STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

PROGRAM REPORT FOR

Leon Regional Juvenile Detention Center

[Provider Name or "Department of Juvenile Justice"]

(State-Operated)
2303 Ronellis Drive
Tallahassee, Florida 32310

Review Date(s): September 18-21,2018

PROMOTING CONTINUOUS IMPROVEMENT AND ACCOUNTABILITY
IN JUVENILE JUSTICE PROGRAMS AND SERVICES

Rating Definitions

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

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

Review Team

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

Juan Youman, Office of Program Accountability, Lead Reviewer (Standard1)
Warren Garrison, Office of Program Accountability, Regional Monitor (Standard 3)
Rhonda Hartwell, Bay Regional Juvenile Detention Center, Assistant Superintendent (Standard 2)
Travis Ligon, Office of Prevention and Victim Services, Procurement Specialist (Standard 5)
Craig Swain, Office of Program Accountability, Regional Monitor (Standard 4)

Program Name: Leon Regional Juvenile Detention Center
Provider Name: State Operated
Location: Leon County / Circuit 2
Review Date(s): September 18-21,2018

MQI Program Code: 32
Contract Number: N/A
Number of Beds: 40
Lead Reviewer Code: 141

Methodology

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

Persons Interviewed

☒ Program Director
☐ DJJ Monitor
☒ DHA or designee
☒ DMHCA or designee

_____ # Case Managers
_____ # Clinical Staff
_____ # Food Service Personnel
3 # Healthcare Staff

1 # Maintenance Personnel
1 # Program Supervisors
_____ # Other (listed by title): _____

Documents Reviewed

☐ Accreditation Reports
☒ Affidavit of Good Moral Character
☒ CCC Reports
☒ Confinement Reports
☒ Continuity of Operation Plan
☐ Contract Monitoring Reports
☐ Contract Scope of Services
☐ Egress Plans
☒ Escape Notification/Logs
☒ Exposure Control Plan
☒ Fire Drill Log
☐ Fire Inspection Report

☒ Fire Prevention Plan
☒ Grievance Process/Records
☒ Key Control Log
☒ Logbooks
☒ Medical and Mental Health Alerts
☒ PAR Reports
☒ Precautionary Observation Logs
☒ Program Schedules
☒ Sick Call Logs
☐ Supplemental Contracts
☐ Table of Organization
☒ Telephone Logs

☒ Vehicle Inspection Reports
☒ Visitation Logs
☒ Youth Handbook
7 # Health Records
7 # MH/SA Records
15 # Personnel Records
10 # Training Records/CORE
7 # Youth Records (Closed)
3 # Youth Records (Open)
_____ # Other: _____

Surveys

7 # Youth
7 # Direct Care Staff
_____ # Other: _____

Observations During Review

☒ Admissions
☒ Confinement
☒ Facility and Grounds
☐ First Aid Kit(s)
☐ Group
☒ Meals
☒ Medical Clinic
☒ Medication Administration

☒ Posting of Abuse Hotline
☒ Program Activities
☒ Recreation
☒ Searches
☒ Security Video Tapes
☐ Sick Call
☐ Social Skill Modeling by Staff
☒ Staff Interactions with Youth

☒ Staff Supervision of Youth
☒ Tool Inventory and Storage
☒ Toxic Item Inventory and Storage
☐ Transition/Exit Conferences
☐ Treatment Team Meetings
☐ Use of Mechanical Restraints
☒ Youth Movement and Counts

Comments

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

Standard 1: Management Accountability
Detention Rating Profile

Indicator Ratings

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

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

Standard 2: Youth Management
Detention Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Detention Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Detention Rating Profile

Indicator Ratings

Standard 5 - Safety and Security		
5.01	* Active Supervision of Youth	Satisfactory
5.02	* Ten-Minute Checks	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	Kitchen Tools	Satisfactory
5.10	* Youth Access & Use of Tools, Cleaning Items	Satisfactory
5.11	Inventory of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.12	* Access to all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.13	Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.14	Confinement Under Twenty-Four Hours	Satisfactory
5.15	Confinement Over Twenty-Four Hours	Satisfactory
5.16	Continuity of Operations Planning (COOP) Drills	Satisfactory
5.17	Escape Drills	Satisfactory
5.18	Fire Drills	Satisfactory

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Strengths and Innovative Approaches

- Farming the Future, is an interactive STEM learning experience at Leon Regional Juvenile Detention Center (LRJDC) which is focused on aquaponics-based productions and 21st century farming. Farming the Future engages the youth on interesting engineering projects where they learn about mini bel siphons and how to make them. In addition, they have planted seeds for harvest including broccoli, swiss chard, peas, and peppers which have been used for cooking in the center's cafeteria. The center will be expanding their greenhouse and terrestrial gardens in January 2019. The youth will be able to plant almost 100 additional pounds of fruits and vegetables.

- The center partnered with the Department of Health and became an official Students Working Against Tabaco (SWAT) location. This has been instrumental in assisting youth to quit smoking and teaching youth in the importance of not smoking.

- The center hosts an annual Staff Appreciation Breakfast and an annual Volunteer Appreciation gathering

- The center is one of two pilot sites for Reducing Isolation in Youth Facilities (RIYF). Research has shown that isolating youth for long periods of time, or as a consequence for negative behavior, undermines the rehabilitative goals of youth corrections. Lengthy periods of isolation can by traumatizing and may result in a serious risk to a youth's health. These risks are magnified for youth with disabilities or histories of trauma and/or abuse. The RIYF initiative is a collaboration between the Center for Coordinated Assistance to States (CCAS), the American Institute of Research (AIR), and CJCA. The nationwide initiative focuses on providing support to those jurisdictions implementing strategies to reduce the use of isolation in youth facilities.

Standard 1: Management Accountability

Overview

Leon Regional Juvenile Detention Center is a forty bed, hardware secure facility located in Tallahassee, Florida. The center house both male and female youth from Leon, Gadsden, Jefferson, Franklin, Madison, Taylor, Liberty and Wakulla Counties. At the time of the annual compliance review, the center had seven vacant juvenile detention officer positions, one administrative assistant position, and one assistant superintendent position which is in the process of hiring a candidate.

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

A review of the employee and volunteer roster at the center revealed a total of fifteen staff were hired since the last annual compliance review. Each staff received a background screening prior to their hire date. The pre-employment assessment passing score was found in each staff record. The Annual Affidavit of Compliance with Level 2 Screening Standards was completed and sent to Background Screening Unit by the January 31 deadline, meeting the annual requirement.

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 policy and procedures in place for the rescreening of staff every five years after their hire date. Upon the five year mark, the center will submit the staff's information to the Department's Background Screening Unit for the rescreening. A review of the employee and volunteer roster at the center found none of the staff were eligible for a five-year rescreening.

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

A review of seven staff personnel records found each staff signed a code of conduct. The center had one staff member terminated due to violations of code of conduct since the last annual compliance review. Six of the staff received retraining on several policies. None of the staff received any suspensions. The center had staff who received commendations, including two staff promotions. The maintenance man received the maintenance man of the year award for the north region. The training coordinator for the center was invited by the Leon County Sheriff Office to attend the Crisis Intervention Training. A review of the incident reports revealed there were no substantiated allegations of improper conduct by staff during the past six months. The process for allowing youth to call the Florida Abuse Hotline or Central Communications Center (CCC) to report suspected abuse, based on seven staff interviews, is to notify the supervisor and allow the youth to make the call. An interview with the superintendent revealed the code of conduct ensures all communication and interaction between youth and staff are professional and respectful in nature. It provides directions for behaviors which are not acceptable and lists all standards of conduct for staff. Five interviewed youth stated they were never stopped from reporting abuse. Two youth stated they never have reported abuse. Five of seven youth stated staff are respectful when talking to youth. Five youth revealed they have never heard staff use profanity when speaking to youth, one youth said they heard staff used profanity once. The other youth revealed they have heard staff use profanity often when speaking to youth. Six of the seven interviewed youth stated they felt safe at the center. The other youth revealed this is a dangerous place and it the does not fit them. The youth stated how they did not like anything at the center but the food. The youth later revealed they just wanted to go to the center which was close to their home. Three of seven staff interviews revealed staff have heard coworkers use profanity once or occasionally when speaking to youth. Six of the seven interviewed staff revealed they have never heard a co-worker using threats, intimidation, or humiliation when interacting with youth. The remaining staff stated he observed staff threatening youth with confinement as a result of the youth not following staff directives. The work conditions at the center were described as poor by one staff, fair by two staff, good by two staff, and very good by two staff

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

The center had thirty-eight Central Communications Center (CCC) reports in the last six months. A random selection of five CCC reports were reviewed. Each of the incidents were reported within the required two-hour timeframe and documented in the logbook. An interview with the superintendent revealed all youth have the right to contact the Florida Abuse Hotline at any time. If staff observe abuse, as mandatory reporters, they are obliged to report any instances of abuse. The CCC is generally contacted by the supervisor or administration when incidents meeting reporting guidelines occur.

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

The center had 144 Protect Action Response (PAR) reports in the last six months. A random selection of fourteen reports were reviewed. Thirteen of the reports were completed by the end of the staff member's workday and included statements from all staff involved. One of the reports was not reviewed/processed within seventy-two hours, reviewed by a PAR instructor, or superintendent/designee, and the Post-PAR interview was not completed. Another report was not completed by the end of the staff member's workday and did not include statements from all staff involved. Three of the report did not contain a post-PAR interview completed within the thirty-minute time frame. The post-PAR interviews were an hour and thirty-six minutes late, two hours and seven minutes late, and one hour and thirteen minutes late. The center's PAR Rate is 11.57, which is above the statewide average of 9.29. An interview with the superintendent revealed PAR incidents are reviewed on video and reports are reviewed in the Departments Juvenile Justice Information System (JJIS) to ensure documentation supports the actions occurred and the PAR was reasonable and necessary when physical interventions occur. Seven staff interviews revealed staff try to talk to youth prior to using physical restraints or mechanical restraints. A review of internal incidents, grievances, and logbooks found no additional PARs need to be reported.

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

Three staff training records were reviewed for pre-service/certification training. Each of the staff were certified within 180 days of their hire date. The training records revealed all of the staff were trained in all of the prerequisite classes to include Protective Action Response (PAR), cardiopulmonary resuscitation (CPR), Automated External Defibrillator (AED), first aid, mental health services, substance abuse services, suicide recognition, prevention and intervention,

safety, security, and supervision, to include emergency plans and procedures, and Department of Juvenile Justice Detention Facility Operations prior to any contact with youth. The staff were also trained in essential skills, orientation, information security awareness, legal, Department of Juvenile Justice: The Organization, gang awareness, interpersonal/communication skills, and detainee behavior and consequences. All of the trainings were documented in the Department's Learning Management System (SkillPro). All of the staff receive training at the academy as well.

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

Seven staff training records were reviewed for in-service training. Each staff completed the required number of hours of training. These training included a cardiopulmonary resuscitation (CPR), first aid, Automated external Defibrillator (AED), and professionalism and ethics. Each of the staff received the minimum requirement of six hours of suicide prevention training. One of the staff did not have the two hours of web-based training in the Department's Learning Management System (SkillPro) in suicide prevention but had six hours of suicide training. Six of the seven staff received a Protective Action Response (PAR) update. The remaining staff was on light duty from May 6, 2016, to February 28, 2018, and did not receive the training. The program provided documentation to support this information. Three of the training records selected were supervisors, who completed at least eight hours of supervisory trainings. All three supervisors received training in medication administration and Epi-Pen auto injector. Three of the seven staff did not have training in trauma-informed care. All of the trainings were not documented in SkillPro. The center has an annual in-service training calendar, which is updated as changes occur.

1.08 Entering Alerts (JJIS) and Sharing of Alert Information (Critical)	Satisfactory Compliance
Superintendents shall ensure Critical and Special Alerts are reviewed and responded to appropriately. *Upon completion of the Admission Wizard, the officer shall ensure all Critical and Special Alerts are listed in JJIS.* *The JJIS alert report shall be reviewed daily by supervisors and administrators to ensure it correctly reflects the status of youth.* *If the electronic system is inoperable, for any reason, the JJDO Supervisor shall ensure the last hard copy of the alerts shall have a written notification or update of the recent admissions or changes to existing alerts on the alert sheet and distribute to all staff within the facility immediately.* *Medical and mental health staff shall review alerts to ensure each alert is correctly tracked and managed.* *The responses and updates by medical, mental health and other staff should be documented in JJIS alerts as they pertain to that critical alert.*	

The center's alerts entered into the Department's Juvenile Justice Information System (JJIS) were reviewed. There was documentation in the center's logbooks and internal alerts to identify youth with medical, mental health, suicide, gang, and security issues. All JJIS alerts were entered into JJIS, as required. All medical alerts are removed by medical staff. All mental health alerts are closed by mental health staff. The center has a process in place to ensure alert information is kept up-to-date and accurate. Information regarding youth alerts are available to all staff during pre-shift meetings, which was observed during the annual compliance review. Each staff also received a copy of the alerts to have with them during the shift. Seven staff interviews revealed staff are informed of alerts specific to youth during shift debriefings, reviewing the logbook, and alert forms. The staff interviewed also revealed management informs staff about issues within the center through staff debriefings, memos, e-mails, and trainings.

Standard 2: Assessment and Performance Plan

Overview

The center's total headcount on the first day of the review was thirty-three youth. Youth admitted to the center are provided with an orientation packet which describes the center's rules and expectations. The youth are given an opportunity to continue their education, participate in group, mentoring, counseling sessions with mental health and detention staff to feel safe while in the center. Youth are also given the opportunity to communicate with their family by phone or writing letters and visitation.

2.01 Admission	Satisfactory Compliance

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

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

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

A review of seven active youth records found each youth received an orientation upon admission. Each youth record contained the arrest affidavit/custody and completed Detention Risk Assessment Instruments (DRAI) and Suicide Risk Screening Instruments (SRSI). All of the reviewed records revealed each youth received a frisk, strip, and/or electronic search, a telephone call, or documented refusal of the telephone call, a meal within the two-hour timeframe prior to the next scheduled meal, and medical and mental health and substance abuse screenings. Two admissions were observed during this annual compliance review and all procedures were followed. Staff were observed interviewing youth and documenting the information in the Department's Juvenile Justice Information System. Each youth received a shower supervised by a staff of the same sex as the youth. Once the admission was over, the youth was escorted their assigned module.

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

A review of seven active youth records revealed an orientation was completed for six of the youth within the twenty-four hours of admission. One of the records reviewed was missing an orientation brochure at the time of admission, which was also resolved during the annual compliance review. One youth did not receive all the required elements of the orientation to include the youth rights form which were provided to the youth during this annual compliance review. There was documentation of the staff and youth reviewing and signing the orientation packets in all seven records.

All seven records reviewed documented the center's rules and regulations were explained to the youth. The grievance process, visitation process, and telephone calls process were all included in the orientation. The process to see medical staff and mental health, calling the Florida Abuse Hotline and/or the Central Communications Center, and behavior management and expectations and consequences for negative behavior were documented in the orientation packet. During the two admissions observed, staff discussed the orientation process to each youth. All seven youth interviewed answered when they were going through the admission process, a staff member provided information about the center's rules and regulations, daily schedule, education services, visitation, abuse reporting, and the behavior management system.

2.03 Classification	Satisfactory Compliance

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

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

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

A review of seven active youth records found documentation which indicated the classification process took place prior to the assignment of a room. The admission wizard provided a review of physical or developmental disabilities, the youth's age, height, weight, level of aggression, gang affiliation, history of sexual offenses including sexual battery charges which were reduced to a lesser offense, Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB), medical and suicide risk identified or suspected, and escape or security risks. Appropriate alerts were entered for youth with a history of sexual offenses, suicide risks identified or suspected, and vulnerability to victimization. Youth were appropriately assigned to a room based on reviewed documentation. The classification process was observed during the two observed admissions, and found the classification process was completed, as required. All seven youth interviewed stated they felt safe at the center.

2.04 Classification of Gang Members	Satisfactory Compliance

All newly admitted youth are screened to determine if he or she is a criminal street gang member or is affiliated with any criminal street gang.

Each facility shall identify a staff person to serve as a gang representative who shall review identified youth for suspected gang involvement or gang activity.

The center has policy and procedures requiring youth admitted into the center to be screened for gang membership and/or affiliations. A review of seven active found each youth was screened, as required. No suspected gang member alerts were entered into the Department's Juvenile Justice Information System (JJIS) alert system due to none of the youth being identified as a gang member or affiliated with one.

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

The center has policy and procedures in place for sharing gang information with the circuit's juvenile probation officer (JPO) gang liaison. None of the seven reviewed open records were for youth with gang affiliations or suspected gang membership. The center's gang liaison notifies the JPO gang liaison by e-mail with all related information and documentation pertaining to the youth. The JPO gang liaison then notifies law enforcement, and the assigned (JPO). The assigned JPO will in turn place an alert into the Department's Juvenile Justice Information System (JJIS) after confirmation the youth is a suspected gang member The JPO gang liaison and center's gang liaison meet once a month to review all youth in secure detention.

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

The center has written policy and procedures in place regarding a youth's personal property at the time of admission. All seven reviewed youth records included an itemized personal property receipt form with the youth's and staff's signatures. Two admissions were observed, and staff were observed completing itemized personal property receipt forms. One of the youth had valuables which were placed in the safe in master control. The youth with valuables did not sign the property bag before it was placed in the safe, but staff documented in the safe logbook the youth was admitted with valuables and placed in the safe. A review of the drop safe bound logbook documented the dates, times, youth names, and the officers placing the property in the safe. The safe is located in master control under camera view and was observed by the annual compliance review team during the facility tour. All of the youth records contained a Letter of Acknowledgement regarding unclaimed property. Seven youth interviews revealed staff check the youth's personal property and signed a form stated the property was correct. Superintendent interview revealed personal property is inventoried, signed by the youth then placed in a secured property room where only Administrators and Designee have access to. Also, a camera monitors the entrance and exit of this property room door. Valuable property is dropped in a cabinet safe with a lock by a Supervisor/Designee that is under surveillance. All property is logged in the safe logbook for added security and record retention.

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

The center has a written policy and procedures in place to safeguard each youth's personal property until it can be returned to the youth and/or guardian. A youth locker assignment and availability report from the Department's Juvenile Justice Information System (JJIS) was reviewed for completed property receipt forms at admission. Youth property is also to be placed in a green mesh bag with a number on it. Six of seven reviewed youth were listed on the assignment and availability report as being placed in a locker (green mesh bag kept in the secured property room). The remaining youth was not included on the report had property placed in a locker (green mesh bag); however, it was not entered into JJIS at the time of admission. Two admissions were observed, and the youths' property were placed in a green mesh bag with a number on it. In the past six months, there were no Central Communications Center (CCC) incidents reported regarding youth property.

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

The center a has policy and procedures regarding the release of youth from secure detention. None of the seven reviewed records were applicable for release; therefore, four closed records were reviewed. In three of the four closed records, the youth were released to either a parent/guardian or the Department of Children and Families (DCF). The remaining youth was released to a residential commitment program. The release wizard in the Department's Juvenile Justice Information System (JJIS) documented the correct youth was released and acknowledged by the staff releasing the youth. The four closed records reviewed had a copy of the photo identification of the person taking custody of the youth, except for the youth released to a residential commitment program. The closed records reflected all property was returned to the youth and all release forms were signed by the youth, the person taking custody of the youth, and the staff completing the release process. One youth release was observed during the annual compliance review. The parent/guardian was observed in the front lobby waiting for the youth. The staff made a photo copy of the parent's/guardian's identification card. The youth received all of their property and signed the property receipt, along with the staff releasing the youth and parent/guardian. The parent/guardian also signed the release wizard, taking custody

of the youth. There were no Central Communications Center (CCC) reports during this annual compliance review period for the past six months related to unauthorized releases.

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

The center has a policy and procedures for releasing youth personal property during the time of the release. The youth, parent/guardian, and releasing juvenile justice detention officer sign receipt of their property upon release. Three of the four reviewed closed records had a photo copy of the person taking custody of the youth and a signed Property Receipt form. There were no calls to the Central Communications Center (CCC) regarding missing property during this annual compliance review period.

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

The center has policy and procedures for releasing youth with prescription medication and after care instructions once discharged.
A review of three closed records of youth released with medication and aftercare instructions found each contained a medication receipt signed by the nurse and parent/guardian picking up the youth with a count of the medication. The name of the medication and verification showing the correct youth was released with medication was documented as well.

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

The center has a policy and procedures in place to review all youth placed in secure detention and home detention weekly. A juvenile justice detention officer supervisor serves as the detention review specialist for the center. A detention review was observed and a representative from the center's administration, education, medical, mental health, the juvenile probation office (by telephone or in person), and the commitment manager by telephone all were present during the detention review. During the detention review observed, each representative spoke on their designated area of expertise about the youth reviewed. A detention review packet was also passed out to all departments present for the meeting. Superintendent interview revealed detention reviews are conducted weekly on Wednesdays at 2:00 p.m. in the conference room. The detention review specialist, an administrator, chief probation officer or designee from probation, medical, mental health, and education participate.

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

During a tour of the center, the daily activity schedule was found to be posted throughout the modules. The daily activity schedule includes personal hygiene, meal times, visitation, education, physical activities, gender-specific programming, and life and social skill groups. There is an activity schedule posted for Monday through Friday and an activity schedule for Saturday and Sunday and Holidays. The center is involved with Students Working Against Tobacco (SWAT) as a restorative justice activity. Mental health staff facilitate gender-specific groups with the females and males. Four of the seven staff interviewed stated the center offers gender-specific programming as part of the daily schedule. An interview with the superintendent revealed the center also uses Eight 2 Great for restorative justice activities.

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

A review of the master control logbook, female module logbook, and male module logbook revealed the daily schedule was followed but has not been documented on a daily and consistent basis. Interviews with the superintendent and supervisors indicated the center is following the activity schedule. A review of shift reports from all three shifts on three different occasions found there was no changes in the daily activity schedule or visitation by the superintendent during the annual compliance review period. Seven interviewed staff revealed the activity schedule is being followed. Six of seven interviewed youth stated the daily activity schedule is being followed.

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

The lead teacher confirmed the youth are in school year-round 250 school days, including ten holidays and ten planning/in-service days. The master control logbook was reviewed and supported school has not been cancelled and the youth attend, as indicated on the daily activity schedule. Seven interviewed youth acknowledged they attend school daily Monday through Friday, unless in confinement consequently due to their behavior.

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

The lead teacher confirmed the youth are provided Type 1 programming while at the center. Type 1 programming requirements include instruction in life skill groups and activities. Career Education programming includes interpersonal, communication, and decision-making skills. The center defined career education programming which is appropriate based upon the age, assessed educational abilities, and goals of the youth at the center, and the typical length of stay and custody characteristics at the center to which each youth is assigned.

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

The center has policy and procedures in place addressing the behavioral management system (BMS). Daily expectations are briefed twice daily on two separate shifts to the youth, and the rules and expectations are posted throughout the modules. The center has a reward system based on points for good behavior and loss of points and level drop for bad behavior. The BMS Champion, a supervisor, at the center is responsible for the management of the levels and maintaining the spread sheet for each youth leveling up on a weekly basis. Maintenance of the BMS includes a list of the youth who are to be rewarded extra items such as pizza parties, snacks, and movies.

All youth are allowed their basic rights of food, clothing, shelter, healthcare, school, exercise, letter writing, telephone calls, visitation, religious opportunities, and daily hygiene regardless of their level. Six of the seven interviewed youth stated the BMS was either fair, good, or very good. One rated the BMS as poor. Six of the seven staff interviewed stated the level system was effective. Six of the seven youth interviewed stated when they received consequences based on their behavior it was fair. One youth never received any consequences.

2.17 Unauthorized Use of Punishment (Critical)	Satisfactory Compliance

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

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

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

The use of drugs to control the behavior of youth is prohibited. This does not preclude the proper administration of medication as prescribed by a licensed physician.

The center has a policy and procedures in place which prohibits corporal punishment. During the annual compliance review period, there were no instances of unauthorized punishment reported. Six of the seven interviewed staff stated levels and points are used as consequences for bad behavior and one staff stated youth miss school due to being in confinement. Four of the seven youth stated behavior consequences included their level being taken, one stated points were taken, and one stated they never received consequences. Seven staff and seven youth all stated youth are not allowed to punish other youth. Six of the seven interviewed youth stated they have been sent to their room for punishment with the door shut and locked while in confinement. One youth stated he has never been sent to his room.

2.18 Grievances	Satisfactory Compliance

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

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

The center has a policy and procedures in place regarding the grievance process. Each module has a grievance notebook which contains all of the necessary forms for the youth. During the annual compliance review period, there were no grievances filed nor were any documented in the Facility Management System. Seven staff interviewed all had knowledge of the grievance process. Six of the seven youth interviewed never filed a grievance while in secure detention. One youth stated the grievance process was fair. All youth knew the grievance process and where the forms were located.

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

The center has a policy and procedures in place regarding trauma-informed care. While touring the center, the soft room was observed and there were soothing colors of the paint and murals throughout the center. Six of the seven reviewed staff records documented staff received training in trauma-informed care.

Standard 3: Mental Health and Substance Abuse Services

Overview

The center utilizes Maxim Healthcare Services, Inc. (MHC) congruently with Camelot Community Care (CCC) to provide mental health services to all youth in their care. A subcontract was made with CCC April 2018. Services provided at the center befit youth requiring mental health, substances abuse, and suicide prevention needs. Staffing at the center is replete with one licensed clinical staff, two non-licensed clinical staff, and a licensed psychiatrist. The licensed mental health staff is the linchpin of mental health and substance abuse services thither the coordination of services provided to the youth at the center. Mental health staff complete and review assessments and make recommendations. Each assessment adequately deduces the services provided to each youth.

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 designated mental health clinician authority (DMHCA) is responsible for the coordination and implementation of mental health and substance abuse services in the center. The center has two licensed mental health professionals, with one serving as the DMHCA. The DMHCA holds an active license in mental health. A review of sign-in sheets verified the DMHCA is on-site weekly for forty hours. The license and agreement with Maxim Healthcare Services, Inc., who subcontracts with Camelot Community Care, Inc., delineates the scope of work. The DMCHA interview revealed mental health and substance abuse services, when needed, are provided to youth by mental health staff.

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

The center contracts for mental health services through Maxim Healthcare Services, Inc. The subcontract with Camelot Community Care ensures mental health and substance abuse services are provided by individuals with appropriate clinical staff. The center utilizes two licensed mental health counselors, ensuring the center's staffing is in accordance with the contract and Rule 63N-1. Both licensed mental health counselors hold an active license.

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

The subcontract with Camelot Community Care ensures mental health and substance services are provided by individuals with appropriate qualifications. One non-licensed clinical staff is utilized at the center and holds a master's-level degree. The staff provides substance abuse and mental health services. Each of the non-licensed staff completed the required twenty-hours of training and completed five Assessment of Suicide Risks (ASR). The staff works under the direct supervision of the designated mental health clinician authority (DMHCA). A review of the direct supervision logs verified the clinical staff receives one hour a week of on-site face-to-face supervision by the DMHCA. The DMHCA is responsible for reviewing and signing each ASR and follow-up ASR, crisis assessment and follow-up, the comprehensive substance abuse evaluations, updates, and initial and individual treatment plans prepared by the non-licensed clinical staff.

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

Mental health and substance abuse needs are addressed in the center's Facility Operating Procedures (FOP). The center utilizes a Juvenile Assessment Center (JAC) to accomplish all initial screenings. The Positive Assessment Change Tool Mental Health and Substance Abuse Report (PACT MHSA) and Referral form, the Department's Suicide Rick Screening Instrument (SRSI), and a review of the Massachusetts Youth Screening Instrument (MAYSI-2) are utilized to screen the youth for any potential mental health and substance abuse needs.

Seven youth records were reviewed. Each youth had a PACT MHSA completed during intake, of which four indicated a need for further assessment and were referred for an Assessment of Suicide Risk (ASR). Four of the seven youth had a MAYSI-2 completed. The remaining three records were non-applicable because the two youth were transferred from another entity other than the JAC and one youth refused. Upon admission, each youth had a SRSI completed, each had a positive ("yes") response on the SRSI, was placed on suicide precautions, and had a mental health referral completed.

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.	

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

Seven youth records were reviewed and each are detained at the center. Four of the seven were detained for thirty-one days or more. Each of the seven screenings indicated the need for a comprehensive assessment. Although three youth were not in the center long enough to complete an assessment, one youth had an assessment completed. Thus, five of the seven records reviewed had documentation of an assessment completed within the thirty-one days of the referral. All of the evaluations were completed on Comprehensive Substance Abuse/Mental Health (SAMH) form in the youth's electronic medical record.

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

Seven youth records were reviewed and each youth was determined to have a serious mental disorder and five of the seven were determined to need substance abuse treatment. One of the seven refused mental health treatment and substance abuse treatment. Each of the six applicable youth were assigned to a mini-treatment team. Mini-treatment teams were comprised of all of the appropriate team members. Each of the applicable youth records had documentation of receiving individual, group, or family counseling by the licensed mental health professional or, in some cases, the non-licensed mental health clinical staff working under the direct supervision of the licensed mental health professional, in accordance with their treatment plan. Regardless of any refusals, each of the seven youth records had a signed Substance Abuse Consent and Release and Authorization for Evaluation and Treatment forms. Reviewed sign-in sheets determined groups included fifteen or less youth. All of the seven interviewed youth rated the mental health and substance abuse services as fair, good, or very good. Interviews with the designated mental health clinical authority (DMHCA) provided insight on the center's process for specialized services. Specialized services are offered by outside

community based mental health treatment agencies. Counseling is offered to youth based on their mental health needs as well.

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

The superintendent has developed a policy and procedures to ensure mental health and substance abuse treatment is focused on reducing or alleviating the youth's symptoms of mental disorder or substance abuse impairment and enable youth to function adequately. Procedurally, all youth needing treatment are assigned to a mini-treatment team comprised of mental health/substance abuse staff, a representative from either administrative, supervisory, and/or education staff, the youth, parent/guardian (if possible), and the psychiatrist/advanced registered nurse practitioner **(**ARNP**),** as applicable. Treatment team occurs weekly and coordinated by the designated mental health clinician authority (DMHCA). Treatment team notes are documented in the youth's chronological notes.

Seven open youth records were reviewed. One youth refused services and another youth refused medication. Thus, of the seven open youth records six were receiving mental health and/or substance abuse services. Each of the six youth records had documentation of an initial treatment plan completed within seven days of initiation of treatment. The treatment plans were consistent with the center's policy and Department Rule 63N-1, including reason for referral, treatment methods, and goals. All of the initial treatment plans were signed by all required parties. Three of the six applicable youth were at the center long enough to receive an individual treatment plan review. Each of the three youth received an individualized treatment plan review completed and signed on Form MHSA 017 within the required timeframe.

Three closed youth records were reviewed. Each record had a discharge plan documented on Form MHSA 011. The discharge plan was provided to the youth and juvenile probation officer (JPO). The JPO provided documentation to the parent/guardian, as applicable.

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

The center's policy allows for psychiatric services to include psychiatric evaluations, psychiatric consultations, medication management, and medical supportive counseling to be provided to youth. Each youth with a mental disorder and receiving psychotropic medication should receive services. The center utilizes a psychiatrist who is board certified in Child and Adolescent Psychiatry pursuant of Chapter 458.

Six of the seven youth records reviewed entered the center on psychotropic medication. One of the seven was not applicable for services and another youth refused psychiatric services. Therefore, five of seven youth reviewed were receiving psychiatric services by the psychiatrist. Each of the five applicable youth received an initial diagnostic interview within fourteen days of admission. The initial diagnostic psychiatric interview included elements specified in Rule 63N-1 F.A.C. Each youth received an in-depth psychiatric evaluation on the Clinical Psychotropic Progress Note (CPPN) within thirty days of admission and all appropriate documentation was included. Each applicable youth had a written and verbal consent by the parent/guardian. Two you were in foster care and documentation contained consent requirements. Only three youth were at the center long enough to have documentation of a monthly CPPN/medication review. The CPPN was completed for each of those three youths. The Collaborative Practice Agreement highlights duties of the advanced registered nurse practitioner **(**ARNP**)** and duties of the physician to address the provision of medication at the center.

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

The center utilizes a suicide prevention plan detailing suicide prevention procedures. The plan includes assessments, training, precautions, supervision, referrals, communication, notification, documentation, immediate response and a review.

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.*	

Six of the seven youth records reviewed were applicable for suicide risk factors upon admission. Each of the six were placed on suicide precautions, an alert in the Department's Juvenile Justice Information System (JJIS) was entered, and each youth received an Assessment of Suicide Risk (ASR). In three of the six applicable records, the youth also received a follow-up ASR. The three applicable youth who received a follow-up ASR were stepped down to close supervision prior to being transitioned to normal routine and standard supervision. Each ASR completed was documented in real time, completed within twenty-four hours, and administered by the licensed mental health professional or a non-licensed mental health clinical staff who completed the required twenty hours of the ASR training and working under the direct supervision of a licensed mental health professional. Each mental health staff conferred with the superintendent prior to transitioning the youth to a lower level of supervision. The conference was recorded in actual date/time the clinician conferred with superintendent. A review of

logbooks determined the beginning and ending times are documented for youth placed on precautions. JJIS alerts were removed prior to stepping each youth down.

Four of the seven interviewed youth reported having been on suicide precautions while at the center. All four youth stated staff watched them the whole time they were on precautions. Seven interviewed staff reported if a youth expressed suicidal thoughts, they would notify mental health staff and put the youth on constant sight and sound. Additional responses included: completing a search and documentation, made by other staff.

None of the youth were held in a secure observation. The center's superintendent has an established review process incorporated into the center's policy for every serious suicide attempt or serious self-inflicted injury and a mortality review for a completed suicide.

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

Seven youth records were reviewed. Six of the seven youth were identified during intake of having suicide risk factors and required a precaution observation (PO) log. Logs were maintained in no more than thirty minute intervals for the duration of each youth being on PO. Logs documented observations made by staff. Logs were reviewed and signed by each supervisor and clinical staff.

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

Ten staff training records were reviewed. Each staff received a minimum of six hours annual training on suicide prevention and implementation of suicide precautions. Mock suicide drills were held on each shift every quarter. All staff with direct contact participated in at least one drill, semi-annually.

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

The center has a written crisis intervention plan. The plan details crisis intervention procedures including notification, alerts, referrals, communication, supervision, documentation, and reviews.

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

The center's policy addresses youth determined to be an imminent danger to themselves or others due to mental health or substance abuse emergencies. Procedurally, the policy includes; staff response, notifications, communications, supervisions, transportation, treatment, documentation, training, and reviews.

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

A review of the program's policy, crisis assessment tool, and staff training records determined the program is adequately prepared to conduct crisis assessments. Procedurally, the youth in crisis are administered a crisis assessment, including assessments, a mental status examination (MSE), determination of danger to self/others, clinical impression, recommendations, and notifications. The center has not had any youth in need of a crisis assessments within the scope of the annual compliance review.

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

One youth returned to the facility from a Baker Act within the scope of the annual compliance review. A mental health referral was completed. The assessment of suicide risk determined the suicide risk alert. The mental status examination (MSE) was completed by the licensed mental health professional. The youth was maintained on a minimum of constant supervision until properly transitioned to a lower level of supervision. The youth's supervision level was not lowered until appropriate assessment was conducted, and mental health staff conferred with licensed supervisor and superintendent. The policy was followed, including the proper procedures.

Standard 4: Health Services

Overview

The center has a contract with Maxim Healthcare Services Inc. to provide healthcare services including medical, mental health, substance abuse, and psychiatric services for youth at the center. The center's healthcare staff consist of one physician who specializes in pediatrics and serves as the designated health authority (DHA), one registered nurse, one advanced registered nurse practitioner (ARNP), two licensed practical nurses, one psychiatrist, and one medical records clerk.

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

Maxim Healthcare Services, Inc. is contractually required to provide comprehensive medical, services at the center. The center has a board-certified physician who has a clear and active license and meet all of the requirements to serve as a medical doctor/designated health authority (DHA). The physician's specialty is pediatrics. The DHA is responsible for the overall clinical direction, policies, and protocols for the medical services provided. The advanced registered nurse practitioner (ARNP) holds a clear and active license to practice in Florida.

A review of sign-in logs for the six months prior to the annual compliance review confirmed the DHA is on-site weekly for at least two hours. The hours are posted on the door of the medical clinic, visible for all to see. The DHA is responsible for making the necessary arrangements for a qualified doctor to cover the center during vacations or extended absences. The ARNP provide services on-site, a minimum of twenty-four hours a week. The ARNP works in collaboration with the DHA, who signed the nurse practitioner protocol/collaborative practice agreement on April 13, 2018. A check of all licensed medical staff confirmed all had current State of Florida medical licenses, verified by the Department of Health.

An interview with the DHA confirmed the DHA conducts physical evaluations, diagnose health problems, prescribes treatment, educates and counsel patients concerning medical conditions, make referrals for off-site care, and reviews protocols to make the necessary changes. The DHA is also available twenty-four hours a day, seven days a week by phone to address all concerns the center has.

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 utilizes facility operating procedures (FOP) and treatment protocols for all health-related concerns. All FOPs and treatment protocols contained the signature of the designated health authority (DHA) and the superintendent. On July 8, 2017, the annual FOP and treatment protocol review was conducted by the DHA and the superintendent. Documentation confirmed all medical staff received a comprehensive clinical orientation to the Department's healthcare policies and procedures, which was provided by the registered nurse.

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.	

A review of seven healthcare records confirmed each youth had a signed Authority for Evaluation and Treatment (AET). All AETs were signed prior to the youth receiving medical treatment. Two AETs were stamped "copy," and three youth records contained limited AETs due to the youth being under the care of the Department of Children and Families. None of the youth whose records were reviewed were over eighteen years of age.

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

A review of seven youth healthcare records (IHCR) found four required parent/guardian notifications. Two youth were prescribed acne medication and one youth required surgery and, subsequently, pain medication and each of their records documented parental notification being sent to the parent/guardian using the Department's approved health services forms for parental notifications. The remaining youth required medical attention due to possibly sustaining concussion; documentation provided confirmed medical staff made several attempts to contact the parent/guardian, but were not successful. Medical staff left voice messages for the parent/guardian informing them of the youth's medical condition. Documentation also supports the telephone calls were witnessed by medical staff. One additional youth IHCR was reviewed which required parental notification due to off-site care confirmed the parental notification was sent, as required.

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

A review of seven youth healthcare records (IHCR) found none were applicable for Clinical Psychotropic Progress Notes (CPPN). Of the seven reviewed youth records, four youth were on psychotropic medications; however, they were provided by the youth's parent/guardian within forty-eight hours of admission. Three additional youth IHCRs were reviewed. All three contained a parental notification along with explanatory information for initiation psychotropic of medication. The CPPNs were accompanied by an acknowledgement of receipt for the parent/guardian to sign and return. Parent/guardians were also contacted by telephone, which was witness by the nurse and documented. None of the applicable youth were under the care of the Department of Children and Families.

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

A review of seven youth individual healthcare records (IHCR) revealed each youth was up-to-date with their immunization requirements. Interviews conducted with medical staff revealed vaccines are verified using the Florida Shots official website. None of the youth reviewed required any exemptions.

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

Seven youth individual healthcare records (IHCR) were reviewed for screening upon admission for healthcare concerns. Each of the seven reviewed records contained a Medical and Mental Health Screening Form completed on the date of admission by a juvenile justice detention officer. Each screening form was reviewed by a registered nurse (RN) or licensed nurse practitioner (LPN) within twenty-four hours of admission. An interview with the nursing staff revealed youth are normally seen by nursing staff within twelve hours, but no longer than twenty-four hours, after admission and admission screenings are completed by nursing staff.

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

The center utilizes the Department's Juvenile Justice Information System (JJIS) to document medical alerts. Seven individual healthcare records (IHCR) were reviewed and revealed three youth had allergies, four youth had medication, one youth had a chronic medical condition, and six had medical grade alerts. All alerts were detailed, and the medication alerts included side effects. According to superintendent, alerts are entered in JJIS during the youth's admission to the center by a juvenile justice detention officer. Information is relayed to the staff during pre-shift meetings. The next shift will have the alert information documented in JJIS alerts as they will review at pass-on. The nurse will follow-up and verify medical alerts. Interviews with seven staff concerning alerts revealed one staff reported staff are informed of alerts by the alert forms, seven reported during staff meetings, and one also reported pass on from pervious shift.

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

A review of seven youth individual healthcare records (IHCR) concluded each contained a Suicide Risk Screening Instrument (SRSI). All seven SRSIs were completed within twenty-four hours of the youth's admission and placed within the IHCR. All SRSIs were completed by medical staff.

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

The center maintains a written policy and procedures which requires healthcare staff to orient each youth to the center within twenty-four hours of admission. Seven individual healthcare records (IHCR) were reviewed for completion of orientation. In all seven IHCRs reviewed, documentation revealed each youth participated in an orientation to the general process of healthcare. Each youth signed and dated to the receipt of orientation. Orientation addressed topics including sick call, the right to refuse care, and what to do in the case of a sexual assault or attempted sexual assault, the role of healthcare staff at the center and to notify staff immediately if they are having side effects from medications, allergies, medical alert issues, and/or when experiencing chest pain, extreme shortness of breath, or faintness while exercising.

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

It is the center's practice is to notify the designated health authority (DHA)/designee when youth are admitted to the center requiring emergency care or routine notification in accordance with the Department's requirements. A review of the facility operating procedures determined appropriate timeframes upon admission. Seven youth individual healthcare records (IHCR) were reviewed; none of the youth required emergency care upon admission. Five youth were identified as possessing a medical concern, chronic condition, or taking psychotropic medications. Each of the five IHCRs indicated the DHA and the advanced registered nurse practitioner (ARNP) was notified within twelve hours and referred for appropriate follow-up services. An interview with the nurse confirmed the DHA is notified of chronic illnesses after completion of the intake. The DHA is notified by phone.

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

The center did not have any applicable youth for this indicator; therefore, this indicator is rated as "Non-Applicable".

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

Seven youth individual healthcare records (IHCR) were reviewed. Each youth had a health related history (HRH) form completed within seven days of admission to the center by a licensed nurse. Five were new HRHs; the remaining two were updated. Documentation provided revealed the designated health authority (DHA) or designee reviewed each HRH form. Each HRH form was completed prior to, or at the same time as, the Comprehensive Physical Assessment (CPA).

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

A review of seven youth individual healthcare records (IHCR) revealed a Comprehensive Physical Assessment (CPA) was completed for each youth. Each CPA was reviewed and initialed by the physician. Each CPA was completed within seven days of admission by a medical doctor or the advance registered nurse practitioner (ARNP). In six youth records, the youth refused the genitalia exam. In the remaining youth records, the doctor deferred the exam due to the age of the youth. Each youth IHCR contained documentation of a refusal of the genitalia exam. A review of the Department's Problem List indicated it was updated for each youth, as required.

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

Three applicable youth individual healthcare records (IHCR) were reviewed for female-specific screenings. Each IHCR contained documentation to support the youth provided verbal consent for a pregnancy test. All three reviewed IHCRs documented a qualitative urine pregnancy test was completed. The youth did not provide verbal consent to gynecological examinations. According to medical staff, the designated health authority will not request a gynecological examination unless a youth has medical concerns, or the youth request the exam. Two of the seven youth interviewed were female and stated they have received prenatal, obstetrical, or gynecological services, when needed, at the center.

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

The center has a written policy and procedures to ensure all youth receive screenings for tuberculosis (TB). A review of seven youth individual healthcare records (IHCR) reflected each youth had a minimum of one verified tuberculosis skin test (TST) documented. Each of IHCRs documented Tier One TB screenings were completed within seventy-two-hours of admission. There were no further evaluations or treatments needed. The information was documented on each youth's Infectious and Communicable Disease form, Admission Wizard, and on the completed Comprehensive Physical Assessment. An interview with the nurse revealed youth are evaluated to determine the probability of exposure.

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

The center has a policy and procedures regarding the completion of the sexually transmitted infection (STI) screenings. The center makes accommodations for all sexually active youth admitted into the custody of the department to be screened and evaluated for STIs. Seven

IHCRs were reviewed, two youth reported not being sexually active, one youth refused STI screenings. The remaining youth test results were noted on the Department's Infectious and Communicable Disease (ICD) form filed in the youth's individual healthcare record (IHCR). Interviews with medical staff revealed youth are screened for risk factors. Youth are asked if they want to be tested, then urine and or blood samples are collected and sent to a lab. Results are received within forty-eight hours and reviewed by clinical staff. Documentation is provided in chronological notes, clinician notes and on the infectious and communicable disease form.

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

Seven youth records were reviewed, of which four consented to human immunodeficiency virus (HIV) testing and treatment. A copy of the consent was filed in the youth's Individual Health Care Record (IHCR), testing was completed, and the HIV results were securely sealed in an envelope marked "confidential" and filed in each youth's IHCR. All counseling, education, and treatment was documented in the youth Individual Health Education Record (HS013) and provided by a certified HIV counselor. Nursing staff confirmed, upon admission, youth are asked if they desire to take a HIV test. HIV counseling is performed by the clinician, labs are drawn, and a post-test performed by clinician. Five of the seven interviewed youth revealed they could ask for an HIV test, the remaining two stated they could not.

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

All youth in the center can make sick call requests and have their complaints treated appropriately through the Sick Call Process (SCP). The SCP is conducted daily, as needed, by a licensed nurse. Medical staff reserve time every day, twice a day, to address sick calls. Sick call request forms and narrative progress notes conform to the professional standard to include all elements of the subjective, objective, assessment, and plan (SOAP) format. There were no youth complaints of any severe pain with which medical staff was unfamiliar with. During seven youth interviews concerning sick calls, two youth reported they are seen immediately, four stated within one day, and one reported they never requested a sick call.

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

Three applicable reviewed youth individual healthcare records (IHCR) included a sick call index, the corresponding Facility Management System (FMS) generated, sick call list, sick call request form, and sick call referral log. All records documented sick calls were conducted by a registered nurse (RN) in less than twenty-four hours of the request being made. A sick call was not observed during the annual compliance review. Youth and staff signed indicating the youth were seen. Interviews confirmed the medical staff are responsible for conducting sick calls. According to staff interviews, two reported youth are seen by the doctor for sick calls and five reported youth are seen by the nurse.

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

The center has a written policy and procedures to ensure all youth in the program have access to healthcare staff while in restricted housing. Three applicable youth individual healthcare records (IHCR) were reviewed. Documentation showed the medical staff made daily visits to ask youth about their health and, when applicable, youth were continued on their prescribed medication. In addition, nursing staff completed detailed narratives in the chronological progress notes in the youth's IHCR for each youth who is treated while in restricted housing.

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

The center has an established policy and procedures for the provision of episodic care and first aid which included documentation requirements for episodic care performed by non-healthcare staff. Emergency medical and dental care, including emergency medical services (EMS), are available twenty-four hours a day, seven days a week.

A review of three applicable youth individual healthcare records (IHCR) found each contained appropriate documentation of the episodic care events. Each youth was seen by healthcare staff. The center maintained an Episodic Care Log to document the provision of episodic care and first aid treatment. A review episodic care documentation found the subjective, objective, assessment, plan (SOAP) format was used. A review of the logs indicated episodic care was administered by the nursing staff. One of the three youth required off-site care and documentation and notification were completed, as required. The center has a total of eighteen first aid kits. All eighteen were inspected and contained all of the approved content, as required. All content was up-to-date, and all first aid kits were resealed with a tamper tag. Documentation and interviews confirmed the nursing staff review inventory and restock all first aid kit monthly and maintained on a log located on each first aid kit. First aid kits were found located throughout the center.

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

The center has a policy and procedures for the provision of emergency care. Mock emergency care drills are held on all shifts at least quarterly. All licensed nursing staff maintain current cardiopulmonary resuscitation (CPR) with Automated External Defibrillator (AED) certifications, which expire in 2019. A list of emergency numbers was posted in master control and in the medical section of the center accessible to staff. The center has one AED which is stored in the medical section of the center. The AED procedures were located on the AED unit, which also provided automated audible application instructions. The AED was checked and found to be well maintained and in properly functioning condition. The AED is in the process of being replaced in October 2018, due to recalls; however, the current battery and pads expire in 2019. Seven interviewed staff reported they can call 9-1-1, if necessary.

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

The center has a written policy and procedures to provide timely referrals and coordination of medical services for youth requiring off-site care. The reviewed documents confirmed the center provides for timely referrals and coordination of off-site healthcare medical services. Information was documented on the episodic care log. Three applicable youth individual healthcare records (IHCR) were reviewed for off-site care. The IHCRs contained a Summary of Off-Site Care form and discharge instruction documents, when applicable. Reviewed documentation confirmed the youth followed-up with the designated health authority (DHA) in one of the three instances. One remaining youth never returned to the center; therefore, follow-up was impossible. The other youth results were negative for a concussion, and follow-up was not needed. Informal interviews with staff reflected all off-site care is coordinated by the center's medical staff.

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

The center has a written policy and procedures for the delivery of treatment to youth identified as having a chronic medical condition. A review of seven youth individual healthcare records (IHCR) found six youth were identified with a chronic medical condition and/or taking prescribed medications. The center maintained a chronic conditions roster to document the youth identified with certain medical conditions. An informal interview with the registered nurse confirmed periodic evaluations are conducted in some cases weekly and others monthly, as needed, based on the conditions. Documentation of chronic condition log was provided. One youth had a lapse in treatment due to surgery.

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

The center has a written policy and procedures to ensure prescribed medication regimen shall be ascertained upon admission to the center. A review of seven youth individual healthcare records (IHCR) found five youth were continued on or prescribed medication after their admission to the center. Four youth were taking prescribed medication prior to entering the center. The medication was brought to the facility by the parent/guardian, verified, and continued on medications by the medical staff and designated health authority (DHA). The other youth was prescribed medication following surgery. Documentation of prescription medication verification was present in each youth individual healthcare record to include contact with the youth's parent/guardian. Orders were obtained from and signed by the DHA. The center has a facility operating procedure developed by the DHA permitting trained non-healthcare staff to verify the medications and assist the youth with self-administration, if needed, prior to nursing staff return to the center.

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

The center has a written policy and procedures ensuring all medications prescribed for youth have a current, valid order and are given pursuant to a current prescription or Practitioner Order. A review of seven youth individual healthcare records (IHCR) found five youth were prescribed or continued on medication. The designated health authority (DHA) orders were documented on the Practitioner Order Form maintained in each youth's IHCR. A review of each youth's Medication Administration Record (MAR) verified medication was initiated and monitored in accordance to the Practitioner Order. A review of practice confirmed over-the-counter (OTC) medication is administered pursuant to approved protocols.

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

The medical staff ensure all medications and sharps are stored and locked in designated areas inaccessible to youth. Medications are stored in a locked medication cart, cabinets, and in the locked refrigerator, all of which are situated in the medical clinic, which remains locked and inaccessible to youth. All medications are stored separately. The center contracts with Diamond Pharmacy Services for the delivery of medication; unused medication is mixed with a solution and disposed of using bio-hazardous waste.

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

The center ensures all medication and sharps are inventoried. A review of documentation for the previous six months verified a perpetual daily running inventory of medication utilization for prescription and over-the-counter (OTC) medication. All medical equipment classified as sharps are securely stored in a locked cabinet. Perpetual and weekly inventory counts were documented for sharps, over-the-counter (OTC) medications, and controlled medications and found no discrepancies. The center has a method for detecting and responding to inventory discrepancies. A random inventory of three different sharps, three prescribed medications, and three over-the-counter (OTC) medications revealed each count was accurate and documented by licensed nursing staff. Nursing staff confirmed the center's practice for shift-to-shift controlled medication counts.

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

The center maintains a written policy and procedures ensuring all controlled medications are inventoried, stored, and documented according to the Board of Pharmacy and Department requirements. All controlled medications are stored behind two locks and shift-to-shift counts are conducted and documented. The number of pills, tablets, or dosages remaining after each

administered dosage was documented on the youth's individualized Controlled Medication Inventory Record. A review of the past six months medications revealed, all counts, and inventories matched medications available.

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

The center has a written policy and procedures ensuring Medication Administration Records (MAR) are maintained for each youth who has a current, valid medication order. A review of seven youth individual healthcare records (IHCR) found five youth were prescribed medication subsequent to admission. The center documented all administration of medications on the MAR form HSO19. The MAR contained all of the required elements including the youth's name, Department identification number, date of birth, youth allergies, precautions, medical grade, medical alerts and current photograph of the youth. Medication start and stop dates were clearly denoted in each reviewed IHCR. Each reviewed IHCR found youth and administering staff initialed the MAR, indicating the youth received their prescribed medication. Licensed nursing staff documented side effect monitoring, weekly. There was one lapses in medication administration due to a youth being in the hospital. None of the five youth refused medication. No youth were prescribed parenteral medication during the time of the annual compliance review.

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

The center has a written policy ensuring medication administration occur as scheduled in a comprehensive, accurate, and organized manner in the facility, only by a licensed nurse. The center has regularly scheduled medication pass. The medical clinic was observed to be clean and well organized. A medication pass was observed during the annual compliance review, the nurse verified the Five Rights of Medication Administration, allergy and alert, and a correct Medication Administration Records (MAR). At the time of the annual compliance review no youth were prescribed parenteral medication.

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

The center has a written policy and procedures to ensure trained, non-healthcare staff are available to assist youth with self-administration of oral prescription medications or over-the-counter medication, when licensed nurses are not available on-site. The nurse shall delegate the delivery, supervision, and oversight of youth during self-administration of medications.
A review of training records verified juvenile justice detention officer supervisors, assistant superintendents, and the superintendent are currently trained to supervise medication administration in the absence of licensed nursing staff. Seven youth were interviewed, five

reported the nurse administers medication. One reported staff, and two reported they do not take medication.

In the absence of licensed healthcare staff, juvenile justice detention officer supervisors (JJDOS) and superintendent or designee are trained to supervise the administration of prescribed and over-the-counter (OTC) medications. A review of training records verified all JJDOSs, superintendent, and assistant superintendents were trained to supervise medication in the absence of licensed healthcare staff. Medication access is restricted to nursing and trained staff.

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

The center has a policy and procedures to ensure the monitoring of psychotropic medication. Seven youth individual healthcare records (IHCR) were reviewed to ensure compliance with monitoring psychotropic medication, of which four were applicable. Three additional records were reviewed. Youth IHCRs indicated the designated health authority (DHA) was notified upon each youth's admission to the center. Each youth receiving psychotropic medication prior to admission was continued on their respective medication and was seen by the psychiatrist within fourteen days of admission for their initial diagnostic evaluation. Documentation verified the psychiatrist monitored youth psychotropic medication every thirty days. Five of the seven youth were applicable for and received a psychiatric evaluation within thirty days of admission to the center. The center does not have standing, emergency, or pro re nata (PRN) orders for psychotropic medications.

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

The center implemented infection control procedures including prevention, containment, treatment, and reporting requirements related to infectious diseases, as per Occupational Safety and Health Administration (OSHA) federal regulations and the Centers for Disease Control and Prevention (CDC) guidelines. A review of documentation supported all staff are trained regarding universal precautions, as well as the center's Exposure Control Plan. A comprehensive process for needlestick post-exposure evaluation is documented. Hepatitis B immunizations are offered to staff. An interview with licensed nursing staff and the superintendent verified there were no cases of reportable infectious diseases requiring notification to the local county health department, CDC, and/or the Department's Central Communications Center (CCC).

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

The center has a written policy and procedures ensuring all staff and youth receive education on infection control. Seven reviewed youth individual healthcare records (IHCR) confirmed, each received infection control training within seven days of admission. Training included guidelines for hand-washing techniques, universal/precautions, prevention/transmission of communicable diseases, prevention of blood borne pathogens, and guidelines for infection control. A copy of the Health Education Record form (HS013) was maintained in each reviewed IHCR. All training and education was provided in accordance with the Center for Disease Control and Prevention guidelines. A review of ten staff training records confirmed staff receive pre-service and in-service infection control training.

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

The center has an exposure control plan which meet the requirements of OSHA standards (29 CFR 1910), with maintenance and documentation of the plan, as per the requirements of the Department. The policy and procedures provide staff with knowledge of appropriate prevention, containment, treatment and reporting requirements of infectious diseases. The exposure control plan was approved and signed by the superintendent for this fiscal year. The center did not have any incidents involving contagious disease requiring the quarantine or hospitalization of youth or staff during the annual compliance review period.

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

Pregnant youth at the center are provided prenatal care at recommended intervals. One applicable youth individual healthcare record (IHCR) was reviewed and revealed prenatal care was initiated immediately upon determination the youth was pregnant. The youth was detained on May 27, 2018, screened and seen by the DHA on June 3, 2018, transported to the community clinic for prenatal care on June 6, 2018, and released from the center on June 8, 2018. Medical staff and trained non-licensed healthcare staff provide routine daily monitoring and observation for indications of pregnancy complications.

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

The center has a written policy and procedures to ensure pregnant youth are provided nutritious foods in sufficient quantities meeting the standards of the minimum daily allowances for pregnant youth. Each pregnant youth is provided prenatal, post-partum, and parenting education on topics directly related to healthcare issues and medical risk for pregnant adolescents. One applicable youth individual healthcare records (IHCR) was reviewed and verified the youth was provided nutritious foods in sufficient quantities to meet the minimum daily allowances for pregnant youth. The youth was detained on May 27, 2018, screened and seen by the DHA on June 3, 2018, transported to the community clinic for prenatal care on June 6, 2018, and released from the detention center on June 8, 2018. During her short detainment period, the youth's weight and diet was monitored.

The youth was provided the required prenatal education within forty-eight hours of admission. pregnant youth receive education regarding alcohol and drug use, smoking, nutrition, sexually transmitted diseases, contraception, prenatal care and the birthing process, postpartum care, basic child care, child/infant development and parenting skills. The IHCR documented the delivery of healthcare education.

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

The center has a policy and procedures to ensure all non-healthcare staff involved in the supervision or treatment of pregnant youth are appropriate education. A review of staff training roster verified the center's registered nurse registered provided training/education to staff involved in the supervision or treatment of pregnant youth. The training/education addressed the monitoring, observation and care of pregnant youth.

Standard 5: Safety and Security

Overview

The center is responsible for the safety and security of the youth, employees, and visitors in the center. All youth movements are controlled and monitored by master control staff. Ten-minute checks are conducted by visual observation and an electronic wand system which are downloaded into a computer and then documented on paper. Youth counts are conducted every hour on each shift and documented in the mod and master control logbooks. Staff turn in personal keys to master control when entering the building. Staff are issued detention keys from the supervisor during shift briefing with documentation noted within the logbook. Maintenance personnel track the vehicles maintenance, tool inventory, and replacement of tools; logs are kept in each of these areas. Logs are kept for monitoring all flammable, toxic and caustics materials according to Occupational Safety Hazard Association (OSHA) guidelines. Maintenance staff are responsible for the disposal of toxic and hazardous materials. Shift supervisors are required to conduct fire, escape, and Continuation of Operation Plan (COOP) drills.

5.01 Active Supervision of Youth (Critical)	Satisfactory Compliance

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

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

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

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

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

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

Youth were observed throughout the week in various areas of the center. Staff were observed in the small classroom. Staff were observed actively supervising youth which included standing in the classrooms and moving around where they could have a full view of the youth. There were two to three staff with the youth at all times. Youth movements were documented in the module logbooks. Staff were positioned with one staff in the front and one in the back of the line during all movements. Staff were observed calling in their location and number of youth when requesting movement. After it was approved, then movement was continued. Four logbooks were reviewed with counts being completed each shift. Logbook entries included movements to and from mods, school, youth exit, and returning to the center. Staff were observed moving youth from school to the dining area for snacks and movement from the dining area to the Alpha Mod. The logbook was inclusive of documentation of movements when youth exit and return to

the center. Seven staff interviews indicated staff believe there is enough staff to provide safety and security for 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 real-time observation manually or electronically. Documentation must include the actual time of each visual observation and initials of the staff conducting the check; pre-printed times are not acceptable.* *There shall be no obstructions (e.g., clothing, memos, pictures) over windows and areas where direct line of sight is needed.* *If an officer, in the course of completing visual observation, is unable to see the youth or any part of the youth's body, the officer shall, with the assistance of another officer, open the door to verify the youth's presence.*	

The center has a total of sixty-seven cameras, of which sixty-six were operational during the annual compliance review. Youth are checked every ten minutes when they are in their room for confinement or sleeping. Five randomly selected dates and times were reviewed for ten-minute checks on each module. Ten-minute checks were conducted by visual observation and an electronic wand system which are downloaded into a computer and then documented on paper. Each check was routinely completed at ten-minute increments as required. the times were documented electronically and accurately.

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).*	

Five logbooks were reviewed which included two from master control and three from the youth modules for the last six months. Formal counts were conducted every hour and documented in master control and youth module logbooks. Counts were documented after each drill was completed. Seven staff interviews indicated emergency counts occur during power outage, missing youth, and major disturbances. Observations from the morning shift count revealed

master control calling for the count and all movement stopped. Each staff called in their count and location called to master control. Master control operator then verifies the count and clears count for movement to resume.

5.04 Logbook Maintenance	Satisfactory Compliance
The program maintains a chronological record of events, incidents, and activities in logbooks maintained at master control and in each living area in accordance with Florida Administrative Code. Each logbook is a bound book with numbered pages. If electronic logbook software is used by the facility, it is password-protected and configured to prevent entries from being deleted or altered after they are saved. *At a minimum, each logbook entry includes the date and time of the event, the names of staff and youth involved, a brief description of the event, the initials of the person making the entry, and the date and time of the entry. Logbook entries are made in black or blue ink, with no erasures or whiteout areas. No logbook entries are obliterated or removed; errors are struck through with a single line and initialed by the person correcting the error.* *Log entries regarding Medical, Special Needs, and Mental Health alerts, or other issues impacting facility safety and security shall be highlighted.*	

The center has separate logbooks for master control, each youth module, visitors, and contracted staff. Logbook entries from master control and the youth modules were reviewed for the last six months. The date was found at the top of each page of each logbook reviewed. All logbooks entries contained a chronological record of events with all required documentation, including the date and time of event, names of youth and staff involved, and a brief description of the event. All entries were documented in black ink, with no whiteout entries. Logbook entries included medical, mental health alerts and safety security issues. All logbooks pages were numbered and in good repair. The master control logbooks had all of the required documentation. The center does not use an electronic logbook.

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.*	

Five logbooks were reviewed for the past six months for this indicator. There was documentation in each logbook of the superintendent or designee reviewing the logbooks on a weekly basis and providing recommendations as to the completeness and accuracy of the information recorded. There was documentation of the supervisor's review for the master control logbook and each living area logbook daily. There was documentation of the juvenile justice detention officers reviewing the logbook maintained in the assigned living area when accepting responsibility for the module at shift change. There was documentation of the superintendent or

designee touring the youth living areas at least once during each shift. Observations revealed all of the required staff, including the superintendent or his designee and supervisors, reviewed and signed the logbook, as required.

5.06 Key Control	Satisfactory Compliance

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

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

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

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

A key inventory shall be maintained by the Superintendent or designee at all times.
(For the entire indicator statement, please reference the Monitoring and Quality Improvement FY 2016-2017 Detention indicators.)

The center has a policy and procedures for key control. Upon entering to the center, staff personal keys are turned into master control and placed in a secure locked box prior to the individual entering the secure area of the center. Staff are then given a chit to verify what number their key is placed on. Keys issued to staff are on a tamper-resistant key ring and documented with the date and time of issue, name of staff, and the time the key was returned. Emergency keys are maintained separately from other keys within master control. All keys were observed to be secured and inaccessible to youth. Key inventories are maintained by maintenance staff. Accountability of keys are done by key ring number, total number of keys on each ring, capability of each key, and to whom the keys are issued and assigned. Staff training for key control was documented. If is there is a discrepancy in the key count, the master control operator is to immediately contact the shift supervisor. If determined a staff mistakenly left the center with issued keys, the staff is to be contacted and asked to return the keys within two hours of notification. If the key is lost, a diligent search is conducted and the center is placed on locked down. The Central Communications Center is contacted. There was no documentation of lost keys within the past six months. A random inventory of keys was conducted for this annual compliance review. The key ring inventory all matched with the total number keys and type of key, as required. If keys are broken or damaged, maintenance staff confiscate the keys, replaced broken keys, and documented in the maintenance key log. Seven staff interviews revealed staff were familiar with the daily tracking of keys within the center. A random check of staff for personal keys was conducted and none of the staff had their keys on them.

5.07 Vehicles and Maintenance	Satisfactory Compliance

The program ensures any vehicle used by the program to transport youth is properly maintained, and maintains documentation on the use and maintenance of each vehicle.

Youth and staff are not permitted to use tobacco products.

Program vehicles are locked when not in use.

The center has a total of five vehicles and each were inspected during the annual compliance review. Each vehicle had the appropriated number of seatbelts, seat belt cutters, window punches, fire extinguishers, biohazard kits, triangles, and flashlights. First aid kits are not left in the vehicles but are taken on every transport. Four of the five vehicle logbooks contained an inspection sheet, which was completed prior to transport of any youth. One vehicle did not have the inspection sheet due to it being a new vehicle and had not reached its inspection date or had been used to transport youth. Checks were done to assure the vehicles are working properly before transporting of any youth. All vehicles had documentation of annual inspections completed as required. All vehicles were locked while not in use and searched when returned to the facility. One seat was observed torn and was checked for contraband during the inspection. Documents were provided to show a work order was completed to fix the seat. The annual compliance review team was unable to observe a transport during the review.

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

The center has a policy and procedures for tool inventory and management. An inventory of tools was conducted which matched items located within the maintenance office. Observations confirmed all maintenance tools were secured and inaccessible to youth. The center uses a shadow board system for most of the handheld tools. A count of tools was completed during the annual compliance review and matched with tools identified on the inventory forms. The center's maintenance staff is primarily responsible for storing and conducting an inventory of all maintenance tools. The center's procedures for missing tools indicates when items are reported lost, the supervisor shall initiate a search of affected areas, and ensure areas are searched and inspected for contraband prior to allowing youth access. Any tool replacement shall be noted, in writing, and verified by the superintendent or designee. A knife-for-life is securely located in each of the mod living areas. Documentation of inventory for these items are noted within the mod logbooks at beginning of each shift. Maintenance reported these tools are inventoried daily.

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

Observations confirmed all kitchen tools and utensils were securely locked and inaccessible to youth. An interview with food service personnel revealed no youth are authorized in the kitchen area. All kitchen knives and sharps are stored in locked cabinets, containing an inventory. Documentation revealed the kitchen staff conducts an itemized inventory of all equipment including knives and utensils prior to each shift. An inventory of kitchen tools was conducted and compared to the actual kitchen tools on-site to determine accuracy. A completed inventory

matched all tools and utensils. The food service manager during her interview explained the process/procedure when dealing with the kitchen tools.

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

Chemicals are secured in locked closets and offices which are inaccessible to youth. Safety Data Sheets (SDS) logs are maintained with the chemicals. One youth was observed cleaning the mod, with staff spraying the chemicals. Seven youth interviews revealed youth are only allowed to youth mops and brooms. Youth interviews revealed staff sprays chemicals on the surface to be cleaned and the youth wipes it off. Staff has control of the chemicals at all times. Seven staff interviews revealed youth are only allowed to use mops, brooms, and scrub brushes.

5.11 Inventory of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory Compliance
The Superintendent is responsible for the implementation of a safety plan addressing proper use, storage, and disposal of chemicals, including flammable, toxic, caustic, and poisonous items. *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's safety plan was reviewed. All flammable, toxic, caustic, and poisonous items are maintained in secured closets and outside storage units. Each area where the chemicals are stored has a Safety Data Sheet (SDS) sheet. A review of the inventory in the SDS book was completed and found to be accurate. One of the SDS sheets had different years logged on it and was not consistent.

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

The center has a policy and procedures which addresses youth access and storage for chemicals and poisonous, flammable, and toxic materials. Chemicals were maintained in locked offices and closets. No youth have access to the chemicals. Youth interviews revealed staff sprays chemicals on the surface to be clean and youth wipes it off. Staff has control of the chemicals at all time. Seven staff interviews revealed youth are not allowed to clean with substances that are toxic, flammable, or poisonous.

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

The center's policy and procedures on the disposal of flammable, toxic, caustic, and poisonous items was reviewed. The maintenance staff are responsible for diluting, handling, and disposing of hazardous waste. The center has not had any chemical spills within the past year. The kitchen staff and administrators stated they do not use grease. The biohazard waste container is in the clinic and is picked up monthly by a bio-hazard waste contractor. This area is inaccessible to the youth.

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

The center's confinement rooms were observed during the annual compliance review. Room windows were free of obstructions. Youth placed in confinement were afforded the same living conditions as provided as the general population which were inclusive of education, meals, large muscle group exercises, bedding, and hygiene. Youth in confinement do not have contact with the general population while engaged in the listed activities. A review of seven incidents where youth were kept under twenty-four hours in confinement was completed. All seven youth rooms were searched prior to placement. The supervisor reviewed the reports within two hours. Three hour reviews were documented within appropriate time frames. In all seven reports, the supervisor or designee documented the need for continued confinement. All seven reports revealed the superintendent reviewed the confinement within twenty-four hours. During the annual compliance review, all seven reports reviewed were completed within one hour of placing the youth in confinement. Staff were observed documenting in confinement report log while the youth was in confinement.

5.15 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.*	

A total of seven confinements were reviewed. All confinement rooms were free of obstructions. The room was searched prior to placing the youth in the room. The confinements were approved by the superintendent or designee to be extended over twenty-four hours. Each initial supervisor review was completed within two hours, and every three hours while the youth was in confinement. There was documentation for the need of continued confinement based on severity of rule violation. All medical and mental health reviews were conducted, as required.

5.16 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's Disaster Preparedness Plan was reviewed, and included annexes attached to the plan. The center conducts drills on a monthly basis to include severe weather, major disturbances, hostage situations, chemical spills, flooding or terrorist threats or acts. The center conducts a Continuity of Operations Planning (COOP) drill prior to hurricane season. All drills were documented, as required.

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

The center's Escape Prevention Plan was reviewed and included the Department's policy and procedures regarding escapes. Although required to conduct escape drills quarterly, the center conducts these drills monthly. All seven interviewed staff stated they have participated in

escape drills. All drills were documented as required and all staff received training on escape drills.

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

The center's Fire Prevention Plan was reviewed. The center conducts fire drills monthly on every shift. Each drill is documented in the master control and the mod logbooks. The drill documentation contained the time the drill started and ended, and the number of youth and staff who participated in the drill. Evacuation plans were posted in all living areas throughout the center. All fire extinguishers were inspected and are up-to-date. Seven staff interviews revealed fire drills are conducted monthly. Seven youth interviews revealed the youth have been instructed on what to do in case of a fire.

Program Name: Leon Regional Juvenile Detention Center	MQI Program Code: 32
Provider Name: State Operated	Contract Number: N/A
Location: Leon County / Circuit 2	Number of Beds: 40
Review Date(s): September 18-21,2018	Lead Reviewer Code: 141

Overall Rating Summary

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All indicators have been rated Satisfactory and no corrective action is needed at this time.