys associated with the key peg. Reconciliation of keys are also conducted by way of master control. When keys are returned, the time and date is entered by the master control next to the staff name returning the keys. The numbered key peg is returned to the staff. A review of the master inventory key log indicated the inventory log matched the actual key rings in use. Review of the key log indicated keys are distributed, as required by master control; however, documentation showed the maser control operator is not consistently initialing the key log when keys are issued or reconciled. A review of seven staff training records verified each staff received key control training on day two of week one of the detention services phase one training plan. A random interview with three staff, during the annual compliance review, verified they had no personal keys, and youth were not permitted to handle center keys. Each staff was in possession of their assigned center keys. Staff knew what to do if keys were missing or damaged. An interview with the center's superintendent clarified a key log binder is maintained

in the superintendent's office. Every staff person assigned keys must sign acknowledging the key peg was issued. All updates or changes requires the superintendent approval and signature. Seven staff were interviewed regarding restricted keys. All staff reported medical record keys, youth property keys, mental health record keys, case management record keys, and kitchen keys were restricted. Seven staff were interviewed regarding the center's daily process for tracking keys. Seven staff reported center keys are assigned to staff. Six staff reported the center tracks keys daily and the center keeps a key inventory. Two staff reported youth do not have access to keys One staff reported a chit or token is provided to visitors, master control is notified of missing keys, the center is searched for missing keys, and youth are searched for missing keys. The center reported there have been no incidents of lost keys or staff leaving with center keys at the end of their shift in the last six months.

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

The center maintains a written policy and procedures for transportation, operation and maintenance of vehicles which are used to transport youth. The maintenance mechanic is responsible for the weekly and monthly vehicle inspections. The center is currently without a permanent maintenance mechanic and is receiving assistance from the regional maintenance mechanic on an as needed basis. The center has interviewed and attempted to fill the position, but has not found a credible candidate. The transportation supervisor has been designated to complete the vehicle checks. The center has a total of five vehicles used to transport youth. Each vehicle had an annual safety inspection conducted by a certified automobile mechanic. Observation of three vehicles verified each was locked when not in use. All three vehicles have the appropriate number of seat belts, a seat belt cutter, a window punch, up-to-date fire extinguishers, and a first aid kit with approved items. A binder is maintained for each vehicle which contains the vehicle mileage log, mechanical restraint key, gas card, vehicle registration, and vehicle policy. Weekly visual vehicle inspection checks are conducted on each vehicle as required and documented on the preventive maintenance check sheets, but there is no documentation to support if emergency equipment or cleanliness of the vehicle is checked. Monthly vehicle checks are conducted using the combined daily and weekly visual checks sheets, but there is no documentation to support the spare tire, battery test, windshield and wipers, and mirrors are inspected. Prior to each transport, a pre-trip vehicle inspection is conducted by two staff, but there is no documentation to support if the vehicle is searched for contraband, if the vehicle has sufficient fuel, verify if the seatbelts are securely anchored, and if the security screen is secure. An observation of a pre-transport activity verified the vehicle was searched by staff prior to the transport, staff searched the youth prior to placing the youth in the vehicle, staff assisted the youth in securing the seatbelt, and the assigned cellular telephone is charged and turned on prior to departure. A review of the transportation logbooks showed inconsistent documentation of pre and post-trip searches. During the annual compliance review, the center made updates to the weekly, monthly and pre-trip vehicle inspection documents to include the all the required elements.

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

The center maintains a written policy and procedures to ensure all tools and equipment are properly maintained, stored, and inventoried. The center is currently without a permanent maintenance mechanic and is receiving assistance from the regional maintenance mechanic on an as needed basis. The center has interviewed and attempted to fill the position, but has not found a credible candidate. A perpetual tool inventory list is maintained by the center and inventoried monthly. All tools are stored in a locked area when not in use. Tools are maintained on a shadow board and marked with an identification number. Review of the inventory verified there were no missing tools. When tools are in use, a security tool tracking form is used indicating the date the tool is being used, what tools are being used, location of where the tools will be used, tool number, time tool was signed out and in, and the signature of the person using the tool. Any tool in need of disposal or replacement is requested by completing a tool disposal/replacement form which the maintenance mechanic signs and requires approval by the assistant superintendent. An interview with regional maintenance mechanic indicated when items are lost or there is reasonable suspicion a youth may be in possession of a tool, the supervisor is notified immediately, and a search is initiated starting with the last area the tool was used. An interview with the assistant superintendent indicated there have been no instances where a tool has been missing in the past six months. Any repair service personnel are identified prior to entering the center and are accompanied by a designated staff when in the secure area. Youth are removed from the area being serviced and not allowed to re-enter the area until it has been searched and cleared by staff. A review of the tool room indicated tools are maintained behind lock and key outside of the secure area of the center.

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

The center maintains a written policy and procedures for storing kitchen tools. Kitchen knives and other hazardous utensils are stored in a locked storage cart, with an inventory list, located in the food service director's (FSD) office; which is also locked when not occupied. There is one key used by kitchen staff to access the utensils. Observation of the storage cart indicated the tools are shadow marked inside the cart. Review of the inventory list verified all tools listed were contained in the storage cart. Any tool in need of disposal or replacement is requested by completing a kitchen tool disposal/replacement form which the FSD signs and requires approval by the assistant superintendent. If a kitchen tool is missing, the supervisor is notified, and a search of the center is conducted starting with the last place the tool was used. An itemized list of kitchen tools is checked by kitchen staff prior to their daily departure. An interview with the FSD indicated there have been no missing kitchen tools in the past six months.

| 5.10 Youth Access & Use of Tools, Cleaning Items (Critical) | Satisfactory Compliance |
|---|---|
| *Youth are forbidden to use or access any tools, including kitchen or medical equipment.*<br><br>*Youth may use cleaning items such as mops, brooms, buckets, and other common household items under direct supervision.* | |

The center maintains a written policy forbidding youth to use or have access to any tools including kitchen and/or medical equipment. Youth are allowed to use cleaning items such as mops, brooms, buckets, and other common household items for general cleaning. Youth are under strict staff supervision when accessing these items. Observation was conducted of two youth using only mops and buckets during the annual compliance review. Seven youth were interviewed and five indicated they use mops and brooms. Two youth stated they do not use any tools. Seven youth were interviewed and four stated they clean with cleaning agent such as bleach, laundry soap, window or toilet cleaner. Each of the four youth also stated staff spray the chemical and they wipe it up. Three youth stated they do not clean. Seven staff were interviewed, and six stated youth are allowed to use mops, and brooms. One staff stated youth do not use any tools.

| 5.11 Inventory of all Flammable, Toxic, Caustic, and Poisonous Items | Satisfactory Compliance |
|---|---|
| *The Superintendent is responsible for the implementation of a safety plan addressing proper use, storage, and disposal of chemicals, including flammable, toxic, caustic, and poisonous items.*<br><br>*All flammable, toxic, caustic, and poisonous items shall be inventoried and secured when not in use. The use of hazardous material shall be consistent with the manufacturers' instruction and all safety precautions shall be followed.*<br><br>*All flammable, toxic, caustic, and poisonous items shall have the Material Safety Data Sheets (MSDS) on hand in the facility. Toxic or caustic materials shall not be allowed to enter into the facility unless an MSDS is on file in an MSDS logbook and posted near items. A master copy of the MSDS logbook shall be maintained in an accessible binder for all personnel to review at all times.*<br><br>*No hazardous chemicals should be mixed, as this could result in an explosion or emission of toxic gas.* | |

The center maintains a written policy and procedures to ensure the proper inventory of flammable, toxic, caustic, and poisonous items. All items are inventoried weekly and securely stored when not in use. Each item observed had a Safety Data Sheet (SDS) on record for each item stored. Observation of the storage area indicated all items matched the inventory list and are stored in a locked shed located outside the secure area of the center.

| 5.12 Access to all Flammable, Toxic, Caustic, and Poisonous Items | Satisfactory Compliance |
|---|---|
| *Flammable, toxic, caustic, and poisonous fluids and other dangerous substances may only be drawn or acquired by authorized personnel.*<br><br>*Youth shall not be permitted to use, handle, or clean-up dangerous or hazardous chemicals or respond to chemical spills. Youth shall not be permitted to clean, handle, or dispose of any other person's bio hazardous material, bodily fluids, or human waste.* | |

The center maintains a written policy and procedures to ensure limited access to flammable, toxic, caustic, and poisonous items. Items may only be acquired by authorized staff. The center maintains a list of authorized staff who are allowed access to the chemical storage. Chemical storage is located outside the secure area of the center. Youth are not permitted to use or handle hazardous chemicals. Seven youth were interviewed and four stated they clean with cleaning agent such as bleach, laundry soap, window, or toilet cleaner. Each of the four youth stated staff spray the chemical and they wipe it up. Three youth stated they do not clean. Seven staff were interviewed and stated youth do not clean with any type of cleaning agent such as bleach, laundry soap, window or toilet cleaner.

| 5.13 Disposal of all Flammable, Toxic, Caustic, and Poisonous Items | Satisfactory Compliance |
|---|---|
| *The Maintenance Mechanic or other trained staff who have the safety equipment for diluting, handling, and disposing of hazardous waste and/or solid waste shall be responsible for disposing of hazardous items and toxic materials in accordance with Occupational Safety and Health Administration (OSHA) Standard 29 CFR 1910.1030 (amended 1-1-2004).* | |

The center maintains a written policy and procedures to ensure flammable, toxic, caustic, and poisonous items are disposed of according to the manufactures Safety Data Sheet (SDS). Chemicals used by the center are stored in a locked shed located outside the secure area of the center. An informal interview with the regional maintenance mechanic confirmed materials are disposed of by evaporation, compaction, or by/with a contacted disposal service. The center reported there have been no chemicals disposed of since the last annual compliance review. The center does not utilize grease for cooking. All kitchen liquid waste is disposed in the kitchen drain. All other liquid waste not resulting from work details is disposed of in a plumbing area designated for this purpose. The center utilizes Meeks Plumbing Inc. to clean the drain trap. A review of invoices for the past six months verified the trap is cleaned quarterly. An informal interview with the assistant superintendent indicated there have been no chemical spills since the last annual compliance review. If a chemical spill occurs, policy dictates a staff will notify master control of the location, a shift supervisor or master control will direct the shutdown of all air handlers, ventilation system, and close all windows and doors. The center will then obtain assistance from outside the center by contacting the necessary emergency contact. Biohazardous waste disposal is the responsibility of medical staff. All bio-hazardous waste is placed in a biohazardous waste container and all bio-hazardous solid waste is placed in a tear-resistant red bag clearly marked as biohazardous. Biohazardous waste is disposed of by Stericycle. A review of documents verified bio-hazardous waste is disposed of monthly.

| 5.14 Confinement Under Twenty-Four Hours | Satisfactory Compliance |
|---|---|
| *Staff shall use behavioral confinement as an immediate, short term response strategy during volatile situations in which a youth's sudden or unforeseen onset of behavior imminently and substantially threatens the physical safety of others or self.* | |

The center maintains a written policy and procedures addressing confinement under twenty–four hours. Behavioral confinement is a temporary response to youth behavior which threatens immediate harm to youth or others. The center has two designated confinement rooms; however, utilizes the youth's assigned sleeping room for confinement. If a youth's behavior escalates while on confinement, or if staff are unable to place the youth in their assigned room, the youth will be placed in one of the designated confinement rooms. Observation of the designated confinement rooms and youth rooms indicated rooms were free from obstruction and each room contained no non-fixed items. Youth who are in confinement have no contact with the general population. The center documents confinements under twenty-four hours in the Facility Management System (FMS). A review of seven confinement reports documented youth placed in confinement were afforded the same services as youth in the general population, which includes: medical, mental health, education, exercise, showers, meals, clothing, bedding, and hygiene items. Documentation reflected confinement rooms were searched prior to youth being placed in confinement. Each report reflected visual observation was conducted in accordance with policy. None of the reviewed confinement reports indicated the youth were to be at risk of suicide. Each reviewed confinement report indicated each was completed within one hour, indicated the reason for the use of confinement, and were reviewed by the juvenile justice detention officer supervisor (JJDOS). Each of the seven confinement reports indicated the superintendent and/or designee reviewed the confinement report within forty-eight hours. Seven staff were interviewed and stated when a youth is placed in confinement, staff must complete a confinement report, conduct and document ten-minute room checks, and search the confinement room. An interview with the center's superintendent reflected once the decision is made to confine a youth, the report is generated in FMS. Supervisors must review and approve the confinement report within two hours of the youth being placed, and every three hours after. A room search is conducted, and the youth is informed of the right to file a grievance. If a youth confinement was not appropriate, the youth will be immediately released. The superintendent or designee must review the report within forty-eight hours of release, and all confinement events are monitored by regional and headquarter staff.

| 5.15 Confinement Over Twenty-Four Hours | Satisfactory Compliance |
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*Confinement beyond twenty-four hours must be approved by the Superintendent or designee.*

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

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

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

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

The center maintains a written policy and procedures to address youth placed in confinement over twenty-four hours. Seven confinement reports over twenty-four hours were reviewed and each was approved by the center superintendent or designee. In each confinement, the regional director was notified and granted approval. Each showed the juvenile justice detention officer supervisor (JJDOS) completed reviews, evaluating the youth every three hours, and documented the need for continued confinement based on the severity of the rule violations, past disciplinary history, or behavior while in confinement. None of the confinements extended beyond three days, therefore, no confinement hearing was required.

| 5.16 Continuity of Operations Planning (COOP) Drills | Satisfactory Compliance |
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*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 maintains a written policy and procedures to ensure a plan is in place to manage various emergencies and disaster events. The center's Continuity of Operations Pan (COOP) was approved by the reginal director on September 13, 2018. Documentation showed there were two COOP drills conducted as required. A bomb threat drill was conducted on September 8, 2018 and a hurricane drill on May 28, 2018. In each instance, there were written scenarios and drill forms, critique forms and e-mails used to document the drills. Seven staff were interviewed and asked what drills they have participated in the last six months. Three staff responded they have participated in a weather drill, one stated a bomb threat drill, six stated escape drill, and five stated fire drill. Drill documentation from each shift is also posted in the staff breakroom for staff to review. Drills are also reviewed during monthly management meetings, monthly all staff meetings, and during shift briefings. An interview with the center's superintendent reflected the center conducts various safety, emergency and medical drills monthly. All drills are documented on the drill forms and staff signs the roster acknowledging they have participated in the drill. COOP drills are to be conducted twice a year, and the evacuation plan is included in the COOP plan.

| 5.17 Escape Drills | Satisfactory Compliance |
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| *The center shall develop, implement, and maintain an escape prevention plan incorporating the Department's established policies and procedure regarding escapes.*<br><br>*The facility shall conduct and document quarterly mock escape drills.* | |

The center maintains a written policy and procedures to ensure it is prepared to address youth escapes. The center has an escape prevention plan which requires all staff to remain alert and attuned to the moods, attitudes, and behaviors of the youth. The plan also addresses procedures for when an escape attempt occurs during a youth transportation. A review of the prevention plan indicated all required elements are included. Mock escape drills are required to be conducted once each quarter. A review of the center's mock escape drill documentation for the past six months, along with corresponding logbook entries, verified the center exceeds the requirements, and conduct drills monthly. Drill documentation from each shift is also posted in the staff breakroom for staff to review. Drills are also reviewed during monthly management meetings, monthly all staff meetings, and during shift briefings. A review of seven staff training records verified annual escape training was completed by each reviewed staff. An interview with seven staff regarding drill participation reflected six reported personally participating in an escape drill.

| 5.18 Fire Drills | Satisfactory Compliance |
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| *Management has implemented a disaster preparedness plan and fire prevention plan.*<br><br>*Monthly fire drills (with procedures being approved by local fire officials) are documented and conducted under varied conditions and on each shift.* | |

The center has a disaster plan, fire prevention plan, and evacuation plan which addresses fire prevention and safety of the center. A fire inspection was conducted on October 24, 2017 by The Florida Department of Financial Services, Division of State Fire Marshal with no violations found. The center has evacuation egress plans posted throughout the center. Each egress plan defined primary and secondary exit routes, and the location of emergency equipment; such as fire extinguishers and first aid kits. The center's disaster plan and fire prevention and evacuation plan were reviewed and approved by the local fire marshal on October 24, 2017. A review of the emergency drill documentation and the corresponding logbook documentation for the past six months verified the center conducts fire drills each month, on each shift, during different times. Seven staff were interviewed, and six stated fire drills take place monthly. One staff stated they have not participated in a fire drill. Drill documentation from each shift is also posted in the staff breakroom for staff to review. Drills are also reviewed during monthly management meetings, monthly all staff meetings, and during shift briefings. Seven youth were interviewed and six stated they have been instructed what to do in the case of a fire. One youth reported they were not instructed on what to do in case of a fire.

Program Name: St. Lucie Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: St. Lucie County / Circuit 19
Review Date(s): September 11-14, 2018

MQI Program Code: 225
Contract Number: N/A
Number of Beds: 50
Lead Reviewer Code: 163

# Overall Rating Summary

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

| Limited Ratings | Failed Ratings |
|---|---|
| 4.08 Medical Alerts | 4.18 HIV Testing |
| 4.11 DHA/Designee Admission Notification | 4.21 Restricted Housing |
| 5.07 Vehicles and Maintenance | |