STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

PROGRAM REPORT FOR

Hillsborough West Regional Juvenile Detention Center

Department of Juvenile Justice

(State-Operated)

3948 West Martin Luther King Jr. Blvd.
Tampa, Florida 33614

Review Date(s): May 14 - 17, 2019

PROMOTING CONTINUOUS IMPROVEMENT AND ACCOUNTABILITY
IN JUVENILE JUSTICE PROGRAMS AND SERVICES

Rating Definitions

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

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

Review Team

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

Marvin D. Bliss, Office of Program Accountability, Lead Reviewer (Standard 1)
Pamela Adams, Office of Program Accountability, Regional Monitor (Standard 5)
Jamila Bacchus, Office of Program Accountability, Regional Monitor (Standard 5)
Donna Connors, Office of Program Accountability, Regional Monitor (Standard 4)
Diana Francis, Pasco Regional Juvenile Detention Center, Assistant Superintendent (Standard 2)
Paul Sheffer, Office of Program Accountability, Regional Monitor (Standard 3)
Jonathan Thompson, Office of Program Accountability, Regional Monitor (Standard 3)

Program Name: Hillsborough West Juvenile Detention Center
Provider Name: State of Florida
Location: Hillsborough County / Circuit 13
Review Date(s): May 14 to May 17, 2019

MQI Program Code: 294
Contract Number: NA
Number of Beds: 93
Lead Reviewer Code: 173

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
- **NA** # Case Managers
- **1** # Clinical Staff
- **1** # Food Service Personnel
- **1** # Healthcare Staff
- **1** # Maintenance Personnel
- **2** # Program Supervisors
- **7** # Youth
- **7** # Direct Care Staff
- _____ # Other (listed by title): _____

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
- **28** # Personnel Records
- **14** # Training Records/CORE
- **4** # Youth Records (Closed)
- **7** # Youth Records (Open)
- _____ # 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	Limited
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	Non-Applicable

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Standard 4: Health Services
Detention Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Detention Rating Profile

Indicator Ratings

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

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Overall Rating Summary for Standard 5

This standard has received a standard-level rating of Failed, a follow-up review of the program shall be conducted within six (6) months of publication of the program report.

Program Overview

The Hillsborough West Regional Juvenile Detention Center is a state-owned detention facility, operated by the Department, located in Tampa, Florida. The center serves youth in Hillsborough counties in Circuit 13. Male and female youth who are detained pending adjudication, disposition, or placement in a residential commitment program are housed in the ninety-three bed center. Youth are provided services which include youth orientation, behavior management, safety and emergency procedures, transportation, mental health, and healthcare services. The center's educational services are provided by the Hillsborough County School Board. The center's management team includes the superintendent, two assistant superintendents, one administrative assistant, ten juvenile justice detention officer (JJDO) supervisors, and fifty-eight JJDOs. Mental health and healthcare services are provided through the contracted provider, Maxim Health Services, Inc., who subcontracts with Camelot Community Care, Inc. to provide mental health services. There is a licensed clinical social worker who is assigned as the center's designated mental health clinician authority DMHCA and one non-licensed staff. Clinical services provided by the center include mental health and substance abuse evaluations, mental health treatment planning, individual, group and family therapy, mental health crisis intervention services, on-site psychiatric services, and availability for substance abuse services for youth with co-occurring disorders. Medical services are provided by Maxim Healthcare Services Inc. to deliver comprehensive medical services to all youth at the center. The contract provides for a designated health authority (DHA) who is a licensed physician. The DHA has a designee who is an advanced registered nurse practitioner (ARNP) in addition to two additional licensed physicians to serve as back-up to the DHA. The medical clinic maintains nursing coverage from three registered nurses (RN) seven days a week from 6:00 a.m. to 9:00 p.m. Food services are provided by Department staff and include menus, meal planning, meal schedules, special diets, nutritional analysis, daily allowance, food preparation, health certifications, food product standards, sanitation, and cleaning. Staff are responsible for the custody and control of youth in their care, providing youth supervision twenty-four hours a day, seven days a week. The center has four living modules which are divided by male and female. There are fifty-six security camera slots at the center, of which forty-seven were being used and all were operational. The maintenance mechanic completes maintenance and repairs to the center's interior and exterior systems and is responsible for overseeing the inventory and storage of chemicals and tools. The center utilizes a hand-held electronic wand to record ten-minute checks while youth are in their rooms. At the time of the annual compliance review, the center had thirty-one vacancies, which included one juvenile justice detention officer supervisors (JJDOS), seven juvenile justice detention officer II positions (JJDO II), twenty-one juvenile justice detention officer I (JJDO I), and two food service workers.

Strengths and Innovative Approaches

- The program maintains a soft room which has calm art, soft wall colors, and two soft benches for seating. This soft room can be used during special visits, counseling sessions which may address past trauma and potentially provoke anxiety, and when a youth just needs a place to step away and calm down.

- The center is repainting the girl's module with gender-specific colors which has a calming effect.

Standard 1: Management Accountability

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

The center has a written policy and procedures for completing initial background screenings on all newly hired staff. Twenty-three new staff members were hired and four volunteers were added to the volunteer list since the last annual compliance review. All new staff members and volunteers were background screened prior to having contact with the youth or confidential youth records. None of the new hires or volunteers required an exemption. All the new direct care staff completed the pre-employment assessment tool and a passing score was documented in the employee records. The hiring authority ensured a review of the Central Communications Center (CCC) Person Involvement Report, the Staff Verification System (SVS) module, the Florida Department of Law Enforcement (FDLE) automated training management system (ATMS) result, and completed any agency personnel file review prior to hiring or utilizing a volunteer having contact with youth, or access to confidential youth records. The program completed the Annual Affidavit of Compliance with Level 2 Screening Standards and forward the form to the Department's Background Screening Unit (BSU) on January 23, 2019. The center utilizes teachers from Hillsborough County Schools. The school board completed the Annual Affidavit of Compliance with Level 2 Screening Standards and forward the form to the Department's (BSU) on December 7, 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 has a written policy and procedures to address five-year re-screening for all staff, volunteers, mentors, and interns with the due date of a re-screening based on the original date of hire or volunteering. Five employees required a five-year re-screening. There were no volunteers requiring a re-screening. Re-screening's were completed on each applicable employee on or prior to the anniversary date of hire. Each re-screening was completed no more than twelve months prior to the anniversary date.

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.

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.

Officers shall not verbally abuse, demean or otherwise humiliate any youth, and shall not use profanity in the performance of their job.

Officers shall not engage in or allow horseplay, either verbal or physical with and/or between any youth.

Officers shall not engage in personal relationships nor discuss personal information related to themselves or other officers with any youth.

Management takes immediate action to investigate or address all allegations or violations of the code of conduct.

The center has a written policy and procedures for employees and volunteers detailing the code of conduct when interacting and communicating with youth. The center is state operated and staff are trained on the Department's code of conduct. The Department's code of conduct prohibits any form of abuse, profanity, threats, harassment, intimidation, horseplay, or personal relationships with youth. Seven staff personnel records were reviewed. Each included a signed form indicating the staff received and reviewed the staff code of conduct. Five staff personnel records were reviewed for disciplinary actions for violations of the code of conduct. One staff member received a verbal reprimand for poor performance, negligence, and violation of agency rule. One staff received written reprimands for poor performance, violation of agency rule, and conduct unbecoming of a public employee. One staff received a written reprimand for agency rule violation and poor performance. Two staff members received written reprimands and re-training for agency rule violations. Based on documentation in personnel records, management addressed all violations immediately. A review of three staff personnel records indicated two received commendations of staff of the month and one received an award for outstanding work using the new behavior management system. Seven youth were interviewed. Six youth reported they felt safe in the center and one youth refused to participate and walked out of the interview. Three of the youth reported they have never been stopped from calling the Central Communications Center (CCC) or contacting the Florida Abuse Hotline. The remaining three youth stated they never needed to call the CCC or the Florida Abuse Hotline. Five youth stated they have never heard staff use profanity. One youth indicated hearing staff use profanity once, but it was not directed at the youth or other youth. Seven staff members were interviewed and four staff members indicated never hearing staff use profanity. One staff member indicated hearing staff use profanity once and two staff members stated they heard staff use profanity occasionally. All seven staff members indicated they have never seen a coworker use threats, intimidation, and/or humiliation when interacting with youth. One staff rated the working conditions at the center as very poor, one rated poor, three rated as fair, and three rated the working conditions as good. An interview with the facility superintendent was conducted and had knowledge of the Florida Department of Juvenile Justice reporting procedures. The facility superintendent indicated a call would be made to the CCC, Florida Abuse Hotline, and parent/guardian for any incident occurring at the center. An investigation into the incident will be

immediately started with any staff involved by removing the youth from the staff's supervision as soon as possible. A review of the incidents indicated no substantiated findings of improper conduct by staff.

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

The center has a written policy and procedures to address incident reporting. The center had fifty-one reportable incidents since the last annual compliance review. A review of five incidents indicated one for a Protective Action Response (PAR) injury, three for compliant against staff incident, and one medical incident. All were reported within the required two-hour time frame or within two hours of staff becoming aware of the incident. All five incidents were documented in the center's logbooks. There were no internal incidents or grievances i which should have been called into the Central Communications Center (CCC) or the Florida Abuse Hotline. Seven youth were interviewed, one youth refused to answer and walked out. Three youth reported they have never been stopped from calling the CCC or contacting the Florida Abuse Hotline. The remaining three youth reported they had been stopped from calling the CCC or contacting the Florida Abuse Hotline immediately when they asked, but were given the opportunity to call as soon as the supervisor came to the module to give them the telephone to place the call. A follow-up with the youth found they received their requested call within fifteen minutes or less. The superintendent was interviewed and was aware of the incident reporting procedures requiring the program to contact the CCC for any reportable incident within two hours of gaining knowledge of the incident or the actual incident.

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

The center has a written policy and procedures to address Protective Action Response (PAR). A review of nine PAR reports which occurred during the annual compliance review period found all nine reports were completed by the end of the staff member's workday and included statements from all staff involved. The PAR incidents did not result in injuries to the youth. None of the youth involved in a PAR incident alleged abuse. All reports included a review by a PAR certified instructor and/or supervisory staff. A post-PAR interview was conducted within thirty minutes after each incident. A review of the PAR incident report by the superintendent or designee was conducted within seventy-two hours of each incident. None of the nine reviewed PARs required a PAR medical review. None of the PARs required the use of mechanical restraints. All techniques applied were approved by the Department and based on the center's approved PAR plan. All reports were completed in the Facility Management System (FMS), which is part of the Department's information system. A review of internal incidents, grievances, and logbooks found no indication of PAR incidents occurring. Seven staff interviews were conducted and found all staff reported the staff attempt to talk to youth prior to using any PAR technique. An interview with the superintendent indicated PAR information is entered into the Department's system and reviewed during the superintendent's meetings.

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

The center has a written policy and procedures in place for pre-service/certification requirements for newly-hired staff including completion of the Department's Juvenile Detention Officer Academy, within 180 days of their hire date. The center's training plan and documentation verified new staff completed a minimum of 120 hours within 180 days of hire in accordance with Florida Administrative Code. A review of six newly hired staff training records indicated the new staff completed pre-service requirements prior to contact with any youth. Each staff was certified in Protective Action Response (PAR), first aid, cardiopulmonary resuscitation (CPR), and automated external defibrillator (AED) within ninety days of hire. One of the seven newly hired staff is scheduled to attend the Department's Juvenile Detention Officer Academy in June and is working on completing the required training. This staff has not had contact with any youth. Five newly hired staff members are on a waiting list for the academy and will complete their required training prior to having contact with any youth. All pre-service trainings were documented in the Department's Learning Management System (SkillPro). Seven staff interviews indicated the staff felt adequately trained to perform their assigned job.

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. *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 provides twenty-four hours of in-service training including mandatory topics specified in the Florida Administrative Code each calendar year and based on their annual training calendar. The center maintains an approved annual in-service training calendar for all staff which is updated as needed. Seven in-service staff training records were reviewed and each staff had a current first aid, cardiopulmonary resuscitation (CPR), and automated external defibrillator (AED) certification. The seven staff training records indicated the staff completed the required twenty-four-hour annual in-service training. The staff received the annual eight-hour Protective Action Response (PAR) update training as required. The staff also completed professionalism, ethics, and suicide prevention training. Of the seven in-service staff training records reviewed, five were applicable for the mandatory supervisor training. Four supervisors had forty hours of annual training and one juvenile detention officer two (JDO II) had seventy-seven hours of annual training. Three staff had the required eight hours of management/supervisory training and two had ten hours. All in-service trainings were documented in the Department's Learning Management System (SkillPro). The superintendent's interview was knowledgeable of the Department's training requirements and ensures staff receives the required 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 has a policy and procedures for entering and sharing alerts in the Department's Juvenile Justice Information System (JJIS). All entries and updates are completed by the appropriate medical, mental health, and supervisory staff in JJIS. The JJIS alert report is reviewed by administration and supervisors to ensure alerts are correctly documented in JJIS during shift briefings. During the annual compliance review, the center had a total of 396 alerts. Nine youth alerts were reviewed. The alerts were documented in JJIS appropriately. The alerts were downgraded, updated, or discontinued by medical, mental health, or administration staff. The center utilizes an internal alert system through the Facility Management System (FMS) in JJIS. Seven staff were interviewed and each stated the center provides each staff a copy of the JJIS alert form and discuss updates with staff during shift briefing.

Standard 2: Assessment and Performance Plan

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

The center has a policy and procedures in place to ensure appropriate screening, documentation, and evaluations are completed on all youth admitted into the center. During the intake process while the youth is being admitted to the center, a juvenile detention officer (JDO) is required to review the intake packet. The packet must consist of an arrest affidavit and/or a court order, detention risk assessment instrument (DRAI), a suicide risk screening instrument (SRSI), and other pertinent documents to include a review of the youth's previous detention record, if applicable. Admitting detention staff will then complete the secure detention intake wizard and document the information into the Department's Juvenile Justice Information System (JJIS). During the review period, seven youth intake records were reviewed and intake staff conducted a review of the screening packets and completed an admissions wizard on each youth. The admission wizard documented each youth was electronically searched and a full body search was conducted upon admission. The admissions wizard indicated six of the seven youth received an intake call. There was no documentation noted if the additional youth refused their call. The admission wizard for all seven youth did indicate mental health, medical, and suicide screening was completed. Records also indicated all seven youth were offered a meal at the time of their admissions. The peer reviewer was able to observe the admission process. The youth was already seated in the intake area and was observed being counseled by mental health personnel. The youth appeared emotional about their first time detainment. Once the youth was calm, the admitting staff took great care to help the youth adjust to the environment by assisting the youth with orientation to the center and taking their time to explain what to expect during the youth's stay. Meanwhile, the booking officer conducted a thorough screening of the intake packet paperwork, such as the SRSI, the Massachusetts Youth Screening Instrument (MAYSI-2) and the Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB), and other applicable documents. The youth was offered a meal during the intake process. The intake staff contacted the youth's parent/guardian to inquire about the youth's medical and mental health history and the youth was permitted to speak to their parent/guardian after the intake staff spoke with the youth's parent/guardian. The juvenile justice detention officer II (JJDOII) was observed completing the detention admissions wizard in JJIS.

2.02 Orientation	Satisfactory Compliance

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

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

The center has a policy and procedures in place stating each youth shall receive an orientation within twenty-four hours of admission to the center which will help familiarize the youth with the center's rules and regulations, expectations and consequences for behavior, how to file a grievance, when visitation and phone calls are conducted, how to request an abuse call, and how to access both medical and mental services. A review of seven youth records indicated all seven youth received a thorough orientation upon admissions covering all required topics. Each reviewed record included a checklist signed by the youth to acknowledge receipt of orientation. Seven youth were interviewed and six reported they received orientation within twenty-four hours of admission to the center and one youth refused to participate in the interview. An admission was observed during the annual compliance review and found the admission was thorough, the staff took great care to not re-traumatize the first-time detained youth, and covered all required topics. The youth was observed signing a form acknowledging they was provided with the required orientation information.

2.03 Classification	Satisfactory Compliance

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

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

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

The center has a policy and procedures in place to address the orientation of each youth. The intake juvenile justice detention officer (JJDO) ensured all youth admitted to the center are classified by the highest level of safety and security which is documented in the Juvenile Justice Information System (JJIS). A review of seven youth intake records indicated each youth was classified and all required information reviewed including youth's physical characteristics, age and level of aggressiveness, mental illness, developmental disabilities, any physical disabilities, history of violent behaviors to include gang affiliation and or association, vulnerability to victimization, sexual offences as well as suicide risk prior to assigning a youth to a unit and sleeping room. A review of several unit logbooks indicated the information regarding a youth's classification status is clearly documented and shared with staff.

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. *In the event gang involvement is suspected, Detention staff should enter the "other suspected gang affiliation" alert into JJIS along with as much detailed information within the alert note as possible.*	

The center has a policy and procedures in place stating each youth admitted to the center shall be screened to determine if the youth is a documented gang member, a gang associate, and/or has suspected gang affiliations. The juvenile justice detention officer (JJDO) completes a gang identification form on all youth who are admitted to the center. A review of seven youth records found each youth had a copy of the completed gang form in their record and the Juvenile Justice Information System (JJIS) admission paperwork indicating all the youth were screened for gang affiliation and/or membership. Three of the reviewed records indicated the youth was classified as a suspected gang member. An alert was found in JJIS classifying the youth as a documented gang member as required.

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. *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.* *Detention staff should include in the email all pictures (when appropriate), copies of written statements, drawings, graffiti, and a description of what gang signs the youth was "flashing."*	

The center has a policy and procedures in place for the notification of the juvenile probation circuit gang representative. The policy states the center will identify the circuit juvenile probation officer (JPO) who is designated as the gang representative to communicate gang activities to local law enforcement. The policy also indicates staff shall email the probation gang representative any pertinent information related to gang activity. Staff are then required to enter an alert entitled, 'suspected gang affiliation' into the Department's Juvenile Justice Information System (JJIS) onto the youth's alert record. E-mail correspondence was reviewed and demonstrated the center is informing the JPO circuit gang representative by email of any gang

activity. The center's intake unit maintains a 'gang binder' with copies of the youth's photo, the Facesheet, alerts, a completed gang affiliation screening form, and the attached email notifications to the representative for Circuit 13. Three of the ten records reviewed met the center's reporting requirements. An interview with the assistant superintendent confirmed two juvenile justice detention officer (JJDO) intake staff handles most of these notifications to the JPO gang liaison.

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

The center has a policy and procedures in place ensuring a youth's personal belongings are collected and itemized during the admissions process. A review of seven youth records indicated all youth admitted to the center came in with some type of property. All seven records contained a copy of the personal property receipt signed by both the youth and the juvenile justice detention officer (JJDO). There were four youth who had property of value. Three out of the seven youth reviewed who had property of value did not have a plastic tag receipt from the tamper proof bag which gets dropped in the center's valuables safe. It was discovered one of the youth's plastic property tag was in a previous closed out record and not moved to the active record. Two plastic property receipt tags of valuable items were not located. All three youth's property of value who did not have the plastic receipt did have their property of value dropped in the center safe is located in the admissions area under the surveillance camera. The tamper proof bags located in the safe were observed during the annual compliance review. Information on valuable property placed in the safe is also recorded in a bound logbook located in the admission area and includes the dates, times, Department of Juvenile Justice Identification number, the youth's name, and the staff's name who is securing the property of value. The property of the two youth without a corresponding plastic tag was able to be accounted for through review of the logbook and is safely secured in the safe. All seven youth reviewed records contained a signed letter of acknowledgement regarding unclaimed property. Seven youth were interviewed and six youth reported staff checked their personal property and had them sign a form stating the personal property was correct upon admission. One youth refused to participate in the interview. The center maintains all non-valuable items in numbered black mesh bags in a locked room for safe keeping. An interview with the superintendent was knowledgeable of the center's policy and procedures as outlined above.

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

The center has a policy and procedures in place for the storage of youth personal property. The center maintains all non-valuable items in a locked property room located in the intake area. The center maintains each youth's non-valuable items, such as clothing and shoes in a numbered black mesh bag which is hung in the property room in a sequenced order. A second mesh bag is attached to the assigned numbered mesh bag to store a copy of the itemized property receipt form which is signed by both the youth and staff who inventoried the youth's property. Seven youth property receipts located in their youth record accurately reflected what was observed in the mesh bags. The center also maintains a drop-safe in the admission and release area where the youth's property is sealed in a tamper resistant bag and dropped until a

center administrator can transfer the items from the safe to a locked filing cabinet, which is only accessible to specified members of administration. The drop-safe and locked filing cabinet are under video surveillance. The center's staff will document the youth's property in the valuable property inventory logbook before placing the youth's property of value in the drop-safe. A review of the youth records indicated four youth were applicable to having property of value by their signed property receipt form. Three youth with valuable items did not have a receipt from the tamper-proof bag in their current record; however, they were located in a previous record for the youth. Each of the four youth's property was located in the drop-safe and accurately documented in the bound valuable property logbook. All signed tamper-proof bags located in the safe contained the date, youth's name, Department of Juvenile Justice Identification number, and a list of the items in the bag. All property storage areas were observed during the annual compliance review. There were no Central Communications Center reports in the last six months involving lost, damaged, or stolen property for the center.

2.08 Release	**Satisfactory Compliance**
When releasing youth from detention, the releasing officer shall verify the court's authorization to release the youth. Care must be taken to ensure all case file information is reviewed to prevent the negligent release of a youth. *All releases from the program are court-ordered, with the exception of deaths, escapes, and expirations of detention time period. In the absence of a written order, documentation of a verbal order in open court may be used for release.* *The on-duty JJDO Supervisor reviews all paperwork prior to release. The JJDO Supervisor is responsible for ensuring there are no holds, court orders, or other legal reasons not to release the youth.* *Questions concerning release are presented and addressed by the Superintendent, or designee, prior to release.* *The releasing officer shall verify the identification of the youth.*	

The center has a policy and procedures in place regarding the release of youth from the center. Four closed youth records were reviewed for release procedures. All records had documentation the on-duty shift supervisor reviewed the paperwork related to the release. The Secure Detention Release Form was utilized, signed by the supervisor, and included a completed checklist demonstrating the supervisor ensured there were no holds, court orders, or other legal reasons to not release the youth. Each of the youth records also reflected the youth's identification and the identification of the parent/guardian or responsible adult was verified prior to release. All required parties signed the applicable release forms in each reviewed youth record and the release date was verified as the correct release date in the Juvenile Justice Information System (JJIS). A release was observed of a youth being released to a case worker. The release paperwork was completed accurately and the supervisor verified the identity of the case worker who was taking custody of the youth upon release. The case worker signed the release wizard as well as other applicable forms. The photo identification of the youth was examined by the releasing supervisor and court orders were also verified. The releasing supervisor referred to an email stating the case worker was taking custody of the youth upon release since the legal guardian was severely ill, which had been discussed during the center's last detention review. The youth was then escorted to the front lobby for release. A review of

incident reports for the past six months indicated there were no incidents of unauthorized releases.

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

The center has a policy and procedures in place regarding the release of a youth's personal property prior to being released from the center. A review of four closed youth records established each record contained property forms signed by the youth, parent/guardian, and the releasing officer indicating the youth's personal property was returned upon their release from the center. During the annual compliance review, a youth being released to their case worker was observed and found the youth was returned their property and signed the form agreeing the youth took possession of their personal property. The youth had no property of value to remove from the locked file cabinet. The releasing staff also signed the form and advised the case worker to sign the return of the property form in the front lobby prior to taking custody of the youth. During an interview with the superintendent it was reported when a youth exits the center without their property, a letter is sent to the youth by the superintendent advising the youth their property would be disposed and/or donated if not retrieve within thirty days of the notice. Several examples were reviewed for the past six months and was evident the center sends out thirty-day notices of impending disposal of property. Documentation was provided to demonstrate any unclaimed property was donated to a non-profit organization.

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

The center has a process in place for the release of prescribed medications and/or medical instructions to the parent/guardian picking up the youth upon release. A review of four closed records found none of the youth were discharged with prescribed medications. Four additional records were provided for youth who were discharged with medications and found each record included copies of the youth's Medication Receipt, Transfer & Disposition forms which were signed by the individual receiving the youth, transporting the youth, and the medical personnel, if applicable. Acknowledgment from the parent/guardian taking possession of the medications and aware of any follow-up or information pertinent to the youth's aftercare.

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

The center has a written policy and procedures in place stating the assigned detention review officer will conduct a detention review on a weekly basis. This review shall address every youth reflected on the census for secure detention, home detention, and home detention with electronic monitoring. The policy also indicates the superintendent and/or assistant superintendent are encouraged to attend the weekly audit. Other parties included in the detention review are the center's mental health provider, a medical provider, circuit chief of

probation and/or their designee, education staff, Department of Children & Families (DCF) representatives, residential commitment mangers, and any other person deemed necessary. A review of the past six months of weekly detention reviews found the center conducts weekly reviews on Thursdays at 1:00 p.m.to ensure proper management of the youth in secure detention. The center's assigned detention review specialist leads the audit. A detention review was observed during the annual compliance review which included the detention review specialist, a representative from the medical department, mental health, the residential commitment manager, a juvenile probation officer (JPO), and a representative from the education department. Parties attended by phone during the review were the circuit chief, assistant chief of probation, and several JPOs. The detention review specialist begin the review of the open alerts requiring to be closed out or updated. Other information shared and reviewed with all parties were the center's current population, the detention review count, electronic monitoring, domestic violent beds, home detention totals, youth in secure detention over 100-days and on commitment status, youth not on a waiting list and youth who are on a waiting list, prolific offenders, courtesy holds, and youth on electronic monitoring. Concerns and progress were discussed by all review attendees for youth in detention and on home detention. Youth pending placement were also discussed and information on each youth's expected release date was provided. The detention review specialist reviewed all youth's ending release dates to check for accuracy. The superintended interview was consistent with the above mentioned policy and procedures.

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

The center has a policy and procedures in place regarding the center's daily activity schedule. The center has both a weekly schedule for normal business days and one for holidays and weekends. The schedule indicates times the youth are to participate in school activities, conduct personal hygiene/showers, have meals/snacks, attend visitation, recreation activity, and participation in small group discussions or social activities. The schedule also reflects when life skills teaching and restorative justice programming are offered, times of phone calls and letter writing are permitted, bed times for youth with higher levels in the behavior management system, and when to conduct unit/facility cleaning. The center did not have a specific curriculum regarding gender-specific programming; however, gender-specific groups with appropriate topics were entered into the Facility Management System (FMS) and interviews with staff further explained additional opportunities for gender-specific programming provided. Prior to February 2019, the center was on twelve hour shifts which was reflected in three of the six months reviewed. A review of unit logbooks reflects the center returned to eight hour shifts in February of 2019 allowing for adherence to the current center's daily activity schedule. Seven youth were interviewed and each reported the center does have a daily activity schedule. During the center tour, it was noted the schedules were posted in the living units for youth to review. Of the seven staff interviewed five reported gender-specific programming is conducted as part of the daily 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. *The on-duty supervisor must approve any significant changes in the activity schedule and shall document the reason for the change(s) in the shift report.* *Any cancellation of visitation shall be approved by the superintendent.*	

The center has a policy and procedures in place regarding the center's daily activity schedule. The center has both a weekly schedule for normal business days and one for holidays and weekends. A review of the center's logbook indicates adherence to the daily activity schedule with a few exceptions. According to the daily activity schedule, youth are to be in class for the morning session between 8:00 a.m. to 10:15 a.m. Some of the unit logbooks documented youth arriving to class late at 8:03 a.m., 8:09 a.m. and twice after 8:15 a.m. When questioned why the youth were arriving late to class, the center stated the youth were acting out and staff had to wait until they were calm enough to go to class. Afternoon sessions are from 12:15 p.m. to 2:30 p.m. It was noted in one logbook entry class was released at 1:45 p.m.; however, the reason for the deviation was noted as teacher meetings. The daily activity schedule states small group discussions and social activities are to occur between 6:30 p.m. to 7:50 p.m. There were several required groups conducted and documented in the logbook; however, the groups occurred during after school snack time from 3:00 p.m. to 3:30 p.m. as part of the enrichment program which does not adhere to daily schedule. Six of the seven nights reviewed found youth were allowed free time from 6:30 p.m. to 7:50 p.m. An interview with a supervisor was conducted and revealed the evening groups are occurring as scheduled; however, staff are forgetting to document them in the logbook. An interview with the assistant superintendent explained eighty percent of the current staff at the center have less than eight months of working experience. Observations of the daily schedule during the annual compliance review week found staff to be adhering to the daily schedule as written. There were instances where outdoor activities were canceled and moved indoors due to weather, such as heat. This was clearly documented in the center's logbooks. Seven youth were interviewed and one youth indicated the daily schedule is not followed, five reported the schedule is followed, and one youth refused to participate in the interview. Seven staff were interviewed and each reported the daily schedule is followed.

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 has a written agreement with Hillsborough County School Board to provide education services to the youth at the center. The center follows the school board's year round programming schedule and are required to have youth in class for twenty-five hours a week and for 250 days a year. Instructional education and career related programming is to be conducted during class time. The youth in the center can earn course credits toward the completion of their education. According to the school agreement youth are to be in class for the morning session between 8:00 a.m. and 9:15 a.m. Some of the reviewed unit logbooks included entries which documented youth arriving to class late at 8:03 a.m., 8:09 a.m. and twice times past 8:15 a.m. When questioned why the youth were arriving late to class, the center stated the youth were acting out and staff had to wait until they were calm enough to go to class. It was noted in one

logbook entry class was released at 1:45 p.m. but the reason for the deviation was noted as teacher meetings. The contract states the youth are to remain in class until 2:10 p.m. in the afternoon. Seven youth were interviewed; however, one youth refused to participate. Each of the six youth who participated in the interview reported the center does offer educational, school and/or career technical instruction classes. The youth attend class Monday through Friday and class courses includes math, science, history, social studies reading, career choices, and life skills. It appears from the logbook entries class were released earlier than the contracted hours on three occasions during the six month review cycle and the approval for the deviation is not documented.

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

The education staff at the center provide career education programming to youth based on their age, assessed educational abilities, and the goals of the youth. Educational staff take into consideration the youth's length of stay and custody characteristics at the center. Type 1 career education instruction is offered and includes behaviors appropriate for youth, personal accountability skills, best practices to prepare the youth for future employment and living standards. Additional career programming includes effective communication, decision-making and interpersonal skills. An educational staff was interviewed and reported the teachers provide résumés writing with youth, discuss hygiene practices, and provide basic life skills and emotional support. Most of the career education is conducted Monday through Friday during the 4th session between 12:13 p.m. to 12:53 p.m. Seven youth were interviewed and six reported the center offers educational, school and/or career technical instruction type classes. One youth refused to participate in the interview.

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. *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.* *The behavioral norms and expectations for youth shall be posted in all living areas and shall clearly specify appropriate and inappropriate behaviors.*	

The center has a policy and procedures in place outlining the newly adopted behavior management system (BMS) which promotes the health and well-being of the youth by providing for a positive environment. The center is one of three centers in the region piloting this new program. Training, planning meetings, and emails were reviewed between the assistant secretary, regional directors, and superintendents regarding the approved project and the launch of the new system in October 2018. The new BMS is called "Adapt & Transform Behavior, LLC." The BMS involves the setting of expectations frequently throughout the day, pulling youth aside privately to discuss expectations by using 'First-Then' statements. Staff are to set expectations for potential problems which may arise. The BMS consists of a 'behavior matrix' and major problem behaviors and consequences for those problem behaviors. The behavior matrix is posted in the living units for youth to see and outlines expectations for various locations in the center such as the dorm, in the classroom, in the chow hall, during line

movement, and on the recreational field. There are sixteen major problem behaviors outlined in the BMS with their consequences. Youth who reach level four which is the highest level are considered on the honor system and receive privileges and incentives for maintaining those behaviors. In the honor system, youth can wear a different color shirt to stand out from the rest of the group. Other privileges include social activities, later bed times, and extra phone calls. The center tracks the youth's levels on a point card. Youth can earn sixty points a day by collecting ten points for correct behaviors in each of the categories of the expected behaviors outlined in the behavior matrix. To enhance this project the center has a registered behavior technician (RBT) who serve under the board-certified behavior specialist and help provide guidance and support both staff and the youth in the implementation of the BMS. Seven staff were interviewed and five reported the BMS is not effective, but they explained in detail it was mainly due to the follow-through by other staff enforcing the system. Two staff reported it as effective. All seven interviewed staff reported administration is proving feedback on the implementation of the project and encouraging its use. A review of unit logbooks had evidence of the level system being utilized and records documenting bedtimes and special activities. Supervisors making the unit rounds also document their feedback on the handling of point cards for each youth and how to track appropriately the levels and whether they level drops get approved or not. Seven youth were interviewed and three stated they felt the new BMS was good, two youth stated they thought the system was poor, one youth indicated they felt it was very poor, and one youth refused to participate in the interview.

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's behavior management system (BMS) addresses consequences for a youth's negative behaviors. The center's BMS encourages the use of verbal direction and dialogue with counseling to allow the youth an opportunity to change their negative behaviors to pro-social appropriate ones. The BMS implemented at the center does not allow for group punishment or corporal punishment of youth. An interview with seven staff stated they never observed staff encouraging youth to punish another youth. All seven staff reported consequences for inappropriate behavior does not include the loss of meals, snack, sleep, or school. Seven youth were interviewed; however, one youth refused to participate. Three of the six youth who participated in the interview reported they lost their level and/or points as consequences for inappropriate behavior, six reported they are not allowed to punish other youth, and three youth reported they are sent to their room for punishment with the door shut and locked. It should be noted the center does use room confinement under eight-hours to re-direct behavior if all other means fail.

2.18 Grievances	Satisfactory Compliance

The grievance procedures establish each youth's right to grieve and ensure all youth are treated fairly, respectfully, without discrimination, and their rights are protected. The process includes:

1. *Informal phase, wherein the JJDO attempts to resolve the complaint or condition with the youth using effective communication skills;*
2. *Formal phase, wherein the youth submits a written grievance resulting in a response from a JJDO Supervisor by the end of the shift (if possible), or otherwise within twenty-four hours; and*
3. *Appeal phase, wherein the youth may appeal the outcome of the formal phase to the superintendent or designee.*

The center has a policy and procedures in place which establishes each youth's right to grieve if they believe they were not treated fairly. The process ensures all youth are treated fairly with respect, without discrimination, and their rights are protected. The three-step process includes an informal, formal, and appeal phase. The grievance policy indicates the informal phase occurs when the youth submits in writing, their complaint or concern to the juvenile justice detention officer (JJDO) for handling and submission into the Juvenile Justice Information System (JJIS) Detention Facility Management. The informal phase allows the JJDO to resolve the issue with the youth and encourages effective communications skills. If the youth is not satisfied with the outcome with the JJDO assigned to the unit, the grievance will move to informal phase where the shift supervisor has until the end of the shift or within twenty-four hours to resolve the complaint with the youth. If the youth is still dissatisfied with the outcome of findings by the shift supervisor, the grievance then moves to the appeal phase. This phase is where the superintendent or designee must review and attempt to resolve the complaint within seventy-two hours of receipt, excluding weekends and holidays. The center had ten grievances during the annual compliance review period. Five grievances were selected at random as part of the sample and all five were resolved in the formal phase with the JJDO receiving the complaint. These five samples were completed within the appropriate time frames and captured both the youth and staff's signatures. These grievances were handwritten, signed, and submitted electronically. Youth acknowledged they were satisfied with the handling of their issues and concerns. An interview with the superintendent confirmed the process and time frames. Seven youth were interviewed and five reported they never filed a grievance, one stated they thought the grievance process was fair, and one youth refused to participate in the interview.

2.19 Trauma-Informed Care	Satisfactory Compliance

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

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

- *A recognition of the high prevalence of trauma*
- *Assessment for traumatic histories and symptoms*
- *Recognition of culture and practices that may be re-traumatizing*
- *Collaboration of caregivers*
- *Training of staff to improve trauma knowledge and sensitivity*
- *Increased staff understanding of the function of behavior (rage, self-injury, etc.) as an expression of trauma*
- *Use of objective and neutral language (avoids labeling of youth)*

The center has a policy and procedures in place ensuring the practice of incorporating trauma-informed care philosophies is embedded in the services they provide for the youth in their care. The practice allows detention staff, providers, and volunteers to recognize and treat each youth interaction as if the youth has suffered past traumatic events. Seven staff were interviewed and five reported reviewing the alerts and findings from the weekly treatment team meetings help recognize with youth's triggers and as a result they are able to avoid setting these triggers off during critical situations. The staff recognized this role is critical to the youth's life and assist with healing and effective treatment. The center has incorporated trauma-informed training for staff and are piloting a new behavior management system (BMS) which helps prepare youth to understand the consequences for inappropriate behaviors with emphasis on effective communication and emotional support. During the center tour, it appeared there is as an overall 'softening" of the environment with soft blue painting on the walls and colorful painted murals throughout the center. The youth have a soft room available to them. Seven staff training records were reviewed and revealed all staff completed the SkillPro training module on trauma-informed care during the annual compliance review period. The center allows the youth to enter the center on a higher level under the BMS to alleviate some of the stress of trying to achieve the level. The center focuses on utilizing verbal interventions and task force team members to counsel with youth to assist with de-escalation of crisis prior to placing youth in confinement which can be traumatic for the youth. An interview with the superintendent reveled all staff are trained to recognize and avoid youth triggers to avoid placing youth in events which could cause a trigger and talk about their triggers. Youth with specific triggers are discussed during shift briefings to ensure all staff are well informed.

Standard 3: Mental Health and Substance Abuse Services

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

The center has a written policy and procedures to address the provision of a designated mental health clinician authority (DMHCA). The center utilizes a sub-contractor, Camelot Community Care, Inc. to provide a dedicated DMHCA. The DMHCA is a properly credential licensed clinical social worker (LCSW) with a State for Florida license which expiring on March 31, 2021. The DMHCA provides forty hours of clinical on-sight supervision and is on-call twenty-four hours a day, seven days a week. While on-site, the DMHCA attends all mini-treatment team meetings, provides supervision to the non-licensed mental health professional, and acts as the focal point for all coordination and the implementation of mental health services. The DMHCA was interviewed and reported in addition to the responsibilities listed above, their duties include conducting and/or reviewing assessments for suicide risk, completing initial and individualized treatment plans, discharge summaries, participating in weekly detention review audits, and conducting weekly mental health groups.

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

The center utilizes a contractor, Camelot Care Community Care, Inc. for the provision of mental health services. The mental health department utilizes a licensed clinical social worker (LCSW) and two licensed mental health clinicians (LMHC) to provide regular mental health services at the center. The three mental health professionals have a current license each with the State of Florida and all with an expiration date of March 31, 2021. Additionally, oversight is provided by the contractor's regional clinical director who also serves as the primary backup in the event of the absence of the DMHCA. The regional clinical director possesses an active license with an expiration date of March 31, 2021. Mental health credentials were validated by utilizing the Department of Health, Medical Quality Assurance website which serves as a central archive website for licensed professionals in the State of Florida.

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

The center has a written policy and procedures to ensure metal health and substance abuse staff have the appropriate credentials. The center utilizes a contractor for the provision of mental health services. The provider employs one non-licensed clinician who provides coverage on the weekdays for the evening shift at the center. The non-licensed mental health professional holds a master's-level degree in a relevant field of study. The center was able to provide documentation of twenty hours on-the-job training in assessing suicide risk, mental health crisis intervention, and emergency mental health services. The reviewed documentation also validated the administration of five assessments of suicide risk or crisis assessments conducted in the physical presence of a licensed mental health professional which allows the non-licensed clinician to conduct Assessments of Suicide Risk (ASR) and prepares them for the designated mental health clinical authority's (DMHCA) approval. A review of direct supervision logs confirmed non-licensed mental health clinical staff also received at least one hour on-site face-to-face direct supervision by the DMHCA a week. All reviewed records confirmed the DMHCA reviewed and signed all ASRs within ten calendar days of administration of the instrument by non-licensed mental health clinical staff.

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

The center has a written policy and procedures related to mental health and substance abuse admission screenings which are approved by the superintendent and the designated mental health clinician authority (DMHCA). A review of seven youth mental health records confirmed the detention center's staff reviewed all prior documentation completed by the juvenile probation officer (JPO) or the Juvenile Assessment Center (JAC) screener upon admission. During the admission process, the juvenile justice detention officer's (JJDO) reviews the Positive Achievement Change Tool (PACT), PACT mental health and substance abuse (PACT MH/SA) Screening Report and Referral, Massachusetts Youth Screening Instrument - Second Version (MAYSI-2), Suicide Risk Screening Instrument (SRSI), and the Vulnerable to Victimization and/or Sexually Aggressive (VSAB) form. In all seven youth records reviewed, an SRSI was conducted at intake with all entries completed which also included a summary and recommendations in the screening results section. Three of the seven youth were applicable for positive responses on the SRSI which resulted in each youth being placed on precautionary observation and appropriate referrals made for further assessment, as required.

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

The center has a policy and procedures in place which regulates the assessment process of each youth upon entry to the program. All youth shall be referred to complete a new comprehensive mental health and substance abuse evaluation within thirty days of admission if a current evaluation is not received from the youth's juvenile probation officer (JPO). Seven youth mental health records were reviewed and each contained documentation of the mental health clinical staff request for an evaluation completed by a community provider within fourteen days of admission. One of the seven records required the completion of the comprehensive mental health evaluation as the remaining six youth were not at the center long enough for the evaluation to be completed; therefore, two applicable records were added to the sampling for review. All three applicable records verified the comprehensive mental health assessments were completed within thirty days of the referral and were completed by the designated mental health clinician authority (DMHCA).

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

The program has a written policy and procedures which defines how the program will provide treatment to youth. Three of the seven reviewed youth mental health records were applicable for receiving services while in the center. Each of the youth were assigned to a mini-treatment team which consisted of the youth, the designated mental health clinician authority (DMHCA), the psychiatrist, a nurse, and the youth's parent/guardian, when available. A review of documentation confirmed each youth was receiving individual and group treatment according to the frequency required by their plan. The records for two of the youth had a copy of a valid Authorization for Evaluation and Treatment (AET). The remaining record contained a court order which allowed for the provision of mental health services. None of the youth were found to be receiving any specific substance abuse services; therefore, they did not require Substance Abuse Consent and Release forms. No specific groups were occurring during the review. The center was able to provide documentation of mental health treatment group and psychosocial skills training groups offered during the past six months. None of these groups had more than ten youth present. An interview was conducted with the regional manager for Camelot since the DMHCA was on vacation. The regional manager confirmed the staff provide individual counseling, some behavioral therapy, treatment planning, discharge planning, and evaluations for youth, as applicable. Seven youth were interviewed regarding how they would rate the mental health services they were receiving at the center. One youth stated the services were

very good, one youth stated they were good, and four youth indicated they had not received any services while in the center. The remaining youth refused to participate in the interview.

3.07 Treatment and Discharge Planning [Contract Provider]	Satisfactory Compliance
The superintendent and DMHCA or mental health and substance abuse clinical staff are responsible for ensuring the development and review of an initial and/or individualized mental health/substance abuse treatment plan for each youth receiving mental health and/or substance abuse treatment in the facility. *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 has a written policy and procedures which defines how treatment planning shall be conducted for applicable youth. Two of the seven reviewed youth mental health records were applicable for the completion of an initial treatment plan. One additional applicable record was provided for review. Each of the three applicable youth's mental health records were found to contain an initial plan which was completed within seven days of admission signed by the members of the mini-treatment team, which included the designated mental health clinician authority (DMHCA). Each of the initial treatment plans reflected the youth would be seen by the psychiatrist for the completion of an initial diagnostic psychiatric interview and would follow through with any recommendations made. The plans were each completed on the Department's Initial Treatment Plan form. One of the seven reviewed youth mental health records were applicable for the completion of an individualized treatment plan. The center was able to provide two additional applicable records for review. Each of the individual treatment plans were completed within thirty days of admission using the Department's Individualized Treatment Plan form. Each plan included the youth's Diagnostic and Statistical Manual of Mental Disorders-Version 5 (DSM-5) diagnosis and their recommended psychiatric services which included prescribed psychiatric medications and the frequency of monitoring to be conducted by the psychiatrist, when applicable. All the individualized plans were signed by the treatment team and each was completed by the DMHCA. None of these youth were applicable for treatment plan reviews. The center was able to provide records for two youth who were in the center long enough to have a treatment plan review. Each of the treatment plan reviews were conducted within thirty days of the completion of their individualized treatment plan. Neither of the youth required any modifications to their existing treatment plan. The review documentation was signed by all members of the mini-treatment team. None of the youth in the sample had a recent discharge. Three closed youth records applicable for mental health treatment were provided for review. Each youth had the Mental Health and Substance Abuse Treatment Discharge Summary completed on the Department's form. Each record contained documentation reflecting the plans were mailed to the youth and parent/guardian and emailed to the assigned juvenile probation officer (JPO). A mini-treatment team for one youth was observed during the annual compliance review. During this meeting, the psychiatrist completed an initial diagnostic psychiatric interview on the youth while a clinician finalized the youth's individualized treatment plan. In addition to the psychiatrist and licensed clinician, the youth and a nurse were also present during the observed meeting.

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

The center's contract with Camelot Community Care, Inc. provides for the services of a psychiatrist weekly for three hours. The provided psychiatrist is a medical doctor (MD) who is certified by the American Board of Psychiatry and Neurology in child and adolescent psychiatry. A review of sign-in logs from the past six months confirmed the psychiatrist was on-site weekly with no lapses for the past six months. A review of documentation confirmed the psychiatrist meets with the designated mental health clinical authority (DMHCA) and other available staff each time they are on-site to review the progress of youth within the center and those scheduled for treatment team. The psychiatrist also communicates with the center as needed to assist in service coordination for new admissions or other situations such as dealing with a youth in crisis or emergencies. Two of the seven reviewed youth mental health records were admitted to the center on psychotropic medications. The center was able to provide the record for an additional youth who arrived with a prescription for psychotropic medications. Each of the three youth were referred for an initial diagnostic psychiatric interview upon admission. All three youth were seen for an initial diagnostic psychiatric evaluation within fourteen days of their admission. All three youth were continued on their previously prescribed medications. Each of the psychiatric evaluations were completed using the Clinical Psychotropic Progress Note (CPPN). Two of the three youth had a valid Authorization for Evaluation and treatment (AET). The remaining youth was in the custody of the Department of Children and Families (DCF) and had a court order which covered two of the youth's prescribed medications. The youth is receiving a psychotropic medication which is not included on the court order. The youth was prescribed this medication at the detention center starting on March 22, 2019. The center had a Prescribing Psychotropic Medication Children in Out-of-Home Care form in the youth's record, which was completed on March 21, 2019. This form allows for the pre-authorization of a youth to receive prescribed medications not listed on the court order, as long as the form is submitted to the court within three business days. The center contacted the DCF case worker to obtain documentation reflecting when the information was submitted to the court or for an order which would allow for the continued use of the medication. As of May 22, 2019, the center has not been able to provide documentation confirming authorization for the youth to take the psychotropic medication. One of the seven youth in the sample was referred to the psychiatrist after admission. The center was only able to provide one additional example for a youth referred to the psychiatrist after admission. Each of the two applicable youth were seen within fourteen days of the referral for an initial psychiatric diagnostic interview, which were completed using the CPPN, including page three. Medication was prescribed for one of the youth and the youth was scheduled to be seen for medication management within one month. Three of the reviewed youth required Tardive Dyskinesia screening; however, none of the youth were in the center long enough to have a follow-up medication management meeting, which would require completion of this screening.

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

The program has a written suicide prevention plan which addresses all required elements. The plan includes procedures in place to identify and assess youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral process, communication, notification, documentation, immediate staff response, and a review process of suicide attempts and mortality review. The plan was reviewed by the superintendent and designated mental health clinician authority (DMHCA) on August 10, 2018.

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

The center has a written suicide prevention plan which addresses how suicide prevention services will be provided for youth in the program and reviews of any serious suicide attempts or incidents of self-injurious behaviors. Three of the seven reviewed youth mental health records received an Assessment of Suicide Risk (ASR) within twenty-four hours of their admission based on their admission screening results. All three youth were immediately stepped down to standard supervision as a result of the assessment. The program was able to provide documentation for three youth who were placed on precautionary observations subsequent to admission due to staff observations. Each of the three youth had an ASR completed within twenty-four hours of being identified as being at risk. The supervision for all six applicable youth was documented on a Suicide Precautions Observation Form. These forms were completed in their entirety to include the identification of “safe housing areas.” All three youth who were identified after their admission were released while on suicide precautions. The parent/guardian for each of the youth were notified using the Detention Suicide Risk Parent/Guardian Notification form. None of the youth required completion of a follow-up ASR. Additional youth documentation was reviewed which reflected the completion of an follow-up ASR prior to moving a youth to close supervision. Each applicable youth was stepped down from close supervision following the center’s suicide prevention plan. Each reviewed ASR reflected a conference was held with a licensed clinician and superintendent/designee prior to reducing the level of supervision for youth. Each reviewed ASR was completed by a licensed mental health professional or by a clinical staff member under the supervision of a licensed clinician. A review of the center’s master control logbook found precautionary observation was consistently documented to reflect the status of youth on heightened supervision. A review of the Department’s Juvenile Justice Information System (JJIS) validated each youth had an

appropriate suicide risk alert opened and closed as required. No youth in the review sample were placed into secure observation. The center provided two applicable examples for review. Each of the records contained documentation reflecting the superintendent/designee and designated mental health clinician authority (DMHCA) authorized placement. Both instances reflected the youth and the secure room were searched prior to placement. Each of the packets included a completed Health Status Checklist form which was completed by a staff member of the same gender as the youth. One of the youth was seen within eight hours of placement, stepped down to constant supervision within twenty-four hours, and subsequently reduced to standard supervision following the completion of a follow-up ASR. The remaining youth was released from the center within eight hours of placement and before a clinician could complete an ASR. Notification of the parent/guardian and assigned juvenile probation officer (JPO) was documented in each case. Mental health staff provided supportive counseling for each youth while in secure observation. The center has five suicide response kits. One is located in master control and the remaining four are located in sub-control for each of the living modules. Each kit was found to contain a knife-for-life, wire cutters, and needle nose pliers. One of the seven interviewed youth indicated they were placed on suicide precautions during their time in the center. An additional youth who was placed on precautionary observation was interviewed. Both youth indicated they were watched at all times by staff. Seven staff were interviewed regarding their responsibilities of youth who expresses suicidal thoughts. Six staff indicated they would notify the DMHCA, place the youth on constant sight and sound supervision, and document their supervision. One staff indicated they would notify mental health and the supervisor. Six staff also indicated they would search the youth and their room for sharp objects. The seventh staff indicated they would notify the supervisor.

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

Three of the seven youth mental health records were reviewed for youth were placed on suicide precautions upon admission to the center. Three additional youth records were reviewed who were placed on precautionary observation subsequent to their admission. There were thirty-two Suicide Precaution Observation Logs available for review in the six applicable reviewed records. The center uses the Department's Suicide Precaution Observation Log form. These forms are printed on green paper for those youth on constant supervision. The close supervision logs are printed on orange paper. This system is in place to ensure each youth's status is easy for staff to recognize. All required reviews by supervisory staff and mental health clinicians were completed and documented on the reviewed logs. Warning signs were clearly documented on the logs, when applicable. Each of the reviewed logs had a safe housing area identified for the youth while they were maintained on precautions. All of the reviewed logs were found to have required thirty-minute observation checks documented legibly with no lapses or missed checks. It appeared as though the observations were not conducted in real time as they were usually documented at exactly thirty-minute intervals. One of the seven interviewed youth indicated they had been placed on suicide precautions during their time in the center. An additional youth who was placed on precautionary observation was interviewed. Both youth indicated they were watched at all times by staff.

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

The center 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. A review of seven staff training records reflected each staff received six hours of training on suicide prevention as part of their annual in-service training. The reviewed training information in the Department's Learning Management System (SkillPro) records found each received the required four hours of instructor-led and two hours of computer based training on suicide prevention. The center maintains a drill binder to document mock suicide drills. In this binder the center also has a tracking form to ensure all staff participate in at least two mock suicide drills a year. The reviewed suicide drills were conducted on each shift at least once a quarter. The reviewed drill documentation confirmed all direct care staff participated in at least one quarterly mock drill on a semi-annual basis. Seven staff were interviewed regarding the location of the center's suicide response kits. Seven staff indicated there is one suicide response kit in master control and one in the sub-control area for each of the four living modules. Three staff also indicated a suicide response kit is maintained in the medical clinic.

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

The program has a written crisis intervention plan which addresses the notification and alert system, means of referral to include youth self-referral, communication, supervision levels, documentation and review, as required. The plan was reviewed by the superintendent and designated mental health clinician authority (DMHCA) on August 10, 2018.

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

The program has a written emergency mental health and substance abuse services plan which addresses immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment, transport for emergency substance abuse assessment and treatment, documentation, and training as required. The plan was reviewed by the superintendent and designated mental health clinician authority (DMHCA) on August 10, 2018.

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

The program has a written crisis intervention plan which addresses all required elements. There were no youth who were in need of a crisis assessment during the annual compliance review period.

3.16 Baker and Marchman Acts [Detention Staff/Contract Provider] (Critical)	Non-Applicable
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 did not have any Baker Acts or Marchman Acts during the annual compliance review period; therefore, this indicator is rated as non-applicable.

Standard 4: Health Services

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

The center has a policy and procedures to address the responsibility of the designated health authority (DHA). Through a contracted agreement, healthcare services are provided to the youth. The contract includes the provision of a designated health authority (DHA). The current DHA has been working at the center since March 2019. There was another doctor assigned as the DHA during the remainder of the annual compliance review period. Both DHAs maintained an active, unrestricted license to practice in the state of Florida with a specialty in family medicine. The licenses of both doctors will expire on January 31, 2021. There was documentation to support the DHA completed Comprehensive Physical Assessments (CPA), sick calls, periodic evaluations, reviewed medication prescribed to the youth, and ordered new medications for applicable youth. The DHA assisted in the development of the health-related policies and conducted an annual review of all medical procedures. The contract provides for a back-up doctor to cover the administrative and clinical duties in the event the DHA is not available. The doctor who substitutes for the DHA is licensed to practice in Florida expiring on January 31, 2021. The back-up DHA has a certification in pediatrics. Both doctors were available for consultation twenty-four hours a day, seven days a week, as required by the contract. Both doctors were cleared by the Agency for Healthcare Administration. The contract requires the DHA to be on-site weekly. The sign-in logs for the medical staff were reviewed and revealed five instances in which nine or more days had elapsed between DHA visits. The lapses were between ten and twelve days. The DHA reported in an interview, they are on-site weekly to conduct periodic evaluations, sick call, and to complete CPAs. The DHA further reported the on-call duties were split with the medical practice partner who serves as the back-up DHA. The DHA reported there were no concerns regarding the health care at the center. The contract requires an advanced registered nurse practitioner (ARNP) to provide medical treatment for the youth. The center's ARNP has a clear and active license with an expiration date of April 30, 2020. There is a collaborative practice protocol in place. A copy of the protocol is maintained in the center. There is a clear supervisory relationship between the DHA and ARNP. The ARNP's duties include the completion of physical assessments, periodic evaluations on applicable youth, and examinations on youth who are referred by the nursing staff.

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

The center has a policy and procedures to address health-related protocols. The health-related policies and procedures were reviewed and signed by the designated health authority (DHA) on April 30, 2019. The policies were signed by the superintendent; however, there was no date with the superintendent's signature. There were three separate policies to address the provision of psychiatric services in which two were signed by the psychiatrist; however, there was no date on the signatures. The policy to address psychotropic medication and monitoring was signed by the DHA on April 30, 2019. The superintendent's signature was not dated and the policy was not signed by the psychiatrist. The DHA conducted an annual review of nursing protocols and each nurse signed the nursing protocol acknowledgement to document their review of the

protocols. The nursing protocols were signed by the superintendent on July 2, 2018 and by the DHA on April 30, 2019. The center hired one nurse and one doctor in the six months prior to the annual compliance review. There was documentation to support both medical staff received orientation on the medical policies and protocols. The orientation was provided by the medical provider's clinical director. The orientation included information on the facility operating procedures, health services forms, and quality improvement standards. There were no general corporate policies.

4.03 Authority for Evaluation and Treatment [Detention Staff/Contract Provider]	Satisfactory Compliance
Each center shall ensure the completion of the Authority for Evaluation and Treatment (AET) or Limited Consent for Evaluation and Treatment authorizing specific treatment for youth in the custody of the Department.	

The center has a policy and procedures to address parental consent. Seven youth individual healthcare records were reviewed. The admission progress notes in each record documented whether a signed Authority for Evaluation and Treatment (AET) was in the record, whether the youth was over the age of eighteen years, or whether a limited AET was completed. There was either a current AET or a copy of the valid AET in six of the seven records. One youth was co-served by the Department of Juvenile Justice and the Department of Children and Families. There was a court order allowing for the provision of routine medical treatment for the youth, as well as a limited AET in the youth's record. There were copies of parental notifications located behind the AET in each applicable record.

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 has a policy and procedures to address parental notification which provides requirements for parental notification and consent when there are changes in the youth's condition and/or treatment. A list of over-the-counter (OTC) medications approved by the designated health authority is sent to all parent/guardians. The form is to be signed and returned to the program to provide the parent/guardian consent for the medications. Seven youth individual healthcare records were reviewed. The admission progress notes in each record documented telephone contact with the youth's parent/guardian were completed or attempted. Each record contained a health-related parental notification which included the list of approved OTC medications, with instructions for the parent/guardian to sign and return the form to the center. There were parental notifications sent for new prescription medications, changes to medications the youth entered the center with, and when a youth was taken off-site for medical treatment. All telephone calls and/or attempts were witnessed by a staff member.

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

The center has a policy and procedures to address the provision of psychotropic medications. Seven youth individual healthcare records were reviewed and two youth were admitted to the

center with psychotropic medication. The center provided a third applicable record for review. Upon notification to the psychiatrist, the medications were continued for all three youth. One youth was co-served by the Department of Juvenile Justice and the Department of Children and Families (DCF). There was an order for the youth approving the provision of two psychotropic medications. The youth had been in the detention center several times starting with an admission on March 22, 2019. The youth was provided a third psychotropic medication which was not on the court order. The DCF form 'prescribing psychotropic medication, children in out-of-home care medical report' was completed and signed by the youth's psychiatrist on March 21, 2019. The form was signed as certified by the youth's DCF case manager on April 2, 2019. The center's clinical director and nurses reported seeing the court order; however, the court order was not available for review. In an effort to obtain the revised court order, telephone calls were placed to the youth's juvenile probation officer (JPO) and case manager. The youth's DCF case manager reported having the court order which would be provided to the center. This was not completed by the last day of the annual compliance review. One youth did not have the prescribed psychotropic medications. The nurse attempted to contact the youth's parent/guardian to verify the medications but was unable to reach them and there was no documentation to support contact was made nor were follow-up contact attempts documented. The psychiatrist ordered the youth to be continued on the medications. In the remaining record, there was a nurse's progress note documenting telephone contact to the youth's parent/guardian. There was documentation to support a Clinical Psychotropic Progress Note (CPPN) and Acknowledgement of Receipt of CPPN was sent to both of the youth's parents/guardians. When applicable for new medication, the CPPNs were sent certified mail as required.

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 has a policy and procedures to address the verification of youth's immunization status which requires a nurse to verify the immunizations upon the youth's admission to determine whether immunizations are needed. The center's practice is for the youth's immunization records to be reviewed by a nurse through the on-line tracking system, Florida SHOTS. The results are documented on the Department of Juvenile Justice immunization tracking record healthcare record checklist. Seven youth individual healthcare records were reviewed and each record contained the youth's immunization record. Each record documented the immunization record was reviewed and immunizations were documented on the Department of Juvenile Justice immunization tracking record for each youth. None of the youth required immunizations; therefore, no parental notification was required.

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 has a policy and procedures to address healthcare admission screening. The policy requires the completion of a Facility Entry Physical Health Screening (FEPHS) on the day of the youth's admission to the center. Seven youth individual healthcare records were reviewed. There was a FEPHS form in each record which was completed by a juvenile justice detention

officer. Each FEPHS was completed on the date of the youth's admission to the center and was reviewed by a licensed nurse within twenty-four hours of the completion of the form. The superintendent was interviewed and reported the healthcare screenings are conducted by the admission officer and medical staff.

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

The center has a policy and procedures to address the placement of youth on medical alerts. The center's nursing staff places and removes youth from the Juvenile Justice Information System (JJIS) alert and the internal alert system, as needed. Seven youth individual healthcare records were reviewed and six youth were applicable for placement on the medical alert for allergies, chronic conditions, requiring a special diet or for taking psychotropic medications. All youth were placed on and removed from JJIS alerts, as required. The admission chronological note in each record documented the completion and/or verification of alerts. During the annual compliance review, a shift briefing was observed. The youth's alerts were discussed. The superintendent was interviewed and reported the alerts are entered by staff and medical staff based on assessments, observation, and/or information provided by youth and parent/guardian. The superintendent further reported alerts are reviewed during shift briefings and staff are given the alert sheet during shift change. Seven staff were interviewed. Four reported learning of youth alerts through the alert form and four reported through the logbook and shift meetings. Two staff reported this was a very good system of communication, three reported this was a good system, one reported it was a poor system, and one staff did not respond to the question.

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 has a policy and procedures to address the screening of youth at risk for suicide for all youth who enter the center. The policy required a Suicide Risk Screening Instrument (SRSI) to be administered upon the youth's admission to the center. A section of the SRSI is to be completed by a medical or mental health provider. The SRSIs are to be completed within twenty-four hours of the youth's admission to the center. The completed SRSI forms are to be maintained in the youth's healthcare record. Seven youth individual healthcare records were reviewed and each record contained an SRSI. The required sections were completed by a nurse or mental health clinician within twenty-four hours of each youth's admission to the center.

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 has a policy and procedures to address the provision of healthcare orientation to the youth. Upon admission to the program, a comprehensive orientation to the center's medical services is provided by a licensed nurse. The nurse completing the admission chronological progress note documents the completion of orientation to healthcare to the youth. The nurses maintain a binder which includes an outline of the orientation information provided to the youth. Seven youth individual healthcare records were reviewed. The health education record in each

record documented the receipt of orientation to healthcare services. The admission progress notes for each youth documented the provision of orientation to healthcare services. The orientation covered how to access sick call, what constitutes an emergency, how medications are administered, to notify staff immediately upon having medication side effects, the right to refuse medical care, what to do in the event of actual or attempted sexual assault, and the non-disciplinary role of healthcare providers. The orientation was provided within twenty-four hours of the youth's admission to the center for each youth.

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

The center has a policy and procedures to address notification of the designated health authority (DHA). The policy requires notification to the DHA upon the youth's admission to the center if the youth has a chronic medical condition or if there is a medical emergency. The center's practice is to notify the DHA upon each youth's admission regardless of the youth's medical history or condition at admission. Seven youth individual healthcare records (IHCRs) were reviewed. In each of the IHCR there was an admission chronological progress note. The note documented the date and time of the notification of the DHA. None of the youth were admitted with an emergent medical issue. There were additional IHCRs reviewed to ensure the required sample size was reviewed for other indicators. In one of the additional IHCRs, the youth was admitted to the center with an emergency medical issue and the DHA was immediately notified of the youth's admission. The youth was sent to the emergency room following the telephone conversation with the DHA.

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

The center has a policy and procedures to address healthcare rescreening requiring a screening to be completed on youth who have been out of the physical custody of the center for longer than twenty-four hours. The screenings are required to be completed within twenty-four hours of the youth's return to the center. Seven youth individual healthcare records were reviewed and one youth was applicable. The center provided two additional applicable IHCRs for review. All three youth had been temporarily transferred to another detention center and subsequently returned. There was a new Facility Entry Physical Health Screen (FEPHS) completed for each youth. Each FEPHS was completed by a nurse on the day of the youth's return to the center.

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 has a written policy and procedures to address the completion of a Health-Related History (HRH) requiring the completion of an HRH within seven days of the youth's admission to the center. Seven youth individual healthcare records (IHCRs) were reviewed. There was either a new or updated HRH in each record documented on the Department's HRH form. Each HRH was completed by a licensed nurse on the day of the youth's current admission to the center.

The HRH forms were consistently completed or updated prior to the completion of the youth's Comprehensive Physical Assessment (CPA). There was documentation to support each HRH was reviewed by the advanced registered nurse practitioner (ARNP) at the time the CPA was being completed. The admission chronological note in each youth's IHCR documented the date the HRH was scheduled and/or 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 has a policy and procedures to address the completion of a Comprehensive Physical Assessment (CPA) which requires the youth's CPA to be completed or updated within seven days of the youth's admission to the center. The admission chronological note in each record documented the date the CPA or focused evaluation was scheduled. Seven youth individual healthcare records were reviewed and each record contained a current CPA and documentation of a focused evaluation. Each evaluation was completed by the advanced registered nurse practitioner (ARNP) within seven days of the youth's admission to the center. Each reviewed CPA was completed as required with a check of the youth's visual acuity, body mass index, scalp, head, cardiovascular, and medical grade. Each CPA contained portions of the evaluation which was deferred by the clinician. There was documentation one youth refused the examination., This refusal was in writing. The ARNP was able to complete the evaluation of the youth who refused on the ARNP's next visit to the center. The applicable youth's problem lists were updated following the completion of the CPA.

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 policy and procedures to address the provision of female-specific evaluations. The standing admission order from the designated health authority (DHA) requires the nurse to perform a pregnancy test on all female youth upon their admission to the center. Seven youth individual healthcare records were reviewed. None were applicable. The center provided three additional applicable records for review. All three youth reported to be pregnant at the time of their admission to the center. A pregnancy test was conducted on all three youth to confirm the pregnancy. The youth provided consent for the pregnancy test. None of the youth were provided gynecological examinations during their Comprehensive Physical Assessments. The admission chronological note in each record documented the result of the youth's pregnancy test. Seven youth were interviewed and none of the interviewed youth were female.

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

The center has a policy and procedures to address the completion of a tuberculosis screening. The standing admission order from the designated health authority (DHA) requires an update of the youth's tuberculin skin test (TST). If a youth's TST is not current at their admission to the center, the nurse completing the admission process conducts a TST. If the screening is positive, the youth is not to be placed in the general population until medically assessed by the DHA.

Seven youth individual healthcare records (IHCRs) were reviewed and all IHCRs contained a current TST. The results of each youth's current TST were documented on the youth's Infectious and Communicable Disease form and on the youth's Comprehensive Physical Assessment. Each reviewed Facility Entry Physical Health Screening form documented the Tier l tuberculosis screening section was completed upon the youth's admission to the center. None of the youth required further evaluation for tuberculosis.

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

The center has a policy and procedures to address sexually transmitted infection (STI) screening which requires the screening of youth upon admission to the center. During the healthcare admission, the nurse completes the sexually transmitted infections screening form with the youth. The form is signed by the youth and the nurse completing the screening. The form is reviewed by the designated health authority (DHA) or advanced registered nurse practitioner (ARNP) to determine whether the youth needs STI testing. If testing is required, the DHA or ARNP will complete an order. Upon the completion of the STI test, the results will be documented and any required treatment started for the youth. Seven youth individual healthcare records were reviewed. All records contained documentation to support the nurse completed the STI screening form on the date of the youth's admission to the center. Each form was reviewed by the ARNP. Further testing was not needed for any of the youth. None of the youth were out of the Department's custody for longer than thirty days.

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

The center has a policy and procedures to address testing for Human Immunodeficiency Virus (HIV). The center has entered into a contract with a local community agency to provide HIV testing and counseling services for the youth. There was documentation the counselor was certified to provide HIV testing services. During the healthcare admission process, an HIV risk assessment is completed by the youth. The assessment is signed by the youth and the nurse conducting the assessment. The youth are presented with the Department's HIV consent form, which allows the youth to consent or refuse an HIV test in writing. The youth who request to be tested are placed on an HIV testing log. The form includes the youth's name, date of birth, Department of Juvenile Justice identification number, and any known allergies. The form documented the date the HIV testing was requested, the date the youth was tested, and the date pre and post-test counseling was conducted. The youth consenting to be tested will be seen by the counselor during the counselor's next visit to the program. The youth are provided the results of the test verbally and the youth will receive pre and post-test counseling on the day of testing. Seven youth individual healthcare records (IHCRs) were reviewed. There was documentation to support each youth completed the HIV risk assessment. Two of the seven youth consented in writing to be tested and five youth refused in writing. The center provided three additional applicable IHCRs for review. There was documentation to support all three youth were tested and each applicable record contained documentation of pre and post-test counseling. The center does not maintain HIV test results in the youth's IHCR. The youth are provided the results verbally by the HIV counselor. The HIV consent form signed by the youth contains information the youth will receive test results in person. Seven youth were interviewed

and six youth reported being able to request an HIV test. One youth walked out of the interview after answering the first question.

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

The center has a policy and procedures to address the provision of sick call. The nurses conduct sick call seven days a week following medication administration. There are blank sick call request forms placed in the youth's living area. The forms are completed electronically and a list of youth to be seen is electronically generated with the youth's name, photograph, date of request, the name of the juvenile justice detention officer who entered the information, and the youth's medical complaint. Upon conducting sick call, the nurse completes the remainder of the sick call form. The completed forms are filed within the progress notes section of the applicable youth's individual healthcare record. The youth signs the sick call list while being evaluated by the nurse. A referral to the designated health authority (DHA) is required when a youth presents a serious health issue or complains of the same issue three times during a two-week period. Seven youth individual healthcare records were reviewed and none of the youth submitted any sick call requests. The center provided three additional applicable IHCRs for review. There were five sick call requests submitted by the three youth. None of the youth presented with the same complaint three or more times in a two-week period nor did any of the youth present with severe pain for which the nurse was unfamiliar. None of the youth had a medical issue which was considered an emergency. Each sick call request was completed by the nurse in the Subjective, Objective, Assessment, and Plan (SOAP) format. Seven youth were interviewed. Two youth reported being seen immediately upon submitting a sick call request, three youth reported being seen within one day, and one youth reported being seen within two days of submitting a request. One youth walked out of the interview after answering the first question.

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 has a policy and procedures to address the provision of sick call. During their admission to the center, youth receive an orientation of the healthcare process which includes information on the sick call process. The sick call request forms are completed electronically and a list of youth to be seen is electronically generated with the youth's name, photograph, date of request, the name of the juvenile justice detention officer (JJDO) who entered the information, and the youth's medical complaint. If a licensed practical nurse (LPN) conducts sick call, the sick call is to be reviewed by a registered nurse (RN) within twenty-four hours. Seven youth individual healthcare records were reviewed. There was documentation in each record to support the youth received orientation to the sick call process during their admission to the center. None of the youth submitted any sick call requests. The center provided three additional applicable IHCRs for review. There were five sick call requests submitted by the three youth. Three sick call complaints were handled by an RN. Two sick calls were completed by an LPN which both were reviewed by an RN within twenty-four hours. All reviewed sick call forms documented the youth's vital signs and the forms were completed in the Subjective, Objective, Assessment, and Plan (SOAP) format. The youth received treatment as prescribed by the nursing protocols. Each youth signed the sick call log to document being seen for sick call. Each sick call event was documented on the applicable youth's sick call index. During the annual

compliance review, a sick call was observed for one youth. The youth provided verbal permission for the observation. The youth submitted a sick call complaint for cold-like symptoms. The sick call was conducted by an LPN in the medical clinic. The youth was escorted to and from the clinic by a JJDO. The JJDO was in the room during the examination of the youth; however, the youth's privacy was maintained. The youth was questioned about their symptoms. The youth's vital signs were taken and documented on the sick call complaint form. The nurse examined the youth while sitting at the desk and with the youth on the examination table. The LPN consulted the nursing treatment protocols and then provided treatment to the youth. The youth signed the sick call log and form. The youth was comfortable with the process. Seven staff were interviewed. One staff reported sick call is conducted by a doctor and six reported sick call is conducted by a nurse. Two staff further reported the sick call complaints are entered into the Juvenile Justice Information System by the staff. Seven youth were interviewed. Two youth reported never having a sick call, three youth reported sick call was conducted by staff, and two youth reported sick call was completed a nurse.

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

The center has a policy and procedures to address access to medical care which includes requirements for youth placed in restricted housing for any reason. The policy requires the supervisor on each shift to question the youth placed in confinement regarding medical related issues. The supervisors are to notify medical personnel staff of the placement of youth into restricted housing. The nursing staff are required to make a daily visit and complete a narrative entry in the chronological notes of the youth's healthcare record. Seven youth individual healthcare records were reviewed and four youth had been placed in confinement. Two youth were in confinement over twenty-four hours and two youth were in confinement for less than twenty-four hours. There was a chronological progress note to document the youth being seen by medical staff in three instances. For one youth, the check by medical staff was documented in the facility management system. Two youth were taking prescribed medication and there was documentation to support both youth received their medication while in confinement. There were three youth placed in medical confinement for various medical issues, there were documented visits by medical staff during each youth's medical confinement.

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

The center has a policy and procedures to address episodic and first aid care for the youth. The policy includes the items required to be placed in the first aid kits. The center's nurses utilize a roster to document youth who require episodic care or first aid treatment. The same roster is used for youth transported for off-site treatment. There are six first aid kits in various locations throughout the center. The first aid kits for all seven transport vans were reviewed as well as the first aid kits placed in two living areas and the kitchen. All of the first aid kits were sealed and each contained all required items. None of the first aid kits contained any expired items nor were there any items which were sensitive to extreme heat. The first aid kits were inventoried monthly by the center's registered nurse and the inventories were documented on a log. Seven youth individual healthcare records were reviewed. Five youth required episodic treatment for a total of eight events. Each instance of episodic care was treated by a licensed nurse and was documented as a progress notes in the applicable youth's individual healthcare record. The

charting narrative was in the Subjective, Objective, Assessment, and Plan (SOAP) format. Seven of the eight instances of episodic treatment were documented on the center's episodic care log. The center did not have examples of episodic/first aid treatment being rendered by a non-healthcare staff.

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

The center has a policy and procedures to address emergency care for the youth. The policy requires all staff to contact 9-1-1 in the event of a potentially life-threatening situation involving a youth. The program's policy requires medical emergency drills conducted quarterly on each shift. The staff are required to maintain certification in first aid, cardiopulmonary resuscitation (CPR), and automated external defibrillator (AED). The training records for fourteen staff were reviewed for receipt of pre-service and in-service training requirements. There was documentation in each record to support training in emergency care. All staff had current certification in first aid, CPR, and AED. There was documentation to support supervisory staff were trained in the use of an epinephrine auto-injector. All of the center's nurses had current first aid and CPR certification. There is a list of emergency telephone numbers including poison control posted in the clinic. There are two AEDs in the center, one located on a living unit and one in the clinic. Both AEDs were observed and the green light was noted on both devices to indicate functionality. The battery on both AEDs expires on March 28, 2021. The center utilizes an outside company to maintain and test AEDs. The devices cannot be opened unless an emergency occurs. The expiration of pads and procedures pamphlet for use are located inside the AED. Both AEDs provide verbal instruction in addition to the pamphlets provided. The center conducted monthly checks of the AEDs to ensure each remained operational. The checks were documented on a log. The center completed quarterly medical drills on each shift. There were drills completed for seizures, choking, non-responsive, dizziness, and tooth loss. For each quarter there were drills on each shift which included CPR techniques. The drill documentation included the type of emergency event, the time the drill commenced, the name of the supervisor in charge, the medical care rendered, the name of the person concluding the drill, any deficiencies and a plan for correction, and the review and critique of the clinical manager. The drill documentation did not consistently include the actual time 9-1-1 was called, the healthcare provider response time, the staff response time, or the time the event was concluded. Seven staff were interviewed and all seven staff reported being able to call 9-1-1 in the event of an emergency

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

The center has a policy and procedures to address the provision of off-site treatment to youth which requires the completion of the Summary of Off-Site Care for all youth transported off-site for medical treatment. The policy also requires the designated health authority (DHA) or advanced registered nurse practitioner (ARNP) to review and initial all orders sent back with the youth to the center. Seven youth individual healthcare records were reviewed indicating there was one youth required off-site medical treatment. The center provided two additional applicable records for review. The youth were taken off-site for a bi-weekly infusion to be examined for a

hernia and for a broken hand. The DHA was notified when each youth was taken off-site. Each example of off-site care was documented with a Summary of Off-Site Care form. There was applicable discharge paperwork presented for all three youth. The DHA or their designee initialed the paperwork to document their review of discharge instructions for two youth. Two youth required follow-up treatment. Two youth were released from the center prior to their follow-up appointment and the information was provided to the youth's parent/guardian. One youth was still in the center and there was an appointment for the youth to receive their bi-weekly infusion. The center uses their episodic log to track off-site care. All three instances of off-site treatment were documented on the episodic log. The center's registered nurse (RN) sends emails to the center's staff regarding youth's off-site medical appointments. The RN also compiles a weekly list of all medical appointments, youth with chronic medical conditions, pregnant youth, youth in confinement, and any recent visits to the emergency room.

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

The center has a policy and procedures to address monitoring youth with a chronic illness. During the youth's admission to the center, a nurse completes the admission chronological note. If the youth has a chronic condition, it is listed on the admission progress note. All youth are placed on a list to be seen by the designated health authority (DHA) or advanced registered nurse practitioner (ARNP) on their next visit to the center. The policy requires youth with chronic medical conditions be evaluated at least every ninety days. The center's practice is to evaluate all youth who have been in the center at least every ninety days, regardless of the youth's medical history. The center's registered nurse (RN) compiles a weekly list of all medical appointments, youth with chronic medical conditions, pregnant youth, youth in confinement, and any recent visits to the emergency room. Seven youth individual healthcare records (IHCRs) were reviewed and four youth were identified a chronic condition. The youth were placed on the list compiled by the RN. There were treatment plans for the youth, when applicable. None of the youth were in the center long enough to have a periodic evaluation completed. The center provided one additional record for review. The youth had been in the center for sixty days and did not have a chronic medical condition; however, the youth was seen by the ARNP for a periodic evaluation. Two youth were taking psychotropic medication and neither had been in the center long enough to have medication management conducted by the psychiatrist. Two youth entered the center taking medications and one youth did not have the medications when admitted to the center. The nurse attempted to contact the youth's parent/guardian to verify the medications, but there was no documentation to support contact was made. The designated health authority (DHA) ordered the youth to be continued on the medications. The center's nurse reported contact was made with the youth's parent/guardian. Documentation was made on a post-it note and not on the admission progress note. The post-it note was not provided for review. The center provided two additional IHCRs for review. In the remaining IHCRs, there was documentation of the youth's medication being verified. All medications the youth entered the center with were documented on the admission progress note in the applicable youth's IHCR. The records documented notification to the DHA for all youth. There was documentation to support a verbal order to continue the medications for each youth.

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

The center has a policy and procedures to address medication verification requirements. If a youth is admitted to the center taking prescription medications, the medication regimen is required to be verified by the nurse conducting the healthcare admission process. The center only accepts medications from a licensed pharmacy with a current patient-specific label on the original medication container. Seven youth individual healthcare records were reviewed. Two youth entered the center taking medications and one youth did not have the medications with them. The nurse attempted to contact the youth's parent/guardian to verify the medications. There was no documentation to support contact was made. The designated health authority (DHA) ordered the youth to be continued on the medications. The center's nurse reported contact was made with the youth's parent/guardian. Documentation was made on a post-it note and not on the admission progress note. The post-it note was not provided for review. The center provided two additional IHCRs for review. In the remaining IHCRs, there was documentation of the youth's medication being verified. All medications the youth entered the center with were documented on the admission progress note in the applicable youth's IHCR. The records documented notification to the DHA for all youth. There was documentation to support a verbal order to continue the medications for each youth.

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

The center has a policy and procedures to address medication management which requires all medications to be given pursuant to a current prescription or physician order. Seven youth individual healthcare records (IHCRs) were reviewed. One youth was admitted to the center with prescription medications and one youth was admitted taking medications but did not have the medications when admitted. The center provided two additional IHCRs for review. In one of the records, the youth was taking medications and had the medications delivered from the parent/guardian. The medications for each youth were ordered to be continued by the designated health authority or psychiatrist. Three youth were ordered to have an epinephrine auto-injector to be used when needed. There was a valid order from the designated health authority for each epinephrine auto-injector. Any changes to medications were provided with a valid order. None of the youth were provided over-the-counter medications not listed on the Authorization for Evaluation and Treatment. There was documentation on each youth's medication administration record to support the youth received all medication as prescribed.

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

The center has a policy and procedures to address the storage of medication and items defined as sharps which includes a process for the destruction and disposal of applicable medications. There is a medical clinic in the administration area of the center which is locked at all times. All medications including prescription and over-the counter (OTC) medications are maintained in the clinic. All prescription medications for the youth, as well as a working supply of OTC

medications are maintained in the locked medication cart. The medication cart which has separate drawers in which various types of medications are stored, is always stored in the clinic. Each youth's medications are maintained separately. There are bulk OTC medications stored in locked cabinets in the clinic. All medications are inaccessible to youth. The narcotics and controlled medications are on the medication cart behind two separate locks. There is a refrigerator in the clinic for medications and medical supplies requiring refrigeration. The refrigerator was observed to contain only medical supplies. All sharps are securely maintained in the clinic. There was documentation to support the center followed their policy regarding the disposal of medications.

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 has a policy and procedures to address the storage of medication and items defined as sharps. The policy includes a procedure to follow in the event of any discrepancies in the counts. There is a clinic in the administrative area of center which is locked at all times. There is a locked medication cart which contains prescription medications for the youth and a working supply of over-the-counter (OTC) medications. The center maintains all bulk OTC medications, syringes, and sharps in the locked cabinets in the clinic. There were weekly and perpetual counts of the sharps and the OTC medications completed by the nurses. The inventories for the past six months were reviewed and the inventories were completed as required. During the annual compliance review, the counts of three sharps including suture removal kits, staple removal kits, and lancets were matched against the current inventory. All counts matched the inventory. Three OTC medications were counted. The counts of all three items matched the current inventory. Three youth specific prescription medications were counted and all matched the current count of the medication.

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

The center has a policy and procedures to address the management of controlled medications including a procedure for conducting shift-to-shift counts. There is a locked medication cart which contains a working supply of over-the-counter (OTC) medications, as well as the prescription medications for the youth. The cart is maintained in the locked clinic. The controlled medications are stored behind a second lock on the medication cart. At the time of the annual compliance review, there were no controlled medications on-site since there were no youth taking a controlled medication. There was one example to review where the center documented a perpetual count of the controlled medication on the applicable youth's Controlled Medication Inventory Record. The inventory documented the youth received the medication as required. There was a perpetual count documented for each dosage. The nurses completed shift-to-shift counts of the medication which were documented by the nurse's initials on the inventory. A shift-to-shift count of controlled medications was not observed during the annual compliance review.

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 has a policy and procedures to address medication administration. The center utilizes pre-printed pharmacy medication administration records (MAR). Seven youth individual healthcare records were reviewed found each youth received a prescription medication, had an epinephrine auto-injector for use if necessary, or was given an over-the-counter (OTC) medications during their stay in the center. There was a MAR to document the administration of medications for each youth. All reviewed MARs contained the youth's name, Department of Juvenile Justice identification number, date of birth, allergies, side effects, medical grade, precautions, and medical alerts. The start and stop dates for the medications were consistently recorded on the MARs. There was weekly monitoring for side effects consistently documented on the MARs. There were no lapses of medication noted. None of the youth refused medications. There is a photograph of each youth with the active MARs to assist in the medication administration process. The active MARs are placed in a binder on the medication cart. A review of applicable MARs documented each youth received medications as ordered. The nurses provide medication to the youth every day; however, trained supervisory staff are authorized to administer medication when licensed medical staff are not on-site.

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

The center has a policy and procedures to address their medication administration process. The medications are administered by licensed nurses, unless a youth requires medication at a time when licensed nurses are not on-site. There were no youth requiring the administration of parenteral medications. During the annual compliance review, the medication administration process by a licensed nurse was observed for two youth. Both youth provided verbal consent for this observation. One youth was provided medication following sick call and one youth was provided medication on a regular basis. Both youth were escorted to the clinic by a juvenile justice detention officer (JJDO). There is a counter in the clinic where both the youth and the JJDO stood on one side of the counter and the nurse stood on the other side with the medication cart as a barrier between the youth and nurse. The youth were asked to identify their name, the medication they were taking, and whether they were experiencing any issues. The nurse's sole responsibility was to provide the medication as the JJDO supervised the youth. The nurse verified the youth, the correct medication for the correct youth, and then poured the medication into an awaiting paper container. The youth was provided a cup of water and were provided the medication in a small paper container. After the youth swallowed the medication, the nurse had the youth to open their mouth and then cough to verify the youth swallowed the medication. The nurse and youth initialed the medication administration record. In this annual compliance review period, the center had two incidents reported to the Central Communications Center (CCC) involving a youth not receiving medication as required. Both reports were closed as there was no evidence of harm to the youth. Seven youth were interviewed. One youth refused to participate in the interviews and walked out, one youth reported receiving medication from a doctor, and five youth reported nurses provided medication.

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

The center has a policy and procedures to address the medication administration process. There are trained non-healthcare staff to assist youth in the self-administration of medication when licensed healthcare staff are not on-site. The center has a list of supervisory staff who are authorized access to medications. The staff on the list were identified by name and title. The medication administration process by non-licensed staff was not observed during the annual compliance review as non-healthcare staff rarely provide medication to the youth. Seven youth individual healthcare records were reviewed. There were no examples in which non-medical staff provided over-the-counter (OTC) medications to the youth. The center provided one applicable record for review. The youth and supervisor initialed the youth's medication administration record to document receipt of the medication. Seven staff were interviewed and all seven staff reported they did not give medication to the youth. Seven youth were interviewed. One youth refused to participate in the interviews and walked out, one youth reported receiving medication from a doctor, and five youth reported nurses provided medication.

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

The center has a policy and procedures to address monitoring youth taking psychotropic medications. The procedures did not include standing orders for psychotropic medications nor for the provision of emergency treatment orders for psychotropic medications. Upon admission to the center, notification is provided to the designated health authority (DHA) for all youth taking psychotropic medication. The DHA and the psychiatrist are notified for youth taking psychotropic medication upon admission. The psychiatrist determines whether the medication should be continued until an evaluation is completed. Seven youth individual healthcare records were reviewed and indicated two youth were admitted to the center with psychotropic medication. The center provided an additional third applicable record for review. The psychiatrist was notified upon admission for all three youth. The psychiatrist ordered the medication for all three youth to be continued until the initial psychiatric evaluation was completed. One youth was co-served by the Department of Juvenile Justice and the Department of Children and Families (DCF). There was an order for the youth approving the provision of two psychotropic medications. The youth entered the center with three medications in which the psychiatrist ordered all three medications to be continued. A psychiatric evaluation was completed for all three youth and the medications were continued for both youth following the evaluation. Each psychiatric evaluation was completed using the Clinical Psychiatric Progress Note (CPPN) and contained all required information including the identifying data, diagnosis, target symptoms of each medication, evaluation and description of the effect of prescribed medication, dosage and quantity of prescribed psychotic medication, side effects, youth's adherence to the medication regime, and vital signs, when appropriate. The evaluations were signed by the psychiatrist and the signatures were dated. None of the youth were applicable for medication monitoring. There were no youth who were in the center long enough to have medication management conducted. None of the youth required Tardive Dyskinesia screening.

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

The center has a combined infection control and exposure control plan. The plan included all required elements such as common infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, hepatitis A, B and C, Human Immunodeficiency Virus (HIV), infectious diseases, other outbreaks or epidemics caused by any other infectious agent, outbreaks of pediculosis, and/or scabies, methicillin-resistant staphylococcus aureus (MRSA), food-borne illnesses, bio-terrorist agents, and chemical exposures in the workplace were on the plan. The plan did not contain information regarding tuberculosis as there is a separate policy which address tuberculosis control and screening. The medical provider has separate instructions for employees to follow for needle stick claims. The infection control plan was reviewed and signed by the designated health authority on April 30, 2019. The superintendent signed to document their review of the plan; however, the superintendent's signature was not dated on the plan. The plan addresses requirements for staff training, hepatitis B vaccination, and post-exposure follow-up. During pre-service training, staff are provided information regarding hepatitis B immunizations. There were no reportable incidents for notification to the local county health department and/or Centers for Disease Control since the last annual compliance review. There are spill kits and personal protective equipment such as bio-hazard bags, gloves, gowns, and masks available to the staff.

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's infection control plan contains requirements for the provision of infection control training for staff and youth. The healthcare records of seven youth were reviewed. There was documentation in each record to support the receipt of infection control education. The Health Education Record in each youth's record documented the education was provided within seven days of the youth's admission to the center. All required elements including hand washing, standard precautions, the prevention of communicable diseases, vaccinations, and the Center for Disease Control guidelines were included. The training records of fourteen staff were reviewed for the receipt of pre-service and in-service training. All records documented training on the center's exposure control/infection control plan and blood borne pathogens. The training was provided annually as in-service and as part of the center's pre-service training. The training was facilitated by a nurse.

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

The center has a combined infection control and exposure control plan. The plan includes all required elements including risk assessment and methods of compliance. The plan was reviewed on April 30, 2019 by the designated health authority. The superintendent signed the plan to document review of the plan; however, the superintendent's signature was not dated on the plan. There was training on the center's exposure control plan provided annually by the center's registered nurse. The exposure control plan is located in the clinic. There is a copy of the exposure control plan in a separate binder in the staff room to allow for staff to access when needed.

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

The center has a policy and procedures to address the care of pregnant youth. The center developed a log on which to track services provided to pregnant youth. The log includes the youth's name, date of birth, date of admission, pre-natal care provided, and education topics provided to the youth. Seven youth individual healthcare records were reviewed and none were applicable. The center provided three additional applicable records for review. All three youth reported being pregnant upon admission and a pregnancy test was conducted on all three youth to confirm their pregnancy. The designated health authority (DHA) was notified for all three youth. The DHA ordered pre-natal vitamins for all three youth. One youth was transported to a women's clinic for an obstetrical visit. The Medication Administration Record (MAR) for one youth was provided for review which documented the youth received the vitamins and supplements daily during their stay in the detention center. During the daily administration of vitamins, the youth was monitored for danger signs of pregnancy complications. The remaining two youth were transferred to other facilities; therefore, their MARs were not available for review. The pregnant youth log documented the care received by two youth as one youth was transferred to another detention center prior to the start of any pre-natal care. All three youth were in the center for less than two weeks.

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

The center has a policy and procedures to address the care of pregnant youth. The center developed a log on which to track services provided to pregnant youth. The log includes the youth's name, date of birth, date of admission, pre-natal care provided, and education topics provided to the youth. The center has a binder of education topics related to pregnancy to be presented to pregnant youth. The topics include alcohol and drug use, smoking, nutrition, sexually transmitted infections, contraception, pre-natal care, birthing process, post-partum

care, basic baby care, shaken baby syndrome, child development/milestones, health and nutrition, anxiety/depression, and parenting skills. Seven youth individual healthcare records were reviewed and none were applicable. The center provided three additional applicable records for review. There was documentation in each youth's record of the receipt of pregnancy related education. Each youth were in the center for less than two weeks. The pregnant youth log documented the specific topics provided to two youth which included no heavy lifting and increase of water intake. The Health Education Record for each youth documented the youth received pre-natal, post-nata, and parenting skills education.

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

The center has a policy and procedures to address the care of pregnant youth which includes training requirements. There was documentation to support the provision of training on female health which included information for pregnant youth including nutrition and diet, complications, medical conditions, and when to notify medical staff.

Standard 5: Safety and Security

5.01 Active Supervision of Youth (Critical)	Satisfactory Compliance

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

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

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

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

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

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

The center has a policy and procedures regarding supervision of youth. During the annual compliance review, observations were conducted and included active staff supervision of youth during their daily activities such as education, lunch, group, and line movement. All youth were accounted for and accompanied by center staff during all observations on each of the four days of the annual compliance review. All communication with the youth were positive and respectful. Youth were orderly and staff were properly positioned to address any concerns during line movement and other activities. Master control staff is responsible for the daily tracking of youth census, authorizing all movement of youth, and maintaining documentation of the census in the master control logbook which was confirmed through observations. Daily census tracking is also documented in each of the three module logbooks, in addition to the Department's Juvenile Justice Information System (JJIS). There is a white board stationed in master control, all three modules, and the intake office which also tracks the youth census. Seven staff interviews were completed and all staff reported counts of youth are conducted before and after each shift. Movement of youth is controlled by the staff in master control and if counts need to be reconciled, movement will be ceased until master control corrects the count with the staff.

5.02 Ten-Minute Checks (Critical)	Limited Compliance
Staff shall visually observe youth on standard supervision at least every ten minutes while they are in their sleeping quarters, either during sleep time or at other times, such as during an illness or room restriction. *Staff conducts observations in a manner ensuring the safety and security of each youth and documents 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.* *There shall be no obstructions (e.g., clothing, memos, pictures) over windows and areas where direct line of sight is needed.* *If an officer, in the course of completing visual observation, is unable to see the youth or any part of the youth's body, the officer shall, with the assistance of another officer, open the door to verify the youth's presence.*	

The center has a policy and procedures in place to visually observe youth on standard supervision at least every ten minutes when youth are in their sleeping quarters to ensure the safety and security of each youth. There shall be no obstructions on the windows and staff must have a direct line of sight to each youth. If a staff is unable to visually see the youth, the staff opens the door with another staff to ensure the youth is present and safe. The program utilizes the Guard Wand system to record checks electronically during sleeping hours which requires staff to physically touch a button outside of each room door with a wand for each check. The Guard Wand system then generates reports for all ten-minute checks conducted utilizing the electronic wand system. When ten-minute checks are required during awake hours, the center utilizes Visual Observation Report (VOR) forms to manually document the ten-minute checks. Alpha dorm check reports were reviewed for six days on March 24, March 31, April 9, April 18, April 26, and May 5, 2019. The Guard Wand software was utilized and documented twenty-three rooms had late checks of three minutes on April 18, 2019. Bravo checks were reviewed for the same six days and there was one room with a late check of three minutes on April 18, 2019 and ten rooms with a late check of four minutes on April 26, 2019. The program has forty-seven cameras and all are operational according to an interview with master control and staff. This video is stored for sixty days. Video of the ten-minute checks corresponding to the reviewed Guard Wand reports were reviewed. The video for Alpha dorm found a staff did not visually check all rooms on March 31, 2019, missing rooms four through seven and eleven through thirteen. One staff did not visually check rooms on April 26, 2019 missing rooms three through six. In each instance, the staff did not pause at the room for visual checks as required by the center's policy. The video for the Bravo dorm appeared to show the staff on March 27, 2019 were not consistently pausing at doors three, four, six, and seven to check the rooms. Additional VORs were requested by the review team; however, the center did not provide them. During the annual compliance review, a VOR was observed on a confinement room door outside of the Alpha B1 unit and the checks were not documented in real time as they were documented every ten minutes.

5.03 Census, Counts, and Tracking	Satisfactory Compliance

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

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

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

The center has a policy and procedures requiring staff to identify the number and location of youth at all times. The youth counts are called into master control at the beginning and end of each shift, following emergencies, prior to and following routine group movement, at population changes, and once randomly during each shift. Staff do not include youth which are not physically present. Logbooks were reviewed for the last six months and found counts were documented as required. Seven staff were interviewed regarding counts and tracking, each staff verified the center's policy. Counts were observed by a review team member and all were completed according to policy.

5.04 Logbook Maintenance	Satisfactory Compliance

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

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

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

The center has a policy and procedures to maintain a chronological record of activities in logbooks in master control and for each living area which were reviewed for the annual compliance review period. The logbooks are bound with numbered pages. Additionally, the center maintains shift reports which are password protected within the Department's Juvenile Justice Information System (JJIS) under the Facility Management System section. The logbooks include the date of entry and incident, time, names of staff and youth involved, a brief description of the incident, and the initials of the person making the entry. The entries are made in black or blue ink and white out is not used. If there is an error, one strike-through is made and

the error is initialed by the staff correcting the error. Entries including medical, special needs, mental health alerts, or facility safety and security are highlighted. The master control logbook labeled January through March 2019 was not dated for pages ninety-one and 113. There were no strike throughs or initials for corrections on pages 116, 259, 271, and 278. There were no initials for overwrites on page 202 for the master control logbook labeled November 2018 through January 2019.

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

The center has a policy and procedures for the superintendent or designee to review all logbooks weekly. A review of the logbooks found the superintendent or designee were completed as required. A review of master control logbooks and unit logbooks found the supervisor reviewed the master control and living unit logbooks when accepting responsibility of the center and documents recommendations where applicable. The staff assigned to a module reviews the logbook in their assigned module. The supervisor tours the living areas at least once during each shift and documents the visit. A review of the logs and supervisory notes found three Bravo rooms and two Alpha rooms were randomly checked. These checks were documented in the logbooks with directions for disposal of any contraband found and critiques of the findings. Documentation indicated the youth had pencils, pens, and extra towels.

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

The center has a policy and procedures regarding maintaining inventory and control of all center keys. Master control staff is designated to operate, distribute, and collect keys. Upon arrival to the center, contractors and visitors are to turn in personal keys to master control to be secured.

Each individual receives a numbered chit token until their visit is completed for a return of personal keys. Staff are also to turn in personal keys placing them in secured lockers. During the first three days of the annual compliance review, several reviewers were not assigned numbered chit tokens for receipt of personal keys due to no more chit tokens were available for distribution. The center was notified of the issue and on the fourth day of the review the center's master control provided each review team member with a key to a security box to secure their keys. Incoming staff on a shift is assigned the same set of keys each time they are on a shift and the key distribution is documented in a key control logbook. The key control logbook logs the name of staff assigned a key, time the key was issued, and/or returned. A review of the center's key logbook confirmed this practice in tracking of keys. Observations were conducted on key storage areas to determine the level of security. All active center keys were stored in a locked cabinet located near master control. Restricted keys and emergency keys are located in a cabinet in master control. The cabinet for restricted keys was not secured and observed actively being open and closed on several occasions throughout the review without being locked by center staff. Administration was notified and revealed to the review team the cabinet is inoperable due to the lock being broken. Staff did not notify the supervisory staff in order for the cabinet to be repaired.

A review of the center's key inventory was conducted to determine if a sample of twelve key rings on the inventory matched the actual key rings in use. Five individual cuff keys included a numbered tamper-resistant key ring; however, all cuff keys were not listed on the key inventory. A check of a supervisor key actively being used revealed sixteen keys; however, the inventory noted fifteen keys. Twelve sets of keys were observed, a total of four keys were broken of which two were attached to the supervisor keys. Administration was notified of the findings and was corrected on-site with a work order request to the maintenance mechanic. Two of the broken keys identified were removed and labeled as key broken with a chit token notification. Administration confirmed the two broken keys on the assigned supervisor key set are not used as egress keys. A random check of three staff for personal keys was completed. Each staff had their assigned set of center keys. In the past six months, there was one report of lost keys on February 10, 2019 to Central Communications Center (CCC). During the annual compliance review, the CCC report remains open and under investigation. An informal interview with staff regarding the procedure for missing keys revealed the center is shut down, searches of youth are completed, movement is tracked, and a call to the CCC is completed within two hours. Seven staff were interviewed and each staff were knowledgeable of the program's key control process as it related to issuance of keys, tracking, and documenting use.

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

The center has a policy and procedures to ensure vehicles transporting youth are properly maintained with documentation on the use and maintenance of each vehicle. The center has seven fifteen passenger vans used for youth transports. During the annual compliance review, preventative maintenance invoices were reviewed which revealed all vans were up-to-date with a required annual inspection. A security check was conducted of the vehicles when not in use and all were observed to be secure. All vehicles used to transport youth were equipped with the

required safety equipment. All seven vehicles were inspected. One vehicle had severe tearing across the back of the backseat cover in the last row and half tearing of the back of the backseat cover on the row in front. Graffiti was written on the two back seat rows. One vehicle had a light fixture pulled out with hanging wires protruding from the ceiling of the vehicle. One vehicle had severe tearing on the corner of the backseat cover at the last row. Administration was notified of the findings and removed these three vehicles from active use until repaired. One vehicle's left rear door has a wire hinge sticking out of the door lock. The door was severely jammed and required numerous pulling and tugging to open. The van was removed from active duty. A review of the center's monthly and weekly checklist inspections of the vehicles for the past six months was completed. There were three vehicles missing three months of monthly inspections, one vehicle was missing five months, and three vehicles were missing one month each. Upon review of the weekly inspections, it was found one vehicle had a total of four weeks of weekly inspections missing. One vehicle had two weeks of weekly inspections missing and one vehicle had one week of weekly inspections missing. In addition, the weekly inspection documentation found the individual completing the inspection and/or supervisor reviewing the inspection was not consistently documented. A youth transport return was observed during the annual compliance review and reflected the vehicle was searched for contraband after use, in addition to the youth being searched upon entry to the center. A youth transport in which one youth and two staff were leaving the center was observed found both the youth and staff were secured with seatbelts prior to leaving the center. The staff had a vehicle folder and assigned cell phone. The inspection of the vehicle prior to departure was not able to be observed.

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

The center has a policy and procedures to address tool inventory and management. Tools are stored in a tool shed which is separate from the center and requires authorized key access to the secured area. An observation of the shed was completed and found the door was open and the shed unsupervised. The center has a shadow board displaying all the tools with a number corresponding for returning and securing purposes. The tools were marked with an identification code identifying the tool as property of the Department. During the observation, it was found two tools were broken, two tools beside each other were flipped with one another on the shadow board, and three tools were missing during the observation. However, the center was able to account for two of the tools after notification to administration. One tool was found on the table unmarked and not labeled which the center was not able to account for. Several ladders located near the tool shed were in a secure area; however, were left unsecured leaning against the side of the building. The center removed the items and secured them within the shed. The center has a daily inventory list to track a perpetual inventory which was found to be completed daily; however, there was no daily tool inventory list completed for November 2018. The center did not utilize a sign-in and out log tracking the use and return of tools for duration of the annual compliance review period. The center completed a monthly tool inventory from November 2018 to April 2019; however, the April 2019 monthly inventory form was blank. The November 2018 inventory notes three tools were marked as not accounted for and there was no explanation provided if the tools were damaged, repaired, or replaced. Two broken tools were listed on the inventory for several months with no supporting documentation of notification for tools as damaged, needing to be repaired, or replaced. The one tool observed to be missing by the review team was accounted for on-site on the March of 2019 inventory checklist; however, there is no documentation what happened to the tool. The tools was identified as an electric tool sharpener valued under three hundred dollars. Each of the monthly inventories were signed off

by required parties. The superintendent explained during an interview, if a tool was missing or damaged, notification will be submitted to administration by the maintenance mechanic and the item will be left on the inventory and shadow board until repaired or replaced.

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

The center has a policy and procedures in place to ensure kitchen sharps, equipment, and other hazardous items are securely stored. The center's policy prohibits the use or access of any tools including kitchen sharps and equipment by youth. The center's kitchen sharps are secured on a shadow board inside a locked cabinet when not in use. During the annual compliance review, a physical count of stored items was conducted to ensure inventory accuracy. The center has twelve kitchen sharps labeled by a number securely locked in a cabinet. One item stored in the cabinet was not listed on the inventory. The center's policy indicates kitchen staff are required to account for an itemized inventory of all kitchen sharps and equipment upon reporting to duty and prior to departure. The center did not provide supporting documentation of this practice for the last six months; therefore, the review team was unable to verify this practice. The center provided a daily sign-in and sign-out sheet of all sharps by kitchen staff. The inventory does not identify a.m. and p.m. time frames for majority of the sign-in and sign-out logged. In addition, the review team could not determine what sharps were used by staff due to staff signing out a knife by color or documenting the knife as a new knife and not the assigned number corresponding to each sharp listed on the sheet. The assistant superintendent was interviewed and was able to indicate the process of reporting missing or damaged kitchen tools by stating the Department of Juvenile Justice reporting procedures.

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. *Youth may use cleaning items such as mops, brooms, buckets, and other common household items under direct supervision.*	

The center has a policy and procedures regarding youth access to tools and cleaning items. Informal interviews with center staff, kitchen staff, and the maintenance mechanic revealed youth do not have access to the areas where kitchen and class A tools are stored. Youth do not have permission to handle the tools. The center tools are secured in locked areas which are inaccessible to youth. During the annual compliance review, two youth were being observed cleaning the center main walkway, one youth was using a broom and another youth was using a mop. Both youth were actively supervised by the center's staff. Seven youth were interviewed one youth refused and walked out following the first question leaving six applicable youth

interviews. Six youth and seven staff were interviewed and each reported youth do not have access to any tools.

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

The center has a policy and procedures to address the inventory of all flammable, toxic, caustic, and poisonous items with inclusion of a safety plan. All flammable, toxic, caustic, and poisonous items are stored in cabinets located in a secured area inaccessible to youth. Chemicals are stored in cabinets near and in the maintenance mechanic office, a paint shed, and a wooden box in a room within the center which has restricted access for only maintenance personnel, superintendent, and assistant superintendents. Upon arrival to the maintenance area, one cabinet storing chemicals was not secured with a lock. The tool shed which also stores chemicals was not locked and was unsupervised. The center corrected the reviewer findings with adding a lock to the cabinet before leaving the area. A review of the Safety Data Sheets (SDS) binder found a corresponding sheet for chemicals present in areas storing these items. The administrators have the responsibility to ensure all chemicals are inventoried and properly secured. A review of the past six months inventory of chemicals from November 2018 to May 2019, noted a perpetual and monthly inventory was completed for most of the chemicals located in the maintenance mechanic office and paint shed. The center does not currently have a sign-in and sign-out log of chemicals used. Several discrepancies were found on each of the reviewed inventories. An accurate beginning and ending total of chemicals on-site was unable to be confirmed for each month. The recorded information of chemicals added and removed from the inventory was recorded incorrectly and did not match from month to month. Are review of the inventories for November 2018 and March 2019, found one item being inventoried was not accounted for. In February 2019, three items inventoried were not accounted for. The inventory of nine chemicals in the shed, eight chemicals in the paint shed, and four chemicals located in a secured room in the center was compared to the actual items on-site. Eleven items did not match what was listed on the inventory as items were less or more than what was recorded. An observation of the chemicals stored in the paint shed found the center has six buckets of paint not listed on the inventory which are being stored on-site for a contractor who left them at the center. The chemical inventory list for the items stored in the room located in the center which stores items used daily by staff, does not have a monthly inventory nor does it have a sign-in, sign-out, or log of staff using these items from this area. The current chemical

inventory log provided to the review team which documented items stored in the room was dated from May 2018.

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. *Youth shall not be permitted to use, handle, or clean-up dangerous or hazardous chemicals or respond to chemical spills. Youth shall not be permitted to clean, handle, or dispose of any other person's bio hazardous material, bodily fluids, or human waste.*	

The center has a policy and procedures in place prohibiting youth access and handling of flammable, toxic, caustic, and poisonous items. The center chemicals are secured in locked areas and are inaccessible to youth. During the annual compliance review, there were no observed incidents of chemicals being accessible to youth. Seven youth were interviewed. One youth refused and walked out following the first question, leaving six applicable youth interviews. Six youth and seven staff were interviewed. Each reported youth do not have access to any chemicals. Youth can utilize mops and brooms for cleaning purposes. Staff follow center procedures to pre-mix household chemical and spray for youth to wipe and clean the assigned area.

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

The center has a policy and procedures addressing the disposal of flammable, toxic, caustic, and poisonous items. The center is contracted with a company to dispose of flammable, toxic, caustic, and poisonous items. In the past six months, the center has disposed chemicals, flammable items, and equipment as required in policy. The superintendent indicated there were no chemical spills since the last annual compliance. The food service kitchen area prepares food with ovens and steamers. The preparation of food which requires the use of grease is not utilized.

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

The center has a policy and procedures to use behavioral confinement as an immediate short-term response to volatile situations exhibited by a youth which substantially threaten the physical safety of themselves or others. Confinement room windows and cameras are free of obstruction and confinement rooms contain no non-fixed items. A review of the center's logbooks during the annual compliance review period, confirmed youth in confinement are provided living conditions similar to those in the general population. Twenty-five youth confinements under twenty-four hours were reviewed. Each confinement report documented

confinement rooms are searched prior to placement. A confinement report is completed within one hour and submitted to the superintendent for a review of confinements within two hours for fairness and appropriateness. Youth are spoken with every three hours by a supervisor and the need for continued confinement is based on severity, history, or behavior is documented. A review is completed by the superintendent within forty-eight hours. Confinements are communicated to education for tracking school assignments. Ten of the twenty-five youth were continued in confinement without proper notation to justify the continued confinement. Many of the notations only documented the youth presenting as calm and confinement was continued or the youth was spoken with and confinement was continued at one or more entries.

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

The center has a policy and procedures for confinement beyond twenty-four hours to be approved by the superintendent or designee, as well as every twenty-four hours afterwards. Five youth confinement reports were reviewed for confinements extending beyond twenty-four hours. Each of the reviewed reports indicated the supervisor evaluated the youth's status every three hours. Youth behavior and conversations were documented as evidence for the need to continue or terminate confinement. Each confinement room was searched prior to placement and a mental health professional reviewed the status of the youth every twenty-four hours. Two of the five youth did not have documentation the regional director was notified and authorized permission for the youth's confinement to extend beyond twenty-four hours. Additionally, there was not supporting documentation for continued confinement prior to twenty-four hours for any of the five youth. The documentation indicated the youth's behavior was appropriate at the time; however, confinement continued. None of the youth were applicable for confinement exceeding three days.

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

The center has a policy and procedures for Continuity of Operations Planning (COOP) drills to be conducted and documented at a minimum of two times a year with one drill completed prior to the first day of June. This plan includes the potential relocation of the center's youth and staff while maintaining operations, safety, and security. The required drills include severe weather, major disturbances, hostage situations, chemical spills, flooding, or terrorist threats/acts. The program's Disaster Preparedness Plan was reviewed and the accompanying annexes. Seven staff were interviewed to determine the knowledge of these policies and each staff acknowledged severe weather and tornado drills were being conducted. The center had documentation of regularly checking their emergency checklist of items in an emergency; however, there was no documentation of COOP drills on emergency reporting drill forms. The COOP drill was documented in the master control logbook and seven staff interviews indicated they participated in a severe weather drill, fire drills, and escape drills.

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

The center has a policy and procedures to develop, implement, and maintain escape prevention which incorporates the Department's policies regarding escape. The center conducts quarterly mock escape drills each shift which are documented on emergency drill forms as escape drills. Seven staff training records indicated all seven staff have been trained annually in escape prevention. The logbooks were reviewed for drill documentation. Seven staff interviews acknowledged escape drills were performed quarterly and training is provided and completed.

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

The center has a policy and procedures to implement a fire prevention plan to conduct monthly fire drills and document the drills for each shift. Drills were being documented on the emergency drill forms as fire drills. A review of the past six months fire drills indicated all staff present and assigned on the shift participated in the drill. The drill procedures were approved by the local fire officials. Seven interviewed staff confirmed fire drills are performed monthly.

Program Name: Hillsborough West Juvenile Detention Center
Provider Name: State of Florida, Department of Juvenile Justice
Location: Hillsborough County / Circuit 13
Review Date(s): May 14-17, 2019

MQI Program Code: 294
Contract Number: NA
Number of Beds: 93
Lead Reviewer Code: 173

Overall Rating Summary

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

Limited Ratings	Failed Ratings
3.08 Psychiatric Services	5.07 Vehicles and Maintenance
5.02 * Ten-Minute Checks	5.08 Tool Inventory and Management
5.06 Key Control	5.09 Kitchen Tools
5.14 Confinement Under Twenty-Four Hours	5.11 Inventory of all Flammable, Toxic, Caustic, and Poisonous Items
5.15 Confinement Over Twenty-Four Hours	
5.16 Continuity of Operations Planning (COOP) Drills	