STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Leon Regional Juvenile Detention Center

Department of Juvenile Justice

(State-Operated)
2303 Ronellis Dr.
Tallahassee, Florida 32310

Review Date(s): August 13-16, 2019

Promoting Continuous Improvement and Accountability
in Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Jill Foy, Office of Program Accountability, Lead Reviewer (Standard1)
Ashley Alban, TrueCore Behavioral Solutions, Regional Health Services Administrator (Standard 4)
Tara Frazier, Office of Program Accountability, Regional Monitor (Standard 3)
Warren Garrison, Office of Program Accountability, Regional Monitor (Standard 5)
Cina Wilson-Johnson, Office of Staff Training & Development, Director (Standard 2)

Program Name: Leon Regional Juvenile Detention Center
Provider Name: State Operated
Location: Leon County / Circuit 2
Review Date(s): August 13-16, 2019

MQI Program Code: 32
Contract Number: N/A
Number of Beds: 45
Lead Reviewer Code: 168

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
2.18 Trauma-Informed Care	1.07 In-Service Training
4.04 Parental Notification/Consent	
4.07 DHA/Designee Admission Notification	
5.10 Inventory of all Flammable, Toxic, Caustic, and Poisonous Items	

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	Failed
1.08	Entering Alerts(JJIS) and Sharing of Alert Information *	Satisfactory

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

Standard 2: Youth Management
Detention Rating Profile

Indicator Ratings

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

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

Indicator Ratings

Standard 3 - Mental Health and Substance Abuse Services		
3.01	Designated Mental Health Clinician Authority (DMHCA)	Satisfactory
3.02	Licensed MH/SA Clinical Staff *	Satisfactory
3.03	Non-Licensed MH/SA Clinical Staff	Satisfactory
3.04	MH/SA Admission Screening	Satisfactory
3.05	MH/SA Assessment/Evaluation	Satisfactory
3.06	MH/SA Treatment	Satisfactory
3.07	Treatment and Discharge Planning	Satisfactory
3.08	Psychiatric Services *	Satisfactory
3.09	Suicide Prevention Plan *	Satisfactory
3.10	Suicide Prevention Services *	Satisfactory
3.11	Suicide Precaution Observation Logs *	Satisfactory
3.12	Suicide Prevention Training *	Satisfactory
3.13	Mental Health Crisis Intervention Services *	Satisfactory
3.14	Emergency Care Plan *	Satisfactory
3.15	Crisis Assessments *	Satisfactory
3.16	Baker and Marchman Acts *	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/Consent	Limited
4.05	Healthcare Admission Screening & Rescreening Form	Satisfactory
4.06	Youth Orientation to Healthcare Services/Health Education	Satisfactory
4.07	DHA/Designee Admission Notification	Limited
4.08	Health-Related History	Satisfactory
4.09	Comprehensive Physical Assessment/TB Screening	Satisfactory
4.10	Sexually Transmitted Infection Screening & HIV Screening	Satisfactory
4.11	Sick Call Process	Satisfactory
4.12	Episodic/First Aid Care/Emergency Care	Satisfactory
4.13	Off-Site Care/Referrals	Satisfactory
4.14	Chronic Conditions/Periodic Evaluations	Satisfactory
4.15	Medication Management	Satisfactory
4.16	Medication/Sharps Inventory and Storage Process	Satisfactory
4.17	Infection Control/Exporsure Control/Education	Satisfactory
4.18	Prenatal Care/Education	Satisfactory

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Standard 5: Safety and Security
Detention Rating Profile

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

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Program Overview

The Leon Regional Juvenile Detention Center is a state-owned detention facility, operated by the Department, located in Tallahassee, Florida. The center serves youth in Leon, Gadsden, Jefferson, Franklin, Liberty, Madison, Taylor, and Wakulla counties in Circuit Two. Male and female youth who are detained pending adjudication, disposition, or placement in a residential commitment program are housed in the forty-five 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 Leon County School Board. The center's management team includes the superintendent, two assistant superintendents, one administrative assistant, nine juvenile justice detention officer (JJDO) supervisors, and thirty-four JJDOs. Mental health and healthcare services are provided through the contracted provider Camelot Community Care, who is subcontracted through Maxim Health Services. Mental health services are provided by one licensed designated mental health clinical authority (DMHCA), one licensed mental health counselor (LMHC), one licensed clinical social worker (LCSW) who is pro re nata (PRN), and one psychiatrist. 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 one designated health authority (DHA), one advanced registered nurse practitioner (ARNP), one registered nurse (RN), and two licensed practical nurses (LPNs). The medical clinic maintains nursing coverage Monday through Friday, from 7:00 a.m. to 8:00 p.m. and on weekends from 8:00 a.m. to 4:30 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 forty-eight security cameras at the center, of which forty-three were operational. The interior of the center was observed to be recently repainted, clean, and free of graffiti. At the time of the annual compliance review, the center had eight vacancies, which included eight juvenile justice detention officer (JJDO) II positions.

Standard 1: Management Accountability

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

The center has a written policy and procedures ensuring all Department employees, contracted providers, volunteers, mentors, and interns with access to youth undergo a criminal history background screening prior to hiring. Since the last annual compliance review, the center had thirteen new hires. The center has one volunteer who has visited the center for the previous three years and has a valid background screening. Each of the thirteen new staff members had a background screening completed by the Department's Background Screening Unit (BSU) prior to their hire date. There were no new contract staff hired since the last annual compliance review. Eleven of the thirteen new staff members are considered direct care staff. Each of the eleven applicable staff members were given a pre-employment assessment in which all received a passing score. The center submitted the Annual Affidavit of Compliance for Level 2 Screening Standards on January 2, 2019.

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 ensuring a rescreening is completed on all staff five years from the date of hire. One staff member was eligible for a five-year rescreening. The five-year rescreening for the eligible staff member was completed prior to the anniversary date of initial hire. There were no contracted staff or volunteers who were eligible for a five-year rescreening.

1.03 Staff Code of Conduct	Satisfactory Compliance

Center staff adheres to a code of conduct prohibiting any form of abuse, profanity, threats, harassment, intimidation, “horseplay,” or personal relationships with youth.

Officers shall maintain the confidentiality afforded to all youth and shall not release any information to the general public or the news media about any youth in the center or who has been in the custody of the Department.

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

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

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

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

The center has a written policy and procedures to ensure staff communicate and interacts with youth in a manner which provides a role model of socially acceptable behaviors. Staff shall be respectful of others and reflect desired behaviors for youth. According to the written policy and procedures, staff must adhere to a code of conduct which prohibits any form of abuse, profanity, threats, harassment, intimidation, or personal relationships with youth. Seven staff personnel records were reviewed for a signed code of conduct. Each of the seven records contained a signed and dated code of conduct. Documentation in three of the seven reviewed records reflected the staff received a verbal reprimand for a violation of the code of conduct. All three staff members received the reprimand subsequently to signing the staff code of conduct. The center could not provide any examples of staff receiving commendations since the last annual compliance review. Five of the seven interviewed youth reported never hearing staff use profanity when speaking to youth. One staff reported hearing a staff use profanity once and another reported staff use profanity occasionally. Additionally, All seven interviewed youth reported they have never heard staff threaten youth and they feel safe at the center. Six of the seven interviewed staff reported they have never heard co-workers use profanity or threatening behavior towards youth. One staff member reported occasionally hearing staff using profanity and threatening or intimidating behavior towards youth. Seven staff were interviewed in regard to the current working conditions at the center. Two staff reported working conditions are very good, three reported good, and two reported conditions were fair. According to the superintendent interview, staff must adhere to a code of conduct which prohibits any form of abuse, profanity, threats, harassment, intimidation, or personal relationships with youth. The superintendent did not provide any examples of employee disciplinary action; however, verbal reprimands were observed in personnel records reviewed.

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

The center has a written policy and procedures ensuring consistency and expediency in reporting of all incident and to provide a process to notify the Central Communications Center (CCC) within the required time frame when a reportable incident may disrupt or has the potential to disrupt the normal operations of the facility. The center had forty-seven reportable incidents to the CCC in the previous six months. This is a decrease of reportable incidents compared to last year's report during the annual compliance review period. Five reportable incidents were reviewed. All five CCC reports reflected they were reported within the required two-hour time frame. One of the five reviewed reports was not documented in the logbook or shift report as required. There were no internal incidents and/or grievances which should have been reported to the CCC. Seven interviewed staff were able to articulate the process in which staff and youth are allowed to contact the Florida Abuse Hotline or the CCC. According to the superintendent interview, the shift supervisor is notified within two hours, the CCC will be called. Prior to the call information will be gathered, administration is notified, administration will notify the regional office, staff involved will complete statements, and submit them prior to the end of their shift.

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

There has been fifty-one Protective Active Response (PAR) incidents at the center within the past six months. Five incidents reports were reviewed. All five incident reports were completed by the end of the staff member's work day, included statements from all staff involved, did not require mechanical restraints, did not result in serious injury to youth or staff, and there were no instances in which youth alleged abuse. In each case, the reports were reviewed and processed within seventy hours by all required parties. Post-PAR interviews were conducted within thirty minutes of the incident in four of the five reviewed reports. One post-PAR interview was checked as completed on the report; however, there was no name or time stamp of the individual completing the interview. None of five reports required a PAR medical review. A review of incidents and/or grievances did not reflect any additional PAR incidents. The center's PAR rate during the annual compliance review period was 5.30, which is below the statewide Detention PAR rate of 11.57. There has been a decrease in the number of PARs since the last annual compliance review. Seven interviewed staff reported staff makes an effort to talk with youth prior to using any physical or mechanical restraints. According to the superintendent interview, all incidents involving PARs are reviewed within twenty-four hours of the incident. If the PAR is found to be used in violation of the policy, retraining and/or disciplinary action will be taken.

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

The center has a written policy and procedures to ensure proper training equips staff with the skills necessary to conduct themselves in a manner consistent with the ethical standards established by the Department. Seven staff training records were reviewed. Each of the seven reviewed staff completed all required pre-service training prior to any contact with youth. Five of the seven staff completed the required 120 hours of training and were certified within 180 days of hire. Two staff members were not employed for 180 days but completed all required training with the exception of attending the academy. All pre-service training was documented in the Department's Learning Management System (SkillPro).

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

The center has a written policy and procedures to ensure proper training equips staff with the skills necessary to conduct themselves in a manner consistent with the ethical standards established by the Department. A review of seven staff training records found six staff were missing at least one or more mandatory training items. One staff was missing cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), and first aid. Three staff were missing suicide prevention and professional and ethics, and four staff were missing active shooter training. Three of the seven reviewed staff members were applicable for the required supervisory training. Each of the three reviewed supervisory staff completed the required eight hours of annual training. All in-service training was not observed to be documented in SkillPro for six of the seven staff reviewed. One of the seven reviewed staff members completed all of the mandatory training topics in which the training was observed in SkillPro. The center has an annual training calendar which is updated when changes occur. According to the superintendent's interview, staff are required to complete Protective Active Response (PAR), CPR/AED, first aid, suicide prevention, and professionalism and ethics. The superintendent reported receiving the following management training such as management, leadership, personal accountability, employee relations, communication skills, and fiscal 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 center immediately.

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

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

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

The center has a written policy and procedures to ensure an alert system is in place to alert staff when mental health, medical, or security issues exist which may affect the security and safety of the youth in the facility. Seven youth were reviewed for mental health, medical, and security alerts. All seven youth were applicable for alerts. In each case alerts were entered, reviewed, and updated as required by the appropriate staff member. Logbooks and shift reports were available for review and reflected alert documentation as needed. Alerts are immediately entered into the center's alert system if a youth is admitted with special needs and/or risks such as suicide, mental health, substance abuse, physical health, or security risk factors. Appropriate staff are notified based on the nature of the youth's alert to include medical, mental health, and food service. The Juvenile Justice Information System (JJIS) alert report is reviewed daily by supervisors and administrators. Information regarding youth alerts are made available to all staff. A shift briefing was observed during the annual compliance review and alerts were observed to be reviewed. Seven interviewed staff reported they were informed of alerts during shift briefings, alert forms, JJIS, logbooks, and the alert board. According to the superintendent, at a minimum all youth with chronic medical conditions are to be placed on the facility alert system and nursing staff will verify all alerts in the medical alert system are accurate and up-to-date.

Standard 2: Assessment and Performance Plan

2.01 Admission	Satisfactory Compliance

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

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

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. The youth intake consists 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. During the annual 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 frisk was conducted by an officer of the same gender upon admission. The admissions wizard indicated each youth received a telephone call or the refusal of the call was documented. The admission wizard for each of the seven youth indicated 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 to include the Prison Rape and Elimination Act (PREA) video. 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. The youth was offered a meal during the intake process.

2.02 Orientation	Satisfactory Compliance

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

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

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. The orientation process is designed to 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 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 reported they received orientation within twenty-four hours of admission to the center. 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.

2.03 Classification	Satisfactory Compliance
All youth admitted to the center shall be classified to provide the highest level of safety and security. Considerations shall include, at a minimum: *1. Physical characteristics (e.g. sex, height and weight);* *2. Age and level of aggressiveness;* *3. Special needs (mental illness, developmental disabilities, and physical disabilities);* *4. History of violent behavior;* *5. Gang affiliation;* *6. Criminal behavior;* *7. History of sexual offenses;* *8. Vulnerability to victimization; and* *9. Suicide risk identified or suspected.* *Youth shall be assigned to a room based on their classification and are reclassified if changes in behavior or status are observed. Youth with a history of committing sexual offenses or a victim of a sexual offense are not to be placed in a room with any other youth. Youth with a history of violent behavior shall be assigned to rooms where it is least likely they will be able to jeopardize safety and security.* *All newly admitted youth are screened to determine if he or she is a criminal street gang member or is affiliated with any criminal street gang. In the event hang involvement is suspected, center staff should enter the "other suspected gang affiliation" alert into JJIS along with as much detailed information within the alert note as possible.*	

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 included the 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 offenses 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 Notification of Juvenile Probation Officer Circuit Gang Representative	Satisfactory Compliance

Each center shall identify the juvenile probation officer (JPO) designated as the circuit gang representative to communicate suspected gang activity.

A referral for youth with suspected gang involvement shall be shared, by e-mail, with the circuit gang representative, indicating suspicions of gang activity such as youth flashing gang signs, gang tattoos, gang-related drawings, or related activity.

Center staff should include in the e-mail pictures (when appropriate), copies of written statements, drawings, graffiti, and a description of what gang signs the youth was "flashing."

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. 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. One 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. There were no other examples available for review of youth documented as gang members. Currently, there is not a juvenile probation officer (JPO) designated as the circuit gang representative to communicate suspected gang activity. The facility presented documentation reflecting there is a supervisor assigned and attends monthly gang meetings with the local sheriff's office.

2.05 Admission of Youth Personal Property	Satisfactory Compliance

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

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 two youth who were admitted with property of value. Both bags had a plastic tag receipt from the tamper-proof bag which gets dropped in the center's valuables drop-safe. The tamper-proof bags located in the drop-safe were observed during the annual compliance review. Information on valuable property placed in the drop-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. Seven youth were interviewed and reported staff checked their personal property and the youth signed a form stating the personal property was correct upon admission. The center maintains all non-valuable items in numbered green mesh bags in a locked room for safe keeping. According to the superintendent, intake staff are responsible to ensure all youths' personal and valuable property is inventoried on the Juvenile Justice Information System (JJIS) property sheet.

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

All property storage areas were observed during the annual compliance review. The center maintains all non-valuable items in numbered green mesh bags in a locked room for safe keeping. The youth personal valuables are stored in a drop-safe in the master control area of the facility. The drop-safe is under video surveillance and the center's staff documents the youth's valuables and places it in tamper-proof bags located in the drop-safe containing the date, youth's name, Department of Juvenile Justice Identification number, and a list of the items in the bag. The valuables are then documented in the valuable property inventory logbook before placing it in the drop-safe. A review of the youth records indicated two youth were applicable to having property of value by their signed property receipt form. The property was located in the drop-safe and accurately documented in the bound valuable property logbook. There were no Central Communications Center (CCC) reports in the last six months involving lost, damaged, or stolen property for the center. According to the superintendent, valuable property is logged and stored in the drop safe.

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

The center has a policy and procedures in place regarding the release of youth from the center. Three closed youth records were reviewed for release procedures. Each record 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, the release paperwork was completed accurately and the supervisor verified the identity of the person who was taking custody of the youth upon release. The photo identification of the youth was examined by the releasing supervisor and court orders were also verified. 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.

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

The center has a policy and procedures in place regarding the release of a youth's personal property prior to being released from the center. A review of three 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 released was observed and found the youth was returned their property and signed the form agreeing the youth took possession of their personal property. It is the center's policy, any property held
at the center for more than thirty days will be considered abandoned. After thirty days, a Notice of Impending Disposal of Property shall be mailed to the last known address. If the youth is on supervision, it is acceptable to have the juvenile probation officer (JPO) sign for and deliver the property to the youth. If the youth cannot be located, the superintended or designee will ensure all money and property are counted and inventoried. One money order shall be sent to the regional fiscal manager who will then forward the money order to the headquarters designee. A record must exist for any property disposed of or cash forward to headquarters. According to the superintendent, property not picked up within thirty days will be considered abandoned and a Notice of Impending Disposal of Property will be sent to the youth's last known address.

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

The center's policy states prescription drugs are given to the person to whom the youth is being released and documented in the release paperwork. The medication release form is completed and given to medical staff. A review of a youth being released was conducted. There were no youth released with medication during the annual compliance review period.

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

During this annual compliance review, a weekly detention review was observed. The attendees included a representative from mental health, education, superintendent, the two assistant superintendents, and a juvenile probation officer supervisor (JPOS). The weekly review had consistent documentation of participation by all parties who have responsibility for the youth. During an interview with the superintendent, the superintendent and/or assistant superintendent, mental health and medical providers, facility staff with pertinent knowledge of youth, JPOs, educational staff, Department of Children and Families representatives, and appropriate residential commitment representatives are encouraged to attend.

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

The center has a policy and procedures in place regarding the center's daily activity schedule. 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 educational programming is 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. Seven staff were interviewed regarding restorative justice activities. Four of the seven interviewed staff indicated the center provides restorative justice activities. Four of the seven staff indicated the center does not offer gender-specific programming as part of the daily schedule., Three staff reported they talk with youth individually and groups held on the modules have gender-specific topics. Five of the seven interviewed youth 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.

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

The center has a policy and procedures in place regarding the center's daily activity schedule. The center has a weekly schedule for normal business days. A review of the center's logbook indicates adherence to the daily activity schedule with a few exceptions. Observations of the daily schedule during the annual compliance review week found staff adhering to the daily schedule as written. Two of the seven interviewed youth h indicated the daily schedule is not followed and five reported the schedule is followed. Seven staff were interviewed and each reported the daily schedule is followed.

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

All youth at detention center are given access to education. School starts at 8:10 a.m. and ends at 2:30 p.m. A review of the education schedule revealed the youth are provided education 250 days a year distributed over twelve months, with a minimum of twenty-five hours of instruction per week. Teachers are also given days for training and planning throughout the school year. Youth enrolled in educational programs at the center have an opportunity to earn course credit for completion of the education and training experience. A review of two master control logbooks dated April 14, 2019 through June 7, 2019 and June 8, 2019 through July 31, 2019

documented there were no missed school days. Seven interviewed staff revealed there is minimal interference of educational instruction. Six of the seven interviewed youth stated they attend life skills, math, science, history, reading, social studies, and career choices at the center. One youth stated they are currently working on obtaining their General Education Diploma.

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

An interview with education staff revealed the center is providing the requirements for Type 1 programming to include life skill groups activities and instructions. The center uses Sunburst and Human Relations Media for curriculum. The career education programming includes communication, interpersonal skills and decision-making skills. The youth also take a career personability quiz.

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

The center has a policy and procedures in place addressing the behavioral management system (BMS). The rules and expectations are visibly posted throughout the modules. The center also has a reward system which is based on points for good behavior, loss of points, and level drop for inappropriate behavior. Seven interviewed staff indicated they believe the center's BMS is effective. Each of the staff felt youth are given an opportunity to explain their behavior and they speak with the youth about alternative acceptable behaviors. Staff interviews indicated only points and level drops can be taken away as a consequence. Two of the seven interviewed youth stated they felt the new BMS was good, two youth stated they thought the system was good, two stated they thought the system was fair, and one youth indicated they felt it was poor. According to the superintendent, the center uses a BMS which involves levels and a point system.

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

The center's behavior management system (BMS) addresses consequences for a youth's negative behaviors. 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 interviewed 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 seven interviewed reported they lost their level and/or points as consequences for inappropriate behavior. Seven interviewed youth reported they are not allowed to punish other youth and three reported they are sent to their room for punishment with the door shut and locked.

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

The center has a policy and procedures 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 youth sign a hard copy of the Grievance form which is maintained in a separate grievance file and uploaded in FMS. The center's three phase process includes an informal, formal, and appeal phase. The grievance policy indicates the informal phase occurs wherein the juvenile justice detention officer (JJDO) attempts to resolve the complaint or condition with the youth using effective communication skills. The youth submits in writing, their complaint or concern to the 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 on the outcome with the JJDO assigned to the unit, the grievance will move to the formal 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 exhibiting violent behavior, filing the grievance will be delayed until the youth is under control. The denial and the reason shall be documented in the logbook. If the youth is still dissatisfied with the outcome of findings by the shift supervisor, the grievance then moves to the appeal phase. The appeal 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 two grievances during the annual compliance review period. Each grievance was resolved 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. Five of the seven interviewed youth reported they never filed a grievance., One youth stated they thought the grievance process was poor and one youth thought the grievance process was good.

2.18 Trauma-Informed Care	**Limited Compliance**

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

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

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

A review of the center's practice of implementing trauma-informed care was conducted. The program uses their behavior management system to assist with trauma-informed care. The center also has speakers to come out to the facility to talk with the staff about the importance of trauma-informed care. A tour of the facility found the center has a soft room with new carpet. The center was found to be painted with soothing colors throughout the facility. A review of seven staff training records found five did not receive trauma-informed care training for 2018. During an interview with the superintendent, it was revealed the implemented trauma-informed practices includes additional training for staff, a change in youth behavior management, a physical softening of the facility and soft room, and a reduction in confinements.

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 detention center currently contracts through Camelot Community Care one designated mental health clinician authority (DMHCA), who is on-site weekly to ensure appropriate and implementation of mental health and substance services is taking place. The DMHCA is licensed in marriage and family therapy under Chapter 491. The current DMHCA started on August 12, 2019 and the former DMHCA was a licensed mental health counselor under Chapter 491. An interview with the current DMHCA, reported they are at the center five days a week. The DMHCA indicated the clinical services provided at the center are mental health, substance abuse, and psychiatric services. The DMHCA stated the center does not offer any specialized services. The communication between the DMHCA and clinical staff is daily while on-site and weekly at a minimum with the psychiatrist. The former DMHCA reported mental health and/or substance abuse provider meets with the superintendent formally two times a week at the detention review and min-treatment team meeting. Department meetings are held on a weekly basis and informally, as needed.

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

The detention center has one designated mental health clinician authority (DMHCA), one licensed mental health counselor (LMHC), and one licensed clinical social worker (LCSW). All three are licensed under Chapter 491. The LMHC received their license on July 25, 2019 and was working at the center under the supervision of a licensed staff as a registered mental health counselor intern (RMHCI). All staff have a master's-level degree and licenses expire in 2021.

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

The center is licensed under Chapter 397 which expires on September 29, 2019, to provide substance abuse outpatient services. The designated mental health clinician authority (DMHCA) supervises licensed mental health counselor (LMHC) and licensed clinical social worker (LCSW) to ensure they are performing services they are qualified to provide based on education,

training, and experience. The licensed mental health staff review and sign Comprehensive Mental Health Evaluations, Updated Comprehensive Evaluation, Initial Mental Health Treatment Plans, Individualized Mental Health Treatment Plans, Assessment of Suicide Risk (ASR), Follow UP ASR, Crisis Assessment, Follow Up Crisis Assessment, Comprehensive Substance Abuse Evaluations, Updated Comprehensive Substance Abuse Evaluations, Initial Substance Abuse Treatment Plans, and Individualized Substance Abuse Treatment Plans. Documentation was provided for the registered mental health counselor intern (RMHCI) of at least twenty hours of training in assessing suicide risk. A licensed mental health staff reviewed and signed the evaluations and assessments during this time. This staff is currently a licensed mental health counselor (LMHC).

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

Seven youth mental health and substance abuse records were reviewed. All seven youth had a Suicide Risk Screening Instrument (SRSI) and Massachusetts Youth Screening Instrument – Version 2 (MAYSI-2) completed in the Juvenile Justice Information System (JJIS) at the contracted juvenile assessment center (JAC) by a trained staff. In all seven records, detention staff reviewed the documentation. The nurse or mental health staff completed the required sections of the SRSI including the "screening results" sections for all seven youth. Six of the seven youth answered "yes" on the SRSI and were referred for an Assessment of Suicide Risk (ASR). All seven youth's results from the SRSI and MAYSI-2 indicated a need for further assessment and a referral was made in six youth records. The superintendent was notified in all six referrals. One youth was admitted from the juvenile assessment center (JAC) with no referral needed; however, the mental health staff determined upon review of the MAYSI-2 a referral for further assessment and an ASR was deemed necessary. All seven youth had elevated suicide risk subscales and were placed on suicide precautions and referred for an ASR. Two youth had results on the MAYSI-2 indicating the need for comprehensive assessment and reported to the mental health clinical staff. During an interview with the superintendent, it was stated the detention officers, nurse, or mental health clinical staff completes the mental health, substance abuse, and suicide risk screenings.. The former designated mental health clinician authority (DMHCA), reported the suicide risk screening is conducted by the juvenile probation officer, detention staff, and mental health clinical staff. Staff is required to conduct several suicide risk screenings and assessments. MAYSI -2 is administered to the youth upon initial intake and indicates the need for referral for in-depth mental health or substance abuse evaluation.

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.	

Seven youth mental health and substance abuse records were reviewed and two were applicable for a mental health evaluation through the detention provider. Both youth had a new mental health evaluation and psychiatric evaluation completed within fourteen days of admission. None of the youth were eligible for a comprehensive assessment through a community provider, nor were they in the center for thirty days. The former designated mental health clinician authority (DMHCA)stated, all youth requiring services are documented into the referral log which is reviewed by the DMHCA.. At the mini-treatment meeting, it is discussed and determined if there is a need for further assessment. By day thirty, all youth having an identified need will have a Comprehensive Assessment of (Substance Abuse and Mental Health Assessment)completed. By review of the Community Assessment Tool (CAT), MAYSI-2 results, or other information obtained during admission screening the determination is made if screening suggests a comprehensive assessment is needed. If a comprehensive assessment is needed, mental health staff request copy of the Treatment Alternatives for Safer Communities (TASC) evaluation from the juvenile probation officer during weekly detention review meetings, by email, or complete the comprehensive assessment in-house. The former DMHCA stated, the substance abuse assessment is requested by mental health staff by providing a list of youth identified in the initial screening to the JPO expeditor. During the mini-treatment meeting it is discussed and determined if there is a need for further assessment and the comprehensive evaluation. The request is made by e-mail to the assigned JPO.

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

Two of the seven reviewed youth mental health and substance records were applicable for this indicator. The two youth required treatment and were assigned to a mini-treatment team consisting at a minimum of mental health clinical staff, one staff from a health service area, youth, and parent/guardian, if possible. Both youth had proper consent for treatment obtain through a signed Authority for Evaluation and Treatment (AET) and all treatment notes were documented to include all required elements. Mental health staff have adequate access to youth to provide treatment services in the center. The center offers psycho-educational groups bi-weekly and individual counseling weekly to the youth.

The former designated mental health clinician authority (DMHCA)stated, upon admission the intake assessment and evaluation identify the need for services. Office of Health Services (OHS) is the primary system of documenting and preserving youth contacts and information. The DMHCA reviews the intake paperwork on youth and ensures screening session and referrals are completed. An ongoing required log which is reviewed by DMHCA. Service note is written in OHS indicating results of the contact. This information is uploaded into the file permanently.

The DMHCA also indicated, initial treatment plans are developed with youth who enters the center on a referral or who have been identified as needing mental health/substance abuse

services. Individualized mental health treatment planning are reviewed at the weekly mini-treatment team meeting and detention review meetings. Input and endorsement is received from medical, mental health, education, and detention staff. Youth's treatment plan is enhanced and if the youth remains at the center over thirty days, an individualized treatment team meeting which includes the youth, medical education, juvenile probation officer, and parent/guardian is scheduled, and an individualized treatment plan is developed.

Seven youth were interviewed about the mental health and substance abuse services they are receiving. One youth rated the services as poor, one youth stated the services was fair, another youth stated good, a fourth youth replied very good, and three youth stated they were not receiving mental health and substance abuse services. One of the seven interviewed youth added the center does not have groups and mental health does not really come around unless they are addressing a youth coming off precautionary observation. A second youth stated they do not go to group or individual therapy. A third youth added the mental health counselor talks with the youth for a second and leaves. This youth would like to be able to talk to the counselor more. A fourth youth specified attending groups but does not remember the name of it. A fifth youth has not attended group yet but plan to attend this week.

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

Seven youth mental health and substance abuse records were reviewed and two youth were applicable. One youth was seen by the licensed psychiatrist on August 13, 2019; therefore, a treatment plan was not developed. The remaining applicable youth had an initial treatment plan in place within seven days of initiation of treatment which contained all the required information. The treatment plan contained the reason for the referral for treatment, initial Diagnostic and Statistical Manual (DSM)-IV-TR and DSM-5-diagnosis/symptoms, initial treatment methods, goals, psychiatric services including psychotropic medication and frequency of monitoring, psychiatrist signature, youth signature, and mini-treatment team members involved in development of initial treatment plan. The individual treatment plan for the youth included the date of the plan, the signature of the licensed mental health professional, DSM-IV-TR or DSM-5 diagnosis, symptoms are treatment focused, treatment goals, strengths/abilities, preferences/needs, psychiatric services including psychotropic medication and frequency or monitoring, and progress notes validate youth are receiving treatment services as stipulated on the treatment plan. The youth's treatment plan was signed and dated by the youth, mental health professional, treatment team members, and a copy was mailed to the parent/guardian. A mini-treatment team was unable to be observed during the annual compliance review.

The former designated mental health clinician authority (DMHCA) stated, individualized treatment plans are developed with youth who entered the center on a referral or who have been identified as needing mental health/substance abuse services. Individualized mental health treatment planning are reviewed at the weekly mini-treatment team meeting and the

detention review meetings. Input and endorsement is received from medical, mental health, education, and detention staff. Youth's treatment plan is enhanced and if the youth remains at the center over thirty days an individual treatment team meeting which includes the youth, medical education, juvenile probation officer, and parent/guardian is scheduled, and an individualized treatment plan is developed.

The former DMHCA stated, the Office of Health Services (OHS) records the plans and services offered. The mental health clinical staff individual reviews all documents provided and then keeps a log of all services provided. All information is available and provided for review on the OHS system. The DMHCA reviews the intake paperwork on the youth, ensures a screening session occurs, referrals are acknowledged and processed, and youth are presented at the weekly treatment team meeting. The detention center maintains operating procedures which outline required activities. The mental health clinician is responsible for reviewing and obtaining the multi team endorsement of the updates and review.

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

The center utilizes a psychiatrist who is board certified in Child and Adolescent Psychiatry pursuant to Chapter 458. According to the provider's contract, psychiatric services will be provided three hours week. A review of the psychiatric sign-in and sign-out sheets reflected the psychiatrist is on-site weekly as required, but not consistently three hours each week. The designated mental health clinician authority (DMHCA) reported the psychiatrist is on site weekly and the time will fluctuate depending on the needs of the youth in the center at the time. Two out of the seven youth were applicable for this indicator; therefore, an additional closed record was reviewed. All three youth's initial psychiatric interview included the reason for the referral, the youth's history, mental status examination, Diagnostic and Statistical Manual (DSM)-IV-TR or DSM-5, treatment recommendation, prescribed medication and the explanation for the need for those medication, frequency of the medication monitoring/management, and the in-depth psychiatric evaluation was conducted within thirty days of referral for all three youth. The in-depth psychiatric evaluation stated reasons and factors leading to the referral, developmental history, psychiatric history, mental status examination, identification of individual, family, and/or environmental factors which may potential account for influence on the youth's difficulties for all three youth. It also provided the DSM-IV-TR or DSM-5 diagnosis, treatment recommendations, prescribed medications, explanation of the need for psychotropic medication, and the signature of the psychiatrist conducting the evaluation.

All three youth had a Clinical Psychotropic Progress Note (CPPN) page 3 completed for psychotropic medication and used the CPPN form as the center's psychiatric evaluation. The psychiatric evaluation identified data, diagnosis, target symptoms of each medication, evaluation and description of effect of prescribed medication of target symptom, the name, dosage, and quantity of the psychotropic medication, side effects, youth's adherence to the medication regime, height, weight, and blood pressure in all three records. Two of the youth's parent/guardian brought the youth's medication to the center and the psychiatrist did not make any changes; therefore, parental contact was not made. The third youth, parental telephone contact was made. In two of the three youth records, the psychiatrist signed all pages of the CPPN. In the third youth record, the psychiatrist did not sign page three of the CPPN. The date

of the signatures was in all three records. In all three records, the psychiatrist documented monitoring for Tardive Dyskinesia. An appropriate Authority for Evaluation and Treatment (AET) was in all three youth records. Two of the three youth remained on the same medication; however, the third youth had a change in medication and verbal parental consent was received and documented on page 3 of the CPPN. There is no documentation of written consent on the Acknowledgment of Receipt of CPPN form, but confirmation was documented the CPPN page 3 was mailed to the parent/guardian.

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

The center has a written suicide prevention plan in place to safely assess and protect youth. The plan was approved by the superintendent and designated mental health clinician authority (DMHCA) on August 12, 2019. The center's suicide prevention plan includes identification and assessment of youth at risk of suicide, staff training, suicide prevention, levels of supervision, referral, communication, notification, documentation, immediate staff response, and the review process.

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.*	

Seven youth mental health and substance abuse records were applicable for this indicator. Six of the seven youth were identified during the screening process at the Juvenile Assessment Center (JAC). The remaining youth was identified by the mental health staff during acceptance of the youth into the detention center. All seven youth were placed on precautionary observation (PO). All seven youth had an initial Juvenile Justice Information System (JJIS) alert entered and suicide risk assessment referral completed. All seven youth had an Assessment for Suicide (ASR) completed and the PO log documented the time in thirty-minute intervals. All seven PO logs were completed in their entirety with a qualified mental health professional involved, consultation with the designated mental health clinician authority (DMHCA) or licensed mental health counselor, notification to the superintendent or designee, and referral made to mental health professional.

All seven youth received authorization to be placed on PO and the ASR was completed within twenty-four hours. A follow-up ASR was completed on all seven youth prior to the removal of a youth from PO, which followed all elements reference to Rule 63N-1, F.A.C. The follow-up included a conference held by the superintendent or designee and licensed mental health professional to reduce level of supervision. In all seven records, the date and time of the step

down to close or standard supervision was documented and discontinuation of constant or close supervision is documented in accordance with the program's suicide prevention plan.

Four of the seven ASRs were completed by a licensed mental health professional and the remaining three ASRs were completed by a registered mental health counselor intern (RMHCI) who completed twenty-four hours of ASR training. Six of the seven youth had documentation in the master control's logbook of when they were placed on PO, stepped down, and when the youth was removed from PO. All seven alerts in JJIS were closed upon removal from PO. Upon placement of the seven youth on constant supervision, the placement in the youth's room was authorized by the superintendent or designee and the DMHCA. All seven youth records verified the health status checklist was completed, the mental health staff provide supportive counseling, PO log documents supervision, and the youth's level was reduced only after a conference between the superintendent or designee and a licensed mental health professional.

Six of the seven PO logs were completed in their entirety. The seventh PO log, the mental health professional did not sign. Six of the seven youth records revealed the parent/guardian and juvenile probation officer (JPO) were notified of the youth's potential suicide risk as indicated on the ASR. Six of the seven youth were removed from PO within twenty-four hours and the remaining youth was continued on PO according to the mental health professional.

The superintendent reported the center does not use secure observation for potentially suicide youth.. The former DMHCA indicated, several measures can be utilized for referrals when a youth appears suicidal. Licensed mental health staff should be contacted by person or telephone for immediate and most prudent course of action. The juvenile justice detention officer (JJDO) may complete the MHSA form which must be reviewed by mental health clinical staff. The former DMHCA was able to describe the procedures for notification of the program director, parent/guardian, and other applicable agencies regarding potentially suicidal youth or youth who have attempted suicide. The JJDO shift supervisor or designee is responsible for notifying the superintendent or designee of potential suicide risk or attempted suicides. The superintendent is responsible for notifying the youth's parent/guardian of the potential suicide risk or suicide attempt, advising them of the most current information available surrounding the event, and documenting the conversation. The superintendent will notify the Department representative of any suicide attempt which results in serious or life threatening injury. The DMHCA or other licensed mental health professional is responsible for notifying the parent/guardian and JPO of the mental health status. Six of the seven interviewed youth stated they have never been placed on suicide watch while at this center. One youth stated yes and reported staff watched constantly while on suicide watch. Seven interviewed staff was able to explain their responsibility if a youth expresses suicidal thoughts.. All staff responded in compliance with the center's suicide prevention plan, notification, referral, supervision, and documentation.

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

Seven youth mental health and substance abuse records were reviewed., All seven youth were placed on a suicide precaution observation (PO) log and were maintained on the log for the duration they were on suicide precaution. All PO logs documented the appropriate level of

supervision, met safe hosing requirements, and observations of the youth's behavior in thirty-minute intervals. All PO logs documented observed warning signs, notification to the superintendent or designee and mental health counselor. Six of the seven PO logs were reviewed, signed, and dated by each supervisor and mental health clinical staff. The one remaining record did not have the mental health staff signature. Five of the seven interviewed stated while they were on suicide precautions staff were with them at all times.

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.	

Five of seven staff received the minimum of six hours annually on suicide prevention and implementation of suicide precautions training which was documented in SkillPro. The center conducted quarterly mock suicide drills on each shift for all staff who come in contact with youth including kitchen and maintenance staff. Half of the center's staff participated in quarterly drills with a minimum of one quarterly drill semi-annually. Half of the staff with direct contact on day-to-day basis with youth, participated in at least one mock drill which included the use of cardiopulmonary resuscitation (CPR) annually. Staff who were unable to participate during a drill have the opportunity to review each drill scenario and procedures in an effort to understand the process and receive the necessary training to respond to an incident of a suicide attempt of incident of serious self-inflicted injury. The field training officer schedules training within twenty-four hours for staff unable to participate. Seven interviewed staff were able to identify the location of the suicide response kit. Five staff stated in master control, one stated master control and medical, and one replied the shift supervisor's office.

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

The center has a crisis intervention plan detailing how to respond to youth in crisis in the least restrictive means possible to protect the safety of the youth and others while maintain control and safety of the center. This plan includes notification and alert system, means of referral, including self-referral, communication, supervision, documentation, and review.

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

The center's emergency care plan details how to handle any youth determined to be in imminent danger to themselves or others due to mental health or substance abuse emergencies

occurring in the center. This plan includes 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 under Ch 394 F.S. (Baker Act), transport for emergency substance abuse assessment and treatment under Ch 397 (Marchman Act), documentation, training, and review. The emergency care plan is in a binder in the superintendent's office, accessible to all staff. The plan was last updated and approved on July 31, 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 (LMHP), or under the direct supervision of a LMHP, to determine the severity of youth's symptoms, and level of risk to self or others. When staff observations indicate a youth's acute psychological distress is extreme/severe and does not respond to ordinary intervention, the superintendent or designee must be notified of the crisis situation and need for Crisis Assessment. A Crisis Assessment is to be utilized only when the youth's crisis (psychological distress) is not associated with suicide risk factors or suicide risk behaviors. If the youth's behavior or statements indicate possible suicide risk, the youth must receive an Assessment of Suicide Risk (ASR) instead of a Crisis Assessment.	

The center did not conduct crisis assessments during the scope of the annual compliance review period. The center has a written crisis intervention plan detailing how to respond to youth in crisis. The crisis assessment tool utilized by the center contains all required elements.

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 a Baker or Marchman Acts during the annual compliance review period; therefore, this indicator rates 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 center.	

The center has a written policy and procedures identifying a designated health authority (DHA) as being clinically responsible for the medical care at the center. The center has a contract with a licensed medical doctor who specializes in family medicine and holds an unrestricted license which meets all requirements for independent and unsupervised practice in the State of Florida. There is a coverage plan in place with a contracted physician from Maxim for scheduled absences or vacations. The covering physician also holds an unrestricted license to practice in the State of Florida. There is evidence of the DHA being on-site for once a week for the past six months as documented on the DHA logs. The DHA reported being available regarding youth needs twenty-four hours a day, seven days a week for acute medical concerns, emergency care, and coordination of off-site medical care. The center maintains a copy of a Collaborative Practice Protocol for the advanced registered nurse practitioner (ARNP) who also hold an unrestricted license to practice in the State of Florida. The ARNP assists with coverage twice a week for an average of six hours for the past six months as evidence by sign-in logs. Current licensure for the registered nurse and two licensed practical nurses employed by the center was validated through the Florida Department of Health Medical Quality Assurance search portal.

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 written facility operating procedures (FOPs) in place for all health-related procedures and protocols utilized at the center. There was documentation to support the FOPs were approved and signed by the superintendent and the designated health authority (DHA); however, there is no date to support when the FOPs were signed. There is no evidence to support nursing staff reviewed or signed the FOPs. Evidence supports the three health care staff reviewed, signed, and dated a cover page for the 2019 nursing protocols. The FOPs are provided by the Department's Office of Health Services. There is no evidence of an annual review of the FOPs origination date range from 2016-2019.

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 procedures in place for achieving or reviewing the Authority for Evaluation and Treatment (AET). A review of seven youth individual healthcare records confirmed all seven youth had a valid copy of the AET signed by the parent/guardian and were stamped as "copy." There were no applicable youth under the care of the Department of Children and Family or eighteen years of age during this review period.

4.04 Parental Notification/Consent [Contract Provider]	Limited 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.	

A review of seven youth individual healthcare records (IHCRs) reflected three applicable youth were given over-the-counter (OTC) medications not included on the Authority for Evaluation and Treatment (AET) in which the parent/guardians were not notified. Two of the seven youth required immunizations which were mailed to the parent/guardian during their previous admission to the center; however, the required immunization were not re-mailed or addressed during the youth re-admissions to the center. Three of the seven applicable youth for chronic conditions did not reflect documentation the parent/guardian were notified of changes with the chronic condition. Four of the seven IHCRs reflected notifications for new medication were not witnessed by an additional staff member. One Clinical Psychotropic Progress Note did not have the psychiatrist signature for the start of a new medication. Additionally, none of the seven youth with medical grades between two through five designated at admission had notification to the designated health authority (DHA) or psychiatrist as notated on the admission chronological note.

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

The center has a written policy and procedures to ensure all youth are screened upon admission in order to determine health care concerns which may warrant a referral for further assessment by healthcare staff. A review of seven youth individual healthcare records (IHCRs) confirmed each youth received an initial medical screening utilizing the Facility Entry Physical Health Screening Form (FEPHS) on the day of admission. All seven youth were initially screened by the juvenile detention officer (JDO). One of the seven youth did not have the screening reviewed by medical staff within twenty-four hours. Documentation reflected three youth had change in physical custody and each case had a rescreen completed. Two female youth were applicable for this indicator and each had a pregnancy screening completed. According to the superintendent, the FEPHS is completed by the doctor, nurse, and staff.

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

Facility Operating Procedures (FOP) contains orientation topics which include access to medical care, access to sick call, what constitutes an emergency, medication process and side effect monitoring, their right to refuse care, what to do if sexually assaulted, and the non-disciplinary role of health care providers. A review of seven youth individual healthcare records indicated four youth received an orientation to the center's healthcare services on the same day of their admission to the center, which is signed by both the youth and the registered nurse. Three youth were missing orientation to sick call, non-disciplinary role of health care providers, and list of health care contact; which was documented on a separate orientation form. Required topics on the observation of intake process is reviewed verbally and was not available to confirm

delivery. The nurse reported youth are informed of the center's designated health authority (DHA) and psychiatrist during the admission process.

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

Six of seven youth were admitted to the center with a medical concern or known or suspected chronic condition. There were no documentation present in the six applicable records to reflect the designated health authority (DHA) was notified as required. In situations where a youth does not require immediate emergency transfer, the DHA or designee must be notified of all youth admitted with a medical condition. This notification may be by telephone or verbally as required by Rule 63M-2.0043. According to nurse reports, the notification will be documented in the youth's individual healthcare record on the admission chronological nursing note. Additionally, as required by the center's medical procedure policy 8013, in situations where a youth does not require immediate emergency transfer, the DHA or designee must be notified of all youth admitted with identified chronic health conditions.

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

A review of seven youth individual healthcare records (IHCRs) indicated each health related history was completed on the Department's Health-Related History (HRH) form which is completed by the registered nurse at the time of the youth's admission and prior to completion of the comprehensive physical assessment (CPA). Five of the seven youth had a HRH from a prior admission, which was updated. All seven IHCRs reflected documentation the designated health authority (DHA) reviewed the HRH during the completion of the CPA. This was accomplished by checking a box on the CPA indicating the HRH was reviewed.

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

The center has a written policy and procedures to address the completion of a Comprehensive Physical Assessment (CPA) by the designated health authority (DHA) or designee. A review of seven youth individual healthcare records (IHCRs) indicated the center utilizes the Department's CPA form for each youth admitted to the center. Five of the seven youth IHCRs had a current CPA on file at admission. The youth had a focused evaluation completed with each re-admission. Two youth had a new CPA completed by the advanced registered nurse practitioner (ARNP) within seven days of the youth's admission. All seven CPAs had all fields of the physical examination completed as required. Five youth had incorrect verbiage of "based on age" documenting a portion of the exam was "deferred by clinician." Documentation confirmed a portion of the exam was refused by five youth as documented on the refusal of treatment form. The refusal form date matched the date of the exam for all five youth. The Problem List was subsequently updated upon completion of the CPA. A review of seven youth IHCRs contained documentation at least one tuberculosis skin test (TST) was administered within the last year.

The TST results are documented on the CPA, the Infectious and Communicable Disease (ICD) form, Medication Administration Record (MAR), and the outside cover of each youth's IHCR. Within the past year, there were no youth admitted to the center with signs or symptoms of tuberculosis.

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

The center has a written policy and procedures in place to ensure all youth are screened and evaluated for sexually transmitted infections (STIs) and human immunodeficiency virus (HIV). Documentation of each screening is reflected on the Department's STI Screening form. A review of seven youth individual healthcare records (IHCRs) indicated seven sexually active youth were screened upon admission and four were referred to the physician, as needed. Each youth had a STI testing completed and ordered by the designated health authority (DHA). One of the female youth was referred to gynecology for further evaluation. There was evidence of documentation of each screening result on the Infectious and Communicable Disease form (ICD). All laboratory results are reviewed, signed, and dated by the DHA and filed in the lab section of the IHCR. There was evidence in each IHCR to support all seven youth were offered counseling and testing. There were no pregnant youth applicable in the sample. Four of the seven youth IHCRs indicated the youth received a HIV test following written consent documented in the IHCR. All reviewed four youth IHCRs provided documentation on the Department's Health Education Record indicating pre-test counseling was completed as required. Two youth did not have evidence of post-test counseling on the Health Education Record. Pre-test and post-test counseling are provided by the DHA or the advanced registered nurse practitioner (ARNP) and documented on a focused chronological note. All HIV results were sealed in an envelope, marked confidential, and filed in the lab section of each youth's IHCR. There was no evidence of a youth's HIV status on the internal alert system.

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

The center has a written policy and procedures in place to address youth sick call requests and to ensure youth are seen in a timely manner. The youth receive information regarding the sick call process during orientation on the same day of admission. A review of seven youth individual healthcare records (IHCRs) found four sick call encounters. None of the youth presented with a similar complaint three or more times within a two-week period. Each IHCR contained documentation of the youth being assessed by a registered nurse (RN) within twenty-four hours. None of the youth required a referral to the designated health authority (DHA) as a result of the sick call request. In three instances, the advanced registered nurse practitioner (ARNP) was consulted by telephone which resulted in one situation where emergency services were necessary. All completed sick call forms were filed with the chronological progress notes in each IHCR. Sick call hours are visibly posted throughout the center. The sick call electronic system is available on each dorm area. Electronic requests are placed by staff to be received by the nurse. An interview with staff confirmed when a licensed nurse is not on-site, the shift supervisor is notified of sick call services as necessary and no longer than four hours after a request is

submitted. If it is determined a higher level of service is needed than the shift supervisor can provide; they will contact the DHA and document the referral on the Department's Report of On-Site Health Care by Non-Healthcare Staff." The sick call process was unable to be observed during the annual compliance review; however, there is a policy which requires youth privacy is ensured during all sick call encounters. Staff report sick calls can be reported in a private manner by noting confidential for the complaint. All four sick calls were entered in the sick call index and the juvenile justice information system (JJIS) generated sick call log. Two instances of restricted housing were reviewed in which both had a medical review completed by the nurse. Seven youth were interviewed in regard to the sick call process. Three youth reported they are seen for sick call within one day, one reported immediately, one reported within two days, and two youth reported never submitting a sick call. Seven interviewed staff reported the nurse conducts sick call. The nurse reported sick call is performed by both RN and licensed practical nurse (LPN). Additionally, the nurse reported the RN conducts daily reviews of sick calls.

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

The center has a written policy and procedures for the provision of episodic care and first aid. One of the seven reviewed youth individual healthcare records (IHCRs) indicated episodic care was rendered and one additional sample was available for review. Care was initially conducted by a non-healthcare staff and followed up by the registered nurse (RN) for the two instances. The non-healthcare staff form contained all required elements to include the date, time, nature of complaint, findings, treatment rendered, youth education, follow up care, signature, etc. One instance required off-site emergency treatment and parental notification. The two youth IHCRs also contained documentation in the Subjective, Objective, Assessment, and Plan (SOAP) format when seen by healthcare staff. Documentation of episodic care is filed in the chronological section of each youth's IHCR. Each episodic encounter was documented on the episodic care log. The center has first aid kits located on each dorm, medical, master control, and the conference room. The first aid kits are fully stocked with non-expired contents and sealed with a breakaway tag. First aid kits are checked weekly by the nurse and documented on the log and replenished as needed. An episodic care log is maintained by the clinic manager.

The center has written policy and procedures to ensure all youth receive appropriate emergency care, monitoring, and follow up. The center maintains two automated external defibrillators (AED) located in the medical office and in administration. The AED procedures are attached to the AED unit. The AED is checked by the nurse each month to ensure the batteries and pads are operable. The AED pads were installed on October 15, 2018 and expire on October 15, 2021. The AED batteries were installed on October 15, 2018 and expire on August 17, 2022. There is a list of emergency phone numbers including Poison Control, located in the medical office and master control. Seven interviewed staff reported being able to call 9-1-1 when a youth is identified with a medical emergency. There was evidence in the staff training records to support six of the seven staff had current cardiopulmonary resuscitation (CPR), AED, and first aid training. All healthcare staff have documented certification in first aid and CPR. A review of medical drills indicates a drill was conducted on each shift on a quarterly basis using various scenarios simulating the use of first aid and/or administration of CPR. Each drill was conducted by the nurse and signed by each center staff indicating their participation. Documentation of each drill is reflected on the emergency medical drill form.

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

The center has written policy and procedures in place to provide coordination of medical services. One of the seven youth individual healthcare records (IHCRs) was applicable for off-site care. Two additional records were available for review. The Off-Site Consultation form was completed for all three off-site instances and were reviewed and signed by the designated health authority (DHA), as required. One sample had documentation the DHA was notified for an emergency event. One instance required follow-up by the DHA which did occur as evidence by the focused chronological note. Referrals are tracked by the clinic manager to ensure follow-up care is provided.

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

There is a written policy and procedures in place to ensure youth who have chronic conditions receive regularly scheduled evaluations and follow up care, as necessary. The center has a system in place for monitoring youth who have chronic illnesses. Youth are tracked by utilizing a Chronic Condition form. According to medical grades, all of the youth are designated with chronic conditions with medical grades between two through five. However, there were two applicable youth with asthma and obesity. Another sample was provided of a youth with hypertension. Three months had not elapsed to require a follow-up. Each individual healthcare record contained a specialized treatment plan. The problem list was updated as necessary.

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

The center has a written policy and procedures in place to ensure medication is received, stored, inventoried, and provided in a safe manner. Three of the seven youth reviewed were applicable for receiving medication upon admission to the center, in which verification included the medication was current and in patient-specific original medication container. In the three instances, neither the designated health authority (DHA) nor psychiatrist were notified to obtain the order, rather medication was not resumed until the youth met with the specific practitioner. Verification of medication was completed by using the Medication Receipt form which was placed in the youth’s individual health care record (IHCR). Restrictive housing is conducted by placing youth on room restrictions; therefore, there were no applicable instances to review. There were three examples of youth receiving over-the-counter (OTC) medication not listed on the Authority for Evaluation and Treatment (AET). Standard Department Medication Administration Record (MAR) is being utilized by the center, including start and stop dates. The MAR contains all required elements. Five examples identified staff initials as well as youth initials for each administered medication. There were no undocumented lapses or errors on the MAR. Nursing staff documented side effect monitoring daily; however, there was no side effect monitoring for any tuberculin skin testing (TST) completed. There were two instances of non-

healthcare staff assisting with the delivery of medication. Observation of medication administration confirmed the six rights of medication delivery are maintained. There were two examples of refusals which were clearly documented on the MAR as well as on the refusal form. There are no standing orders, emergency treatment orders, pro re nata (PRN) orders for psychotropic medications. None of the youth required parenteral medication. Three youth had recent history of psychotropic as confirmed by history and parental contact; however, the practitioner was not notified. The three applicable youth were seen by the psychiatrist within fourteen days. Thirty-day medication monitoring has not been required. A psychiatric referral is in the IHCR for each youth. There is one Clinical Psychotropic Progress Note (CPPN) page 3 not signed by the psychiatrist when a new medication was prescribed.

Medication administration is conducted by the registered nurse (RN) as scheduled and in medical clinic. Observation of morning medication pass was conducted. The youth approached the medication cart individually to receive their prescribed medication. Secondary staff was positioned at the door providing supervision while monitoring the medication process. The Six Rights of Medication Administration were followed prior to administering youth medication. The nurse initialed each medication documenting medication was given. The youth was instructed to show their mouth and cough to make sure the youth swallowed the medication. Secondary staff performed an additional mouth check. Medication administration responsibility is only delegated to staff following completion of the center's training curriculum conducted by the RN. The center does not have a list of staff who have access to clinic nor medication storage area. There were two instances of youth receiving OTC administered by non-licensed staff. There was documentation of treatment rendered by non-licensed staff on the Report of On-Site Healthcare by Non-Healthcare staff but was not documented on the MAR. The center destroys medication on-site with the pharmacy consultants using the Rx destroyer bottle. The last medication destruction was in April 2019. During an interview with the clinic manager, it was stated there is not a class 2B license; however, there is an active license. Six of the seven interviewed youth reported a nurse gives medication. One youth reported staff gives medication. Seven reported they do not give youth medication.

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

The center has a written policy and procedures in place to ensure all medications are secured and inventoried. Observation of the clinic confirmed medications were stored in a locked medication cart located in the health services department. All medications were stored separately and inaccessible to youth. A perpetual daily running count was maintained for over-the-counter (OTC) medications; however, there is no running count for regular prescribed medications. The center has a process in place to return medications as needed to the pharmacy or they are destroyed on-site by the pharmacy consultant and clinic manager. During observation of medication inventory, all controlled medications were stored in a locked area inside the locked medication cart. There is documentation to support all controlled medications are counted two times daily by the licensed nurse and witnessed by the center's staff, medical staff, or a non-licensed staff. The center maintains bulk supply of OTC medications in a locked closet located in the health services department which are counted weekly. There is a method for detecting and responding to inventory discrepancies; however, the clinic manager was unable to identify a method for regular prescribed medications. There is documentation for

weekly counts of OTC and sharps for the last six months. Two of the three sharp counts matched the inventory. The inventory for insulin syringes exceeded the documented count by one. Two of the three running OTC counts matched the inventory. There were two acetaminophen not accounted for. Three of the three overstock OTC counts matched the inventory. There was no count or inventory for non-controlled prescription medications. There were only two controlled medications available and both inventories matched. The medication refrigerator was labeled and locked at the time of the review.

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

The center has written infection control procedures which include prevention, containment, treatment, and reporting requirements per Occupational Safety and Health Administration (OSHA) federal regulations and the Centers for Disease Control and Prevention (CDC) guidelines. Infection control procedures address all required types and categories of diseases, common infectious diseases, contagious illnesses, bacterial infectious diseases, tuberculosis, hepatitis, pediculosis, scabies, methicillin-resistant staphylococcus aureus (MRSA), foodborne illnesses, bio-terrorist agents, and chemical exposures in the workplace. Documentation supports the center provided education to all staff and youth. A review of seven youth records indicated each youth received infection control education upon admission during the orientation process on prevention of communicable diseases and prevention of bloodborne pathogens, which is documented on the education record. A review of seven staff training records indicated the required training was completed. There were three instances of sexually transmitted diseases available for review which required notification to the Leon County Health Department. According to seven staff interviews and seven staff records reviewed, the center staff are offered hepatitis B vaccination series. The center has an Exposure Control Plan (ECP) written in accordance with OSHA standards. All staff have access to review the ECP. The center reports there were no staff exposures to infectious diseases.

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

There were no pregnant youth applicable for specific health education related to prenatal care. Women's health training material is available for staff. Six of the seven reviewed staff received women's health training. One of the two applicable interviewed youth reported female services were received as needed at the center. One youth reported services were not needed.

Standard 5: Safety and Security

5.01 Active Supervision of Youth (Critical)	Satisfactory Compliance

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

Youth are in sight of at least one juvenile justice detention officer (JJDO) at all times (with the exception of sleeping hours or time secured in rooms).

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

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

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

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

An observation of staff during daily activities was conducted during the four-day review period. Activities include recreation as the youth were outside playing basketball, breaks as the youth were in their assigned living units, line movements, lunch, and education. There was a total of three female youth being actively supervised by a minimum of three female staff during each day of the review period. A minimum of two staff were observed supervising the male youth. At times, there were female staff and male staff or all male staff supervising the male youth. The center staff increased to five staff during times the male youth were in the recreational area or when there were more than eight youth at a time. When a youth left a group or a program area, staff were assigned to supervise the youth and notification was sent to all staff including the staff assigned to master control by utilizing two-way radios. No movement occurred prior to the staff assigned to master control authorizing the movement. All movement was in accordance with the Florida Administrative Code. At no time was staff observed allowing youth to exercise control over or provide discipline or care of any type to another youth. A review of the logbooks determined the counts were conducted at the beginning and end of each shift. A census sheet and the center's logbook is utilized as a method of tracking. A random sample of seven staff were interviewed and each reported, staffing was inadequate and put emphasis on inadequate staffing during the weekends. There were no justification made as to why the staff felt there was inadequate staffing. Observations determined there was adequate staffing at the center.

5.02 Ten-Minute Checks (Critical)	Satisfactory Compliance

Staff shall visually observe youth on standard supervision at least every ten minutes while they are in their sleeping quarters, either during sleep time or at other times, such as during an illness or room restriction.

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

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

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

An observation of ten-minute visual observations of youth by the center's staff determined staff conducted the required visual observations. Observations included staff visual observations during sleep time or other times. Staff was observed conducting visual observations of the youth in a manner ensuring the safety and security of each youth as staff paused to look inside the secure room and leaned towards the window. Staff were in the direct line of sight as needed. At no time the juvenile justice detention officer (JJDO) was unable to see the youth. An observation of the center's cameras was conducted. The center utilizes forty-eight cameras as five cameras were not operational. The five none operational cameras did not hinder the safety and security of the facility. The center utilizes an electronic wand to ensure the checks are being conducted within the required frequency. An observation of two different shifts from a sample of videos of six different days and times determined compliance. A computer program, Guard1plus keeps track of the wand utilized by JJDOs when conducting reviews. An electronic sensor is mounted on the entry of the secure rooms. As the JJDO conducts the ten-minute checks, the JJDO hold the wand in their hand extending it near the sensor. Guard1plus captures this action by the JJDO while storing the data. The data generated by Guard1plus documented actual times as staff appropriately conducted checks within the required time frame. A random sample of seven staff were interviewed, each reported checks are conducted every ten minutes.

5.03 Census, Counts, and Tracking	Satisfactory Compliance

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

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

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

Daily observations determine census counts of the youth were taken. The juvenile justice detention officers (JJDOs) in collaboration with master control, documented the head counts at the beginning and end of each shift, emergencies, routine group movement, population change, and random head counts. This is accomplished by the JJDOs utilizing two-way radios. A review of the program's logbooks determined headcounts, youth movements, and daily census are documented as required. A random sample of seven staff were interviewed, each reported emergency counts are conducted when a youth is missing, not visible, or after a major disturbance. Documentation did not include youth not physically present.

5.04 Logbook Maintenance	Satisfactory Compliance

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

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

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

Then center utilizes a logbook in each living unit and master control. The logbooks maintains a chronological record of events, incidents, and activities. The logbooks are bound with number pages. Each entry included dates, times, names of staff, youth involvement, brief descriptions of events, and the name of the person making the entry. Medical, special needs, and mental health alerts or issues were highlighted. Logbook entries were reviewed for each living unit for the past six months. Entries were made in ink and the logbooks were bound with sequential pages. The master control logbook documented all the required entries.

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.

Logbook entries were reviewed for each living unit for the past six months. The center utilizes three living areas, B one, B two, and G one. The male youth utilize B one and B two, and the female youth utilize G one. Documentation included the captains who are designated by the superintendent, reviews the logbooks weekly. The entries were conducted in blue ink. The juvenile justice detention officer supervisor (JJDOS) reviewed the facility logbook maintained at master control for each shift daily.

5.06 Key Control	Satisfactory Compliance

Each center is responsible for maintaining inventory and control of all facility keys.

All keys shall be placed on a tamper-resistant key ring designed to inhibit the removal of keys.

Emergency key rings shall be maintained separately from other facility keys, in master control, in a secure location designated by the Superintendent. These keys shall be notched or otherwise identifiable by touch.

The key(s) on these rings shall provide egress through facility exterior doors providing access to evacuation areas.

A key inventory shall be maintained by the Superintendent or designee at all times.
(For the entire indicator statement, please reference the Monitoring and Quality Improvement FY 2019-2020 Detention indicators.)

An observation of the center's key control was conducted. Each key was placed on a tamper-resistant king ring. The center's emergency keys were maintained in a locked cabinet attached to the wall within master control. Only the superintendent, captains, supervisors, and the maintenance staff have access the center's emergency keys according to the superintendent and confirmed observations. The conducted observations determined the emergency keys provide the action of going out and leaving out though the facility exteriors doors providing access to evacuation areas. The center supervisors for each of the three shifts maintain the inventory for all keys. The center utilizes a documented name separate key log. The document captures for each shif, the ring number, the number of keys on each ring, capability of each key, and to whom the key is issued to. The log also documents the date and time the key was issued and returned The log also documents the weekly administrative key accountability. Issuance of keys occur during shift debriefing. Seven staff records were reviewed, each staff had key control training. An observation of staff during daily activities was conducted during the four-day review period. Observation confirmed juvenile justice detention officers (JJDOs)were responsible for

the security of their issued keys and were accountable for their issued keys during their work schedule. The issued keys were on the JJDOs at all times. Youth were not observed to have control of the keys at any time during the annual compliance review. There were no accounts of the facility's keys leaving the grounds during the scope of the review. Personal keys were observed being secured in master control prior to entering the facility. The center's policy delineates the proper key control requirements and training for staff. The policy requires for staff to report all missing or lost keys immediately upon gaining knowledge. Seven staff reported the center's daily process for tracking keys includes using the key log, a chit, and utilizing master control to properly secure and store personal and visitors' keys. Staff also reported the center's practice is to keep inventory of keys, prohibit youth from accessing keys, replacing damage keys, and searching the facility and youth for any reported missing keys.

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

The center has a total of seven vehicle of which five are used to transport youth. During an interview with the maintenance staff, it was revealed the vehicles are inspected prior to use by the juvenile justice detention officers (JJDOs) and when items are found or suspected to be out of compliance. The center did not have instances of a vehicle being out of compliance. Documentation included each of the five vehicles being searched before and after each transportation. The JJDO completed the searches. Documentation reviewed for the past six months included the maintenance staff conducting weekly visual checks and monthly vehicle checks to include all appropriate requirements. An observation of staff before and after transportation was conducted. Observation determined a copy of the current transportation procedures were in each of the five vehicles. Each of the five vehicles were observed to be free of contraband, a secure screen, had sufficient gasoline, vehicle logs, gas credit card, appropriate number of seat belts, a seatbelt cutter, window puncher, fire extinguisher, first aid kits with approved items by the designated health authority (DHA), and vehicle registration. After transports, the staff documented a search of the vehicle for contrabands and remaining youth. Invoices included annual safety inspections and any deficiencies corrected.

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

The centers utilizes a locked storage room located in sally port. The kitchen also maintains sharp tools in a locked cabinet attached to the wall. Each tool was inspected monthly. The results of the inspections are reviewed by the superintendent. There was no evidence of broken tools upon observations. The center maintains a perpetual inventory of all tools and the superintendent reviewed each tool. Kitchen staff inventoried each tool daily during shift change. There was no evidence of discrepancies upon observations. There were no documented instances of lost tools by the center. Tools and equipment with the potential to cause death or serious injury are maintained with strict control in lock secure areas inaccessible to youth. The maintenance tools are marked with an identification code. The issuance and return of tools are

not being documented. Interviews with the maintenance staff and superintendent determined, it is the program's practice to allow the superintendent and captains to have access to maintenance tools. Maintenance staff reported other staff utilizes the tools as well but did not have an account for tool issuance and return. The kitchen tools are separate and stored securely. The issuance of kitchen tools and returns of tools are documented daily. An observation of the center's policy on maintenance and kitchen tools determined staff adhere to the required procedures for tool inventory and management. Each tool room was secure and inaccessible to youth. All tools were accounted for by the maintenance staff. Maintenance did not maintain documentations for the issuance and return of tools. Kitchen staff did maintain documentations for the issuance and return of tools. The maintenance staff reported, the superintendent and captains are the only staff with access to the maintenance tools other than maintenance. The superintendent, captains, and maintenance staff each reported using tools. There was no documentation of the issuance and return of maintenance tools.

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

The center utilizes three living areas, B one, B two, and G one. Each living area was clean. Seven interviewed staff and youth reported youth using mops and brooms. Youth were forbidden to use any other tool and are under strict supervision while handling mops and brooms.

5.10 Inventory of all Flammable, Toxic, Caustic, and Poisonous Items	Limited 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 utilizes two storage units for flammable, toxic, caustic, and poisonous items located outside in two storage units in front of the sally port entrance which is inaccessible to youth. A key lock is used to secure the storage units. Maintenance, kitchen staff, and captains have access to the storage units. The center's safety plan cover inventory and secure storage. The inventory items did not match the on-site inventory. There were various discrepancies. All flammable, toxic, caustic, and poisonous items were stored in the secure area inaccessible to

youth. A review of the center's safety plan determined procedures to address a chemical spill or injury while handling dangerous materials. The Material Safety Data Sheets (MSDS) to the flammable, toxic, caustic, and poisonous materials and items determined there is an SDS for all materials.

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

Flammable, toxic, caustic, and poisonous fluids and other dangerous substances are stored in secure areas inaccessible to youth. The center utilizes two storage units for flammable, toxic, caustic, and poisonous located outside in front of the sally port entrance and in the kitchen's storage inaccessible to youth. Seven staff and seven youth reported, youth are not allowed to clean with flammable, toxic, caustic, and poisonous fluids and other dangerous substances.

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

Observations determined flammable, toxic, caustic, and poisonous fluids and other dangerous substances are stored in secure areas inaccessible to youth located outside in two storage units in front of the sally port entrance and in the kitchen's designated storage area. A review of the center's facility operating procedures determined all hazardous items and toxic materials are disposed of in accordance with Occupational Safety and Health Administration (OSHA) Standard. There were no signs of kitchen waste being disposed of inappropriately as observations revealed. An interview with maintenance personnel determined, it is the practice of the facility to dispose of flammable, toxic, caustic, and poisonous items and materials in accordance of OSHA as Leon County Waste Pro is utilized.

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

The center utilizes three living areas, B one, B two, and G one for confinement. The rooms on each mod were free of obstruction. Seven confinement reports under twenty-four hours were reviewed. Each room utilized did not have safety hazards. Each of the seven youth had a confinement report. The confinement report was completed in the Facility's Management System (FMS). The juvenile justice detention officers supervisors (JJDOS) reviewed each confinement within two hours of each of the seven youth and documented any special needs for each of the seven youth reviewed. The confinement report was evaluated by the JJDOS and

documented the youth's status every three hours for six of the seven youth. The JJDOS did not document two of the required four evaluations for one of the youth. The captains reviewed each of the seven confinement reports within forty-eight hours for each of the youth reviewed. All instances of continued confinement were stated clearly in each of the confinement report. The need for confinement was documented every three hours for six of the seven youth. The JJDOS did not document two of the required four evaluations for one of the youth.

5.14 Confinement Over Twenty-Four Hours	Satisfactory Compliance

Confinement beyond twenty-four hours must be approved by the Superintendent or designee.

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

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

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

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

The center had two confinements over twenty-four hours during the last six months. Documentation on the confinement report captured the superintendent's approval for confinements extended beyond twenty-four hours. None of the two youth reviewed were on confinement over forty-eight hours. Documentation on the confinement report captured the juvenile justice detention officer supervisor (JJDOS) continued to evaluate and document the youth's status every three hours. The JJDOS documentation captured the current youth's behaviors. Permission was granted to continue each of the two youth's confinements beyond twenty-four hours as it was captured on the two youth's confinement reports located in the facility's management system (FMS). Each confinement was approved by the regional director. None of the reviewed confinements extended beyond three days.

5.15 Continuity of Operations Planning (COOP) Drills	Satisfactory Compliance

COOP drills shall be conducted and documented, at minimum, twice a year, with one drill being completed prior to the hurricane season, which begins June 1st.

The center utilizes a binder to maintain the Continuity of Operations Planning (COOP) drills. The center had documentation of completing a COOP drill prior to June 1, 2019. The center completed a total of eleven drills within the last year covering severe weather, major disturbances, hostage, chemical spills, and flooding scenarios. Dills were also located in the center's logbooks. Two of the seven interviewed staff reported participation in a weather

scenario COOP drill. The remaining staff reported participating in other drills such as fire and escape.

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

A review of the center's escape prevention plan determined the center has a process to maintain safety & security in the event the center needs to respond quickly and appropriately. The plan delineated appropriate levels of supervision, staff vigilance, and proper building maintenance in escape drills. The center utilizes a binder to maintain the escape drills. The center conducted and documented quarterly mock escape drills for each shift on each quarter excluding October through December 2018 quarter during the first shift The center had documentation of the remaining required quarterly escape drills for the first shift. Seven staff were reviewed and each had annually training of escape prevention. Drills were also located in the center's logbooks. Seven staff were interviewed and each reported they participated in the drill.

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

A review of the center's fire prevention plan determined the center has implemented a disaster preparedness plan. The center utilizes a binder to maintain the fire drills. Drills were found to be conducted monthly, facility wide, and on each shift. The center had documentation of conducting monthly fire drills. Drills were also located in the center's logbooks. Seven staff were interviewed and reported participation in fire drills.