STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Leon Regional Juvenile Detention Center

Department of Juvenile Justice
(State-Operated)
[2303 Ronellis Drive
Tallahassee, Florida 32310

Review Date(s): September 29, 2020 - October 2, 2020

Promoting Continuous Improvement and Accountability
in Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Craig Swain, Office of Accountability and Program Support, Lead Reviewer (Standard 1)
Dorline Jordan, Bay Regional Juvenile Detention Center, Field Training Officer (Standard 2)
Lea Herring, Office of Accountability and Program Support, Regional Monitor (Standard 3)
Juan Youman, Office of Accountability and Program Support, Regional Monitor (Standard 4)
Sylvonia Parris, Volusia Regional Juvenile Detention Center, Juvenile Detention Officer Supervisor (Standard 5)

Program Name: Leon Regional Juvenile Detention center
Provider Name: N/A
Location: Leon County / Circuit 2
Review Date(s): September 29 ,2020 - October 2, 2020

MQI Program Code: 32
Contract Number: N/A
Number of Beds: 45
Lead Reviewer Code: 169

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.

Overall Rating Summary

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

Limited Ratings	Failed Ratings
5.09 Vehicles and Maintenance	
5.15 Confinement Under Twenty-Four Hours	

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	Grievances	Satisfactory
1.09	Entering Alerts(JJIS) and Sharing of Alert Information *	Satisfactory

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

Standard 2: Youth Management
Detention Rating Profile

Indicator Ratings

Standard 2 - Assessment and Performance Plan		
2.01	Admission	Satisfactory
2.02	Orientation	Satisfactory
2.03	Classification	Satisfactory
2.04	Notification of JPO Circuit Gang Rep	Satisfactory
2.05	Admission of Youth Personal Property	Satisfactory
2.06	Storage of Youth Personal Property	Satisfactory
2.07	Release	Satisfactory
2.08	Release of Youth Personal Property	Satisfactory
2.09	Release of Meds, Aftercare Instructions	Satisfactory
2.10	Review of Youth in Secure Detention and Home Detention	Satisfactory
2.11	Daily Activity Schedule	Satisfactory
2.12	Adherence to Daily Schedule	Satisfactory
2.13	Educational Access	Satisfactory
2.14	Career Education	Satisfactory
2.15	Behavior Management System	Satisfactory
2.16	Unauthorized Use of Punishment *	Satisfactory
2.17	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	Non-Applicable
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/Consent	Satisfactory
4.05	Healthcare Admission Screening & Rescreening Form	Satisfactory
4.06	Youth Orientation to Healthcare Services/Health Education	Satisfactory
4.07	DHA/Designee Admission Notification	Satisfactory
4.08	Health-Related History	Satisfactory
4.09	Comprehensive Physical Assessment/TB Screening	Satisfactory
4.10	Sexually Transmitted Infection Screening & HIV Screening	Satisfactory
4.11	Sick Call Process	Satisfactory
4.12	Episodic/First Aid Care/Emergency Care	Satisfactory
4.13	Off-Site Care/Referrals	Satisfactory
4.14	Chronic Conditions/Periodic Evaluations	Satisfactory
4.15	Medication Management	Satisfactory
4.16	Medication/Sharps Inventory and Storage Process	Satisfactory
4.17	Infection Control/Exposure Control/Education	Satisfactory
4.18	Prenatal Care/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	Behavior Management System	Satisfactory
5.03	Unauthorized Use of Punishment *	Satisfactory
5.04	Ten-Minute Checks *	Satisfactory
5.05	Census Counts and Tracking	Satisfactory
5.06	Logbook Maintenance	Satisfactory
5.07	Logbook Reviews	Satisfactory
5.08	Key Control	Satisfactory
5.09	Vehicles and Maintenance	Limited
5.10	Tool Inventory and Management	Satisfactory
5.11	Youth Access & Use of Tools, Cleaning Items *	Satisfactory
5.12	Inventory of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.13	Access to all Flammable, Toxic, Caustic, and Poisonous Items *	Satisfactory
5.14	Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.15	Confinement Under Twenty-Four Hours	Limited
5.16	Confinement Over Twenty-Four Hours	Satisfactory
5.17	Continuity of Operations Planning (COOP) Drills	Satisfactory
5.18	Escape Drills	Satisfactory
5.19	Fire Drills	Satisfactory

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Program Overview

Leon Regional Juvenile Detention Center is a state-owned detention facility, operated by the Department, located in Tallahassee, Florida. The center serves youth in Leon, Gadsden, Jefferson, Franklin, Liberty, Madison, Taylor, and Wakulla counties in Circuit Two. Male and female youth who are detained pending adjudication, disposition, or placement in a residential commitment program are housed in the forty-five-bed center. The services provided by center included, but are not limited to education, medical, mental health, and crisis intervention and stabilization. The center's educational services are provided by the Leon County School Board.

The center's mental health and healthcare services are provided through Camelot Community Care. Mental health services are provided by one licensed designated mental health clinical authority (DMHCA), one licensed mental health counselor (LMHC), one licensed clinical social worker (LCSW) who is pro-re-nata (PRN), and one psychiatrist. Clinical services provided by the center include mental health and substance abuse evaluations, mental health treatment planning, individual, group and family therapy, mental health crisis intervention services, on-site psychiatric services, and availability for substance abuse services for youth with co-occurring disorders. Medical services are provided by one designated health authority (DHA), one advanced registered nurse practitioner (ARNP), one registered nurse (RN), and two licensed practical nurses (LPNs). The medical clinic maintains nursing coverage Monday through Friday, from 7:00 a.m. to 8:00 p.m. and on weekends from 8:00 a.m. to 4:30 p.m.

Food services are provided by Department staff and include menus, meal planning, meal schedules, special diets, nutritional analysis, daily allowance, food preparation, health certifications, food product standards, sanitation, and cleaning. The center's leadership consist of the superintendent, two assistant superintendents, and one administrative assistant. Staff are responsible for the custody and control of youth in their care, providing youth supervision twenty-four hours a day, seven days a week. The center has four living modules which are divided by male and female. There are forty-eight security cameras at the center, of which forty-three were operational. The interior of the center was observed to be recently repainted, clean, and free of graffiti. At the time of the annual compliance review, the center had nine vacancies, which included eight juvenile justice detention officer (JJDO) II positions and one assistant superintendent.

Standard 1: Management Accountability

1.01 Initial Background Screening (Critical)	Satisfactory Compliance
Background screening is conducted for all Department employees and volunteers and all contracted provider and grant recipient employees, volunteers, mentors, and interns with access to youth and confidential youth records. A contracted provider may provide training and orientation to a potential employee before the screening process is completed. However, these individuals may not have contact with youth or confidential youth records until the screening is completed, the determination is "Eligible," a copy of the criminal history report has been reviewed, and the employee demonstrates he or she exhibits no behaviors warranting the denial of employment. An Annual Affidavit of Compliance with Level 2 Screening Standards is completed annually.	

The center maintains a written policy and procedures requiring the completion of a background screening for all employees, volunteers, and interns prior to hiring and utilizing the services. Since the last annual compliance review, the center hired seventeen new employees and utilized the services of eight volunteers. Each background screening was reviewed, documentation reflected each initial background screening was completed by the Department's Background Screening Unit (BSU)/Clearinghouse, prior to each hire date. Two staff and one volunteer required exemptions, which were obtained prior the hire date. Documentation provided confirmed, each direct-care staff completed a pre-employment assessment tool and received a passing score prior to being hired. A total of thirteen contracted staff are assigned to the center. Each background screening was reviewed, documentation provided confirmed, each contracted staff (including teachers, therapists, and medical staff) received an initial background screening prior to hire. The Annual Affidavit of Compliance with Level Two Screening Standards was completed and submitted to the Department's BSU on January 9, 2020, 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 maintains a written policy and procedures requiring the completion of a background rescreening every five years for applicable staff. There were four staff applicable for requiring a five-year rescreening since the last annual compliance review. Reviewed documentation reflected each staff received a five-year rescreening within the required time frame. Each re-screening/re-submission was submitted to the Background Screening Unit (BSU)/Clearinghouse at least ten business days prior to the five-year anniversary date.

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

The center has a policy and procedures regarding staff code of conduct. The center utilizes the Department of Juvenile Justice's employee handbook which contains a code of conduct in which all staff must adhere to. Five staff personnel records were reviewed, and each contained the acknowledgement, receipt, and review of the Department's Code of Conduct. None of the five staff records contained documentation of disciplinary action or commendations. According to the superintendent, the center did not have any instances which required disciplinary actions or commendations during this annual compliance review period.

A review of the internal incidents, Department's Central Communications Center (CCC) reports, and Protective Action Response reports determined there were no incidents which should have been documented as a violation of a code of conduct. According to the superintendent, center staff adhere to a code of conduct prohibiting any form of abuse, profanity, threats, harassment, intimidation, horseplay, or personal relationships with youth. Officers shall not verbally abuse, demean or otherwise humiliate any youth, and shall not use profanity in the performance of their job. Management will take immediate action to investigate or address all allegations or violations of the code of conduct.

Five interviewed staff all reported they are required to notify their supervisor when a youth want to make an abuse report, and the supervisor makes the call. One of the five staff reported hearing staff use profanity when speaking with youth often, the remaining staff reported never hearing staff use profanity. Five youth were interviewed concerning abuse reporting, one youth reported never being stopped from reporting abuse and three youth reported never having a desire to report abuse. The remaining youth reported being stopped from reporting abuse. During the annual compliance review, the youth was offered the opportunity to report abuse and turned it down. Four youth reported staff are respectful when talking with youth and others. The remaining youth reported staff are not respectful and do not maintain confidentiality. Two youth reported hearing staff using profanity when talking with youth, the remaining three reported never hearing staff use profanity. All five youth reported never hearing staff threaten a youth.

The interview results were discussed with the superintendent. During the annual compliance review, the superintendent reviewed the Department's Code of Conduct, confidentiality standards, and abuse reporting policy with staff during pre-shift. All staff sign acknowledging they understand the Department's Code of Conduct.

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

A center tour was conducted during the annual compliance review, observations confirmed signs posted throughout the center of the Florida Abuse Hotline and Department's Central Communications Center (CCC) telephone numbers. The center had a total of forty-three incidents reported to the Department's CCC within the past six months. Five selected incidents confirmed, each was reported to the CCC within the required time frame. Four of the incidents were noted in the logbook at the same time the CCC was initially contacted. The remaining call was not answered by CCC and the caller did not enter the note in the logbook until the CCC returned the call. The internal incidents and/or grievances and logbook documentation were reviewed and reflected there were no additional incidents which should have been reported to the CCC and were not. An interview with the superintendent confirmed, whenever there is a reportable incident in the center or outside, the center will notify the CCC within two hours of the incident or within two hours of becoming aware of the incident.

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

The center maintains a policy and procedures detailing the use of Protective Action Response (PAR). The center had a total of seventy-one PAR incident reports within the past six months. A review of seven selected PAR reports was conducted. Documentation confirmed, each of the reports were completed by the end of the staff member's workday and included statements from all staff involved. Each of the PAR reports contained a review by a PAR certified instructor and a post-PAR interview conducted with the youth within thirty minutes after the incident. Six of the seven incidents reviewed confirmed the superintendent/designee reviewed the PAR reports and made comments within seventy-two hours. The remaining PAR incident took place on October 18, 2019 and reviewed by the superintendent on January 16, 2020. According to the superintendent, the incident was reviewed within the required time frame; however, the wrong date was entered.

Each report was maintained electronically in the Facility Management System (FMS) within the Department's Juvenile Justice Information System. None of the incidents reviewed required mechanical restraints, none resulted in serious injury or required medical attention, and none of the youth alleged any abuse. During the annual compliance review period, the center's PAR Rate was 3.53, which is below the statewide average of 14.25.

An interview with the superintendent revealed the center uses physical intervention techniques in accordance with Florida Administrative Code. When staff use a physical intervention technique, such as countermove, control techniques, takedown or application of mechanical restraint, a PAR incident report is completed and filed in accordance with the Florida Administrative Code. Five staff interviewed all reported, staff talk to youth prior to using physical restraints or mechanical restraints.

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

The center has a written policy and procedures ensuring all newly hired staff are trained in accordance with Florida Administrative Code within 180 days of hire. A review of five staff training records was conducted for pre-service training requirements. Documentation confirmed each staff completed all of their required training; however, only two of the five staff met the 180-day time frame. The remaining three staff missed their 180-day time frame by three days, seven days, and thirty-four days, respectively. Documentation provided confirmed the COVID-19 pandemic hindered the timely completion of the required trainings.

Reviewed documentation reflected each staff completed all of the required trainings including, but not limited to, Protective Action Response (PAR), first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), mental health services, substance abuse services, suicide prevention, safety and security emergency plans, human trafficking, Department detention facility operations, supervision, active shooter, and Prison Rape Elimination Act (PREA) prior to having any contact with youth. All training was conducted by qualified trainers and documented in the Department's Learning Management System (SkillPro).

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

The center maintains a written policy and procedures which requires staff to complete twenty-four hours of annual in-service training each calendar year after completion of certification. The center provides in-service training for staff through a combination of instructor-led courses and web-based courses in the Department's Learning Management System (SkillPro). The three juvenile detention officer training records were reviewed for in-service training. Documentation confirmed two staff completed all mandatory refresher trainings. The remaining staff completed all of the trainings with the exception of one, human trafficking.

Two supervisory staff records were reviewed for in-service training and supervisory training. Reviewed documentation confirmed both staff completed the required in-service training and reflected as accordingly in SkillPro. A review of the supervisor's training records revealed one completed eight hours and the other completed seven hours of supervisory training. The

supervisor trainings were not documented in SkillPro; however, documentation provided revealed supervisory trainings accrued during supervisory team meetings.

1.08 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 maintains a policy and procedures which allows each youth the ability to file a grievance if they believe they were not treated fairly. The process ensures all youth are treated fairly with respect, without discrimination, and their rights are protected. The center's grievance process includes three phases, informal, formal, and appeal phase. The grievance policy indicates the informal phase occurs wherein the juvenile justice detention officer (JJDO) attempts to resolve the complaint or condition with the youth using effective communication skills. However, if it is not resolved successfully, youth have access to grievance forms within their mods, which allow youth to enter the formal phase of the grievance process.

The superintendent and the five staff interviewed explained the grievance process and what takes place at each phase in the process. According to the superintendent, the center did not have any grievances to review since the last annual compliance review. Five youth interviewed concerning the grievance process, two reported never filing a grievance, and the remaining three were knowledgeable about the process.

1.09 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 juvenile justice detention officer supervisor (JJDOS) shall ensure the last hard copy of the alerts shall have a written notification or update of the recent admissions or changes to existing alerts on the alert sheet and distribute to all staff within the center immediately.* *Medical and mental health staff shall review alerts to ensure each alert is correctly tracked and managed.* *The responses and updates by medical, mental health, and other staff should be documented in JJIS alerts as they pertain to the specific alert.* *JJDOSs shall inform staff of alerts during shift briefing. When a JJDOS receives changes to the alert list, he/she shall notify the staff affected by changes and add the information to the shift briefing for the oncoming shift upon receipt of the information.*	

The center has a written policy and procedures to ensure an alert system is in place to alert staff when mental health, medical, or security issues exist which may affect the security and safety of the youth in the center. Five youth records were reviewed for mental health, medical, and security alerts. All five youth were applicable for alerts. All alerts identified in youth records and those listed in the Department's Juvenile Justice Information System (JJIS) matched. The center verifies all youth alerts, contacting parent(s)/guardian(s) if necessary. All five youth had alerts entered by medical staff. Four of the five youth reviewed had a medical grade of two to five and had a corresponding alert(s) in JJIS created by nursing staff. Documentation reviewed confirmed alerts are only entered by staff with the required credential for the field.

A pre-shift meeting was observed during the annual compliance review. The shift supervisors discussed each youth alerts and each staff were provided the center alert list which contained all alerts for each youth in the center. Five staff were questioned concerning the youth alerts, four staff had a copy of the youth alerts which were provided during their pre-shift meeting. The remaining staff left their copy in the logbook. According to the superintendent, at a minimum, all youth with chronic medical conditions are to be placed on the facility's alert system. Nursing staff shall verify all alerts in the medical alert system are accurate and up-to-date. Five staff were interviewed and reported they are informed of youth alerts during shift briefings and provided alert forms. Observation of a shift briefing confirmed this process.

Standard 2: Assessment and Performance Plan

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

Five youth records were reviewed, each record contained the arrest affidavit/court orders, Detention Risk Assessment, and a Suicide Risk Screening Instrument. According to the Admission Wizard, each youth was frisked searched, and/or electronically searched by an officer of the same sex. Each youth was provided the opportunity to call their parent/guardian; If the youth refused the phone call, the information was documented on the Admission Wizard. Each youth was provided a meal. Each youth record contained a completed medical, mental health, and suicide screening. During the annual compliance review, a youth admission to the center was observed. The observation confirmed the admission officer completed all requirements of admission.

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

The center has a policy and procedures in place requiring each youth to receive orientation within twenty-four hours of admission to the center. Five youth records reviewed confirmed; each youth received an orientation within twenty-four hours of their admission to the center.

Each reviewed record included an orientation checklist signed by the youth acknowledging receipt of orientation. The center's orientation process covered all the required topics as outlined by the policy. An admission was observed during the annual compliance review and confirmed the admission officer provided detailed information concerning the youth orientation. The officer covered all required orientation topics. The interaction between the youth and the admission officer was positive, professional, and respectful. Five youth were interviewed regarding orientation, each youth stated staff informed them of the rules and regulations, daily schedule, education services, visitation, abuse reporting, and behavior management system.

2.03 Classification	**Satisfactory Compliance**

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

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

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

All newly admitted youth are screened to determine if he or she is a criminal street gang member or is affiliated with any criminal street gang. In the event hang involvement is suspected, center staff should enter the "other suspected gang affiliation" alert into JJIS along with as much detailed information within the alert note as possible.

The center has a policy and procedure in place requiring all youth admitted to the center to be classified in order to provide the highest level of safety and security. A review of five records indicated all youth were classified and assigned rooms based on physical characteristics, age, special needs, mental health, gang affiliation/member, history of violent behavior/crimes or sexual offenses, and suicide risk. Documentation confirmed each youth's room assignment was approved by the center superintended/assistant superintendent. According to the superintendent, if a youth is placed on human trafficking alert by error information will be forward to headquarters human trafficking coordinator for review and possible closure.

2.04 Notification of Juvenile Probation Officer Circuit Gang Representative	Satisfactory Compliance
Each center shall identify the juvenile probation officer (JPO) designated as the circuit gang representative to communicate suspected gang activity. *A referral for youth with suspected gang involvement shall be shared, by e-mail, with the circuit gang representative, indicating suspicions of gang activity such as youth flashing gang signs, gang tattoos, gang-related drawings, or related activity.* *Center staff should include in the e-mail pictures (when appropriate), copies of written statements, drawings, graffiti, and a description of what gang signs the youth was "flashing."*	

The center has a policy and procedures in place requiring each youth admitted to the center to be screened to determine if the youth is a documented gang member, a gang associate, and/or has suspected gang affiliations. A review of five records, interview with superintendent, and staff interview revealed none of the youth in the center are suspected or documented as a gang member. According to the superintendent, if a youth is suspected as a gang member information will be documented, emailed along with any pictures, written statements, drawings, graffiti to a detective assigned to the gang unit within local law enforcement who confirm the information then share it with all stakeholders, including but not limited to, the juvenile probation officer assigned to the youth.

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

A review of five youth records indicated each youth admitted to the center came in with property. Each record contained a property sheet with items detailing the youth property. The youth and staff signed verifying inventoried items and the Letter of Acknowledgement of unclaimed property was signed by youth and staff. One youth was admitted with property of value. Two additional youth admitted with valuables were reviewed. Each youth has a valuable property is stored in a plastic bag along with a receipt of items within the bag. Each bag is placed in a safe located in master control. Information on valuable property placed in the safe was also recorded in a bound logbook located in the admission area and includes the dates, times, Department of Juvenile Justice Identification number, the youth's name, and the staff's name who is securing the property of value.

Five youth were interviewed, each reported staff inventoried property and property sheet signed. The superintendent stated youth personal property is maintained securely and returned to them in a timely manner. All property is document in the Department's Juvenile Justice Information System (JJIS) and any items left after thirty days will be disposed of. Any youth on supervision the juvenile probation officer will be allowed to retrieve property.

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

The center has a written policy and procedures in place to ensure the youth's personal property is inventoried, maintained securely, and returned to the youth in a timely manner upon their release from the center. All property storage areas for non-valuable and valuables were observed during annual review. All youth property was stored in green mesh bag located in a locked room. Each bag had the Department's Juvenile Justice Information System (JJIS) printed property sheet signed by both youth and staff. Each property sheet documented the youth's Department of Juvenile Justice identification number, date and list of items. A review of three youth records applicable for having property of value was conducted, each contained a signed property receipt form. There have been no Central Communications Center (CCC) reports documented involving lost, damaged or stolen property for the center. The superintendent stated, valuable property is documented and stored in drop safe.

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

The center has a policy and procedure in place for releasing youth. Four closed records were reviewed, each contained all of the required paperwork to release a youth. Documentation confirmed all of the required paperwork was reviewed and signed by supervisor and releasing officer. In each youth record, the Secure Detention Release form was utilized, signed by releasing officer and included no holds, legal reasons, courts orders which would prevent the youths release. The youth and parent/guardian identification were verified prior to release. Youth release date was verified using the Department's Juvenile Justice Information System. All required parties sign the release form and included any medical information or future court dates. A youth release was observed during the annual compliance review, all procedures were conducted appropriately. A review of the Central Communications Center reports for the past six months confirmed there were no unauthorized releases.

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

The center has policy and procedure in place inference to the release of youth personal property. A review of four closed records indicated youth property was released to youth and signed by youth, parent/guardian and staff acknowledging the return of property. During the annual compliance review, a release of youth property was observed and found property was returned and form signed stating youth took possession of their property. The center policy states if property is left over thirty days property will be considered abandon and a Notice of Impending Disposal of Property will be sent to last known address. In the event a youth is on supervision, the juvenile probation officer will be authorized to sign property release form to deliver to youth.

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

The center has a written policy and procedures in place to ensure prescribed medication along with medication instructions are provided to the parent/guardian at the time the youth is released. A review of four closed youth records was conducted. According to the Department's Juvenile Justice Information System (JJIS) Release Wizard, two youth had medication upon release. The center utilizes a Medication Wizard to ensure all medications accompanied the youth upon their release. Both of the applicable reviewed records confirmed medication and medical instructions were provided to the youth and the parent/guardian upon release. There was no observation of youth released with medication during the annual compliance review.

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

During the annual compliance review, a weekly detention review was observed. The participants were the superintendent, assistant superintendent, detention review specialist, medical, mental health, and by telephone the juvenile probation officer. Documentation confirmed, the center is conducting weekly detention reviews. According to the superintendent, the detention review is designed to gather information from all stakeholders involved in the youth's stay at the center.

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

The center has a written policy and procedures to address the daily activity schedule. During the annual compliance observations confirmed, youth are provided the opportunity to participate in constructive activities while in the center. The center provided a copy of the daily schedule for review, which documented the days, times, and all elements outlined by the Department's

policy. During the annual compliance review, a daily activity schedule was observed and posted in common areas occupied by youth. The center logbook and module logbook show the daily activity schedule is being followed. Five youth and five staff were interviewed and all confirm the daily activity schedule is being followed.

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

The center has a written policy and procedures which outlines adherence to a daily schedule. A review of the center's daily activity schedule was reviewed along with logbooks for various dates, confirmed the center's adherence to the daily schedule. During the annual compliance review, observations of the daily activity schedule showed it being followed by staff and documented in logbooks. A review of the center's daily activity schedule, in comparison with logbooks for various dates within the past six months, confirmed the center's adherence to the daily schedule. The logbooks nor shift reports indicate any significant changes in the schedule. Five youth were interviewed, each stated the daily activity is being followed. All five staff interview stated daily activity schedule is being adhered to.

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

All youth at detention center are given access to education. School starts at 8:10 a.m. and ends at 2:30 p.m. A review of the education schedule and school district calendar revealed the youth are provided education 250 days a year distributed over twelve months, with a minimum of twenty-five hours of instruction a week. Teachers are given days for training and planning throughout the school year. Youth enrolled in educational programs at the center have an opportunity to earn course credit for completion of the education and training experience. A review of master control logbooks documented there were no missed school days. Staff interviews and student interviews revealed there is minimal interference of educational instruction. Four of the five interviewed youth stated they attend life skills, math, science, history, reading, social studies, and career choices at the center. One youth stated she had earned her General Equivalency Diploma (GED).

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

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

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

The center has a policy and procedures in place regarding trauma-informed care. According to the superintendent, the center incorporated trauma-informed practices into current operations to deliver services and to provide care to youth in custody, acknowledging the role violence and victimization play in the lives of the youth entering the center. During the annual compliance review, observation confirmed the implemented trauma-informed care in the center. The center has a soft room, soft colors painted on walls of the center, and staff are trained in trauma-informed care. Five staff records reviewed and confirmed each received trauma informed care training as required.

Standard 3: Mental Health and Substance Abuse Services

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

The detention center contracts through the provider Camelot Community Care to provide mental health and substance abuse services in individual, group, and when possible, family counseling. The designated mental health clinician authority (DMHCA) is licensed mental health counselor (LMHC), under Chapter 491. The LMHC is a full-time employee, having started the same month as the review, and is on-site forty hours a week. The previous DMHCA is now one of the two licensed clinical social workers (LCSW) providing counseling services. A copy of the LMHC's licensure and contract was available while on-site during the annual compliance review.
An interview with the DMHCA was conducted and confirmed her credentials as an LMHC. In addition, the license is clear and active within the State of Florida. The DMHCA confirmed being on-site at the center five days a week for forty hours each week. Additionally, the DMHCA oversees the services of two licensed clinicians for the planning and delivery of mental health services. The DMHCA meets with staff daily, either in person, or by email or telephone. The DMHCA meets with the psychiatrist weekly.

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

The detention center currently has two licensed clinical social workers (LCSW) providing services to the youth. Previously, there were two licensed mental health counselors (LMHC) providing services. All licenses are clear and active under Chapter 490 and 491. All licenses were made available for review during the annual compliance review.

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

The center does not employ any non-licensed clinical staff; therefore, this indicator shall be rated as non-applicable.

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

Five youth records were reviewed for mental health and substance abuse admission screenings. The Suicide Risk Screening Instrument (SRSI) and a Massachusetts Youth Screening Instrument – Version 2 (MAYSI-2) assessments were completed by probation staff and reviewed by detention staff. Each of the five youth records contained a completed SRSI which was completed during the youth's intake. The SRSI and MAYSI-2 were documented within the Department's Juvenile Justice Information System (JJIS). Each of the youth records indicated a nurse and/or mental health staff completed the applicable sections of the SRSI as required. There were complete entries, including a summary and recommendations in the "Screening Results" sections. Two of the five records found the youth had a yes response on the SRSI and were appropriately placed on suicide precautions. All five screenings were completed by trained staff. Four of the five records showed the results of the SRSI and MAYSI-2 indicated a need for further assessment and a referral was made for each of the applicable records. As required, the superintendent was notified of the screening instrument findings. Two youth had elevated suicide risk subscales and were placed on suicide precautions and referred for an Assessment of Suicide Risk (ASR). Two youth had results on the MAYSI-2 indicating the need for a comprehensive assessment. A referral for a comprehensive assessment was reported to the mental health clinical staff.

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 with 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.	

Five youth records were reviewed and four were applicable for mental health and substance abuse evaluations as a result of the screening process. One youth record was identified after admission and referred to the detention provider. Each of the referrals resulted in completion of a new mental health and or substance abuse evaluation, which was completed by the detention provider. Each of the five mental health or substance abuse evaluations were completed within thirty days of referral. None of the youth reviewed, required a comprehensive assessment through a community provider.

3.06 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/substance abuse treatment in the center. *All youth who receive mental health and/or substance abuse treatment while in at the center shall have a discharge summary completed documenting the focus and course of the youth's treatment and recommendations for mental health and/or substance abuse services upon youth's release from the center.*	

Five youth records were reviewed for treatment planning. Two out of the five youth reviewed include either an initial or individualized treatment plan, so an additional record was provided for review to make a total of three records reviewed. Two records contained an individualized treatment plan as the initial plan and one record contained an initial treatment plan. Each record reviewed had an initial treatment plan in place within seven days of initiation of treatment. Each of the initial treatment plans were developed on the Department's Initial Mental Health/Substance Abuse Treatment Plan form. All three records had a documented reason of referral for treatment, along with an initial Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) and Diagnostic Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis. The treatment plans included initial treatment methods, along with initial treatment goals. All three records required psychiatric services. Each of the individual or initial treatment plans included the signature of the licensed mental health and substance abuse professional. In addition, the signatures were documented for the youth and the mini-treatment team members involved in development of initial treatment plan.

A total of three youth records were applicable for review for individualized treatment plan. Two of the records utilized the individual treatment plan as the initial plan and one record included both the initial and individual treatment plan. Two of the three plans were applicable for an individualized treatment were completed within the thirty-first day of the youth's admission. One record included the youth's refusal for treatment in the chronological notes, which delayed treatment one month. The youth's date of admission to the detention center was on April 11, 2020, he received an initial psychiatric evaluation on May 7, 2020, the initial treatment plan which was refused on May 12, 2020, the youth requested services on June 4, 2020, and treatment started on June 9, 2020. Each of the three applicable individualized treatment plans included the signature of the licensed mental health professional within ten days of completion. The three treatment plans included an initial DSM-IV-TR or DSM-5 diagnosis. Each of the treatment plans included symptoms which were treatment-focused, treatment goals, strengths/abilities, and preferences/needs. All three applicable youth records required psychiatric services. One of the three applicable records included psychotropic medication and frequency of monitoring, along with pharmacological interventions. A review of each of the three applicable youth progress notes, validated youth received treatment services as stipulated on the treatment plan. The three individualized treatment plans reviewed were signed and dated by the youth, mental health and substance abuse professionals, treatment team members, and the parent/guardian, when possible. Two of the three applicable records included thirty-day individualized treatment plan reviews which were completed within the time frame and were signed by the clinical staff, youth, and licensed mental health professional. Two youth records were applicable for psychiatric treatment services. The youth's treatment plan included treatment and services provided by a licensed psychiatrist.

Three closed youth records were reviewed for mental health and substance abuse treatment discharge summaries. The three youth records contained mental health and substance abuse treatment discharge summaries, which were completed upon each youth's transition or discharge from the center. Each of the mental health and substance abuse treatment discharge summaries were provided to the juvenile probation officer, parent/guardian (as allowed), and the youth. Five youth were asked to rate the mental health services at the center and three youth stated good and two youth reported they did not receive services.

3.07 Mental Health and Substance Abuse Treatment [Detention Staff/Contract Provider]	**Satisfactory Compliance**
Mental health and substance abuse treatment planning in Department facilities focuses on providing mental health and/or substance abuse interventions which will reduce or alleviate a youth's symptoms of mental disorder and/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 at the center, must be assigned to a mini-treatment team.*	

Five youth records were reviewed for mental health and substance abuse treatment. Two out of the five youth reviewed, required mental health and or substance abuse treatment, so an additional record was provided for review to make a total of three records reviewed. Each of the three youth requiring treatment, were assigned to a mini-treatment team. Each of the mini-treatment teams consisted of a mental health clinical staff, a staff from a different service area, the youth, and when possible, youth's parent/guardian. The three applicable youth determined to be in need of mental health treatment, received individual, group, or family counseling. Treatment was provided according to the frequency required by the youth's plan. Two of the three applicable youth were determined to be in need of substance abuse treatment. Each youth received individual, group, or family counseling according to frequency required by the youth's plan. Each of the three youth requiring mental health treatment had a proper consent for treatment; an Authority for Evaluation and Treatment (AET) found in the youth record. Treatment notes for the three identified youth were found documented on the Department's Counseling/Therapy Progress Note form. Mental health staff have adequate access to youth in order to provide treatment services. Group therapy is limited to ten or fewer youth for mental health treatment groups and fifteen or fewer youth for substance abuse treatment groups.

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 employs a psychiatrist, who is licensed pursuant to Chapter 459, Florida Statutes, and is certified in child and adolescent psychiatry, from the American Board of Psychiatry and Neurology. The provider does not employ a licensed and certified psychiatric advanced practice registered nurse (APRN), under Chapter 464, Florida Statute.

An additional youth record was provided to make three applicable records reviewed for psychiatric services. Two of the three applicable youth entering the center were referred for an initial diagnostic interview and seen within fourteen days of admission. One record was a self-

referral and the initial diagnostic interview was completed the next day. The initial psychiatric interview included the reason for the referral, history (medical, mental health and substance abuse history), mental status examination, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) or Diagnostic Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis and symptoms, treatment recommendations, prescribed medication, explanation of the need for psychotropic medication, and frequency of medication monitoring/management.

Each of the three youth in receipt of psychotropic medication had documented monitoring for Tardive Dyskinesia monthly, as required. Additionally, each youth record contained an Authority for Evaluation and Treatment (AET). None of the three reviewed records required a new psychotropic medication, discontinuation, or dosage of medication to be significantly change. None of the youth reviewed for psychotropic medication were in foster care. One youth had reached the age of eighteen and was responsible for authorizing his health care and release of his healthcare records.

All three youth had a Clinical Psychotropic Progress Note (CPPN) page 3, completed for psychotropic medication and stated the reasons and factors leading to the referral. The psychiatric evaluation identified data, diagnosis, target symptoms of each medication, evaluation and description of effect of prescribed medication of target symptoms, the name, dosage, and quantity of the psychotropic medication, side effects, youth's adherence to the medication regime, height, weight, and blood pressure in all three records. All three records documented whether there was telephone contact with the youth's parent/guardian to discuss medication and the psychiatrist signed all pages of the CPPN with date of the signatures. In all three records, the psychiatrist documented monitoring for Tardive Dyskinesia. An appropriate Authority for Evaluation and Treatment (AET) was in all three youth records. One youth was not prescribed medication, one youth did not have any change in medication; however, the third youth had a change in medication and verbal parental consent was received and documented on page 3 of the CPPN. According to the center's clinical staff, no telepsychiatry services were delivered.

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

The center has a written suicide prevention plan in place to safely assess and protect youth. The plan was approved by the superintendent and designated mental health clinician authority (DMHCA) annually. The center's suicide prevention plan includes identification and assessment of youth at risk of suicide, staff training, suicide prevention, levels of supervision, referral, communication, notification, documentation, immediate staff response, and the review process, as referenced in the Department's Rule 63N-1.

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, available information, or staff observations 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 at a minimum of constant supervision.* *All youth 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 (ASR).*	

An additional youth record was provided to make three applicable records reviewed for suicide prevention services. All three youth reviewed were identified to be at risk during admission screening and subsequently placed on precautionary observation. An alert was initiated for each of the six youth and entered into the Department's Juvenile Justice Information System (JJIS). Each of the youth had a suicide risk assessment referral. For each of the three youth, an Assessment of Suicide Risk (ASR) documented the assessment in real time and the completed ASR indicated the level of supervision for each youth. Two youth records reviewed were placed on close supervision and one youth placed on standard supervision. Suicide Precautionary Observation Logs were generated as a result and were completed in their entirety.

None of the youth reviewed were neither released, nor was supervision stepped down, prior to receiving an ASR. Each ASR documented a consultation with the designated mental health clinical authority (DMHCA). In addition, the superintendent or designee was notified immediately of the youth's suicide risk and precautionary observation was authorized. An ASR for each of the youth was completed within twenty-four hours. None of the youth were identified as having been in crisis or required a Follow-Up ASR. All ASRs reviewed included the date and time the youth was stepped down to close supervision or removed to standard supervision. All three youth were discontinued from close supervision was documented in accordance with the program's suicide prevention plan. All ASRs were completed by a licensed clinical staff professional and results of the ASR include recommendations for supervision and follow-up when needed. There was evidence within the logbook and on the ASR where administrative or supervisory staff provided instructions related to the suicide risk assessment findings, to include beginning and ending times for any youth placed on suicide precautions. Alerts within JJIS were found for each of the three youth.

One additional record was provided and reviewed for secure observation. Placement for secure observation was authorized by the superintendent and DMHCA. The secure room designated in writing as "secure room" was documented on the log sheet. There was no health status checklist complete in approximately seven days total while the youth was in secure observation. Suicide Precaution Observation Logs were completed in their entirety. A Follow-Up ASR was not required within eight hours due to the youth placement into secure observation was the result of the ASR completed by a licensed mental health staff. The parent/guardian and juvenile probation officer was notified of a youth's potential suicide risk as indicated by the ASR and the chronological notes. Mental health staff provided daily mental health supportive services. The observation logs documented supervision and the youth's level was reduced only after the superintendent and licensed mental health professional agreed during their conference. At-risk

youth who are recommended for disciplinary confinement are placed in secure observation. Documentation of discontinuance was noted in the logbook and in the youth's mental health file.

The superintendent has an established review process for every serious suicide attempt or serious self-inflicted injury (requiring hospitalization or medical attention) and a mortality review for a completed suicide. The multidisciplinary review included, circumstances surrounding the event, written procedures relevant to the incident, relevant training received by involved staff, pertinent medical and mental health services involving the victim, possible precipitating factors, and recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and/or operational procedures. Interview with the superintendent confirmed a suicide precaution method provides the placement of youth who demonstrate at risk or suicide risk behaviors a secure room with one to one supervision or constant supervision.

Five staff were interviewed concerning their responsibilities when a youth expresses thoughts of suicide. Each staff reported mental health would be contacted and the youth would be placed on constant sight and sound and four staff state searching the youth's room for sharps and document supervision. Each staff was aware of the location of the suicide response kits. One of the five youth interviewed reported they were placed on precautionary observation and was watched by staff the entire time. The remaining youth reported never being placed on suicide watch while in the center.

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

Two of the five youth reviewed were applicable for the review of Suicide Precaution Observation Logs. An additional youth record was provided to complete an example of three records reviewed. In all three records, each Precautionary Observation Log was documented on the Department's Suicide Precaution Observation Logs form, which was maintained for the duration the youth was on suicide precautions. Each of the logs documented the appropriate level of supervision and observations of the youth's behavior. The documentation was in real time and did not to exceed thirty-minute intervals. There were no warning signs observed. Each of the Precautionary Observation Logs were reviewed and signed by each shift supervisor. Two youth with a history of precautionary observation (PO) placement were interviewed and reported staff were with them at all times while on PO.

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

Five staff in-service training records were reviewed for completion of suicide prevention training. Each of the five staff received a minimum of six hours annual suicide prevention and implementation of suicide precautions training. Training consisted of two hours of training in the Department's Learning Management System (SkillPro) and four hours of instructor-led training. Training at the center included monthly mock suicide drills for each shift which exceeded the quarterly drill requirement for each shift. The mock suicide drills included all staff who come in contact with youth. A review of the mock suicide drills demonstrated each of the reviewed staff

participated in quarterly drills. In addition, fifty percent of staff with direct contact, on a day-to-day basis, with youth, participated in at least one mock drill, which included the use of cardiopulmonary resuscitation (CPR) annually. Staff members who are not present during a quarterly drill have the opportunity to review drill scenarios and procedures during shift briefings.

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

The center has a written mental health crisis intervention plan which details crisis intervention procedures and practices. The written crisis intervention plan includes the following procedures: notification and alert system, means of referral (includes youth self-referral), communication, supervision, documentation, and a review process.

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 center, requires emergency care to be provided in accordance with the center's Emergency Care Plan. The Crisis Intervention Plan and Emergency Care Plan may be combined into an integrated crisis intervention and emergency services plan which contains all the elements specified in Rule 63N-1, Florida Administrative Code.	

The center has a written emergency care plan which included the following: immediate staff response, notifications, communication, and supervision. In addition, the emergency care plan included process for authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment under Chapter 394, Florida Statute (Baker Act), transport for emergency substance abuse assessment and treatment under Chapter 397, Florida Statute (Marchman Act). The emergency care plan included procedures for documentation, training, and a review process. The center's written emergency care plan was last updated and approved September 21, 2020. The location of the written emergency care plan is located in the superintendent's office and accessible to all staff.

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

The center has not had any youth requiring a crisis assessment during the annual compliance review period. An informal interview was conducted with the center's designated mental health clinician authority (DMHCA) which confirmed there have been no youth requiring a crisis assessment since the last annual compliance review. The center would utilize the Department's Crisis Assessment form, if necessary, located within the Department's Juvenile Justice Information System (JJIS) Electronic Medical Records system.

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 record was provided for review, from February 2020, of a youth who was Baker Acted. The youth was placed on suicide precautions upon re-admission from the Baker Act. A mental health referral was completed by a 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 confers with licensed mental health staff and the superintendent or designee. The youth returning from the Baker Act was placed on constant supervision. A mental health referral was completed indicating a Mental Status Examination (MSE) must be completed. A suicide risk alert was entered in the Department's Juvenile Justice Information System (JJIS) as a result of the Assessment of Suicide Risk (ASR) and alert or supervision of the youth was not discontinued until a completed assessment was confirmed.

Standard 4: Health Services

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

Leon Regional Juvenile Detention Center has a contract with Camelot Community Care, Inc. to provide medical services at the detention center. The center has a board-certified and licensed physician and holds and unrestricted license and meets all requirements for independent and unsupervised practice in Florida to serve as the designated health authority (DHA). The DHA's license expires January 31, 2022 The DHA has a specialty in internal medicine with experience in adolescent health. The DHA interview revealed he performs Comprehensive Physical Assessments (CPA), conducts periodic evaluations, sick call, and policy and procedure development. A review of the sign-in logs for the past six months prior to this annual compliance review, confirmed the DHA is on-site weekly for at least one hour on Mondays. The DHA is available twenty-four hours a day, seven days a week by phone to address all concerns. During vacation or schedule absences, the DHA makes request to Camelot Community Care, Inc. and they provide an available doctor. The DHA reveals he communicates with the center staff regarding youth medical needs one on one when on-site and by phone after hours.

The center employs an advanced practice registered nurse (APRN) who holds an unrestricted license to practice in Florida which expires on April 30, 2022. The APRN provide services on-site, a minimum of ten to fifteen hours a week. The APRN works in collaboration with the DHA and signed the nurse practitioner protocol/collaborative practice agreement. The APRN stated her role at the center is to perform CPAs, Health Related History, sick call, periodic evaluations as indicated per protocol. A check of all licensed medical staff confirmed all had current State of Florida medical licenses, verified by the Department of Health.

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

The center has Facility Operating Procedures (FOP) and treatment protocols for all health-related procedures. All FOPs and treatment protocols contained the signature of the designated health authority (DHA) and the superintendent. There was documentation of an annual review of all treatment protocols by the DHA and superintendent. There was documentation of all newly employed health care personnel receiving a comprehensive clinical orientation to the department's healthcare policies and procedures, which was provided by the registered nurse. There was documentation of the nursing staff reviewing, signing, and dating, a cover page on which all FOPs, treatment protocols, and other procedures were listed annually.

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 five youth Individual Healthcare Records revealed each of the youth had a current original or legible copy signed Authority for Evaluation and Treatment (AET) filed in the record. Each AET was obtained prior to providing medical services.

4.04 Parental Notification/Consent [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 five youth Individual Healthcare Records (IHCR) found each had documented parent/guardian notification. Three of the five youth required parental notification for over-the-counter medications not covered by Authority for Evaluation and Treatment form. One of the five youth required parental notification for vaccinations and immunizations. All five of the youth required parental notification for new medication. For each parental notification, there was documentation of telephone calls, attempts and verbal approvals which were witnessed. A review of progress notes confirmed parent/guardian consent where obtained verbally or in writing.

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

A review of five youth Individual Healthcare Records found each youth received a medical and mental health admission screening for their most recent admission. Each of the screenings were completed on the day of admission by a juvenile justice detention officer (JJDO). There was documentation of each form being reviewed with youth by a licensed practical nurse or higher within twenty-four hours. None of the youth had a change in their physical custody since their arrival to the center requiring a healthcare admission rescreening. All three of the female youth reviewed received a qualitative urine pregnancy screening test with the youth's verbal consent. Superintendent interview revealed the medical and mental health admission screening is completed by the admitted JJDO and reviewed by the nurse and doctor.

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

A review of five youth Individual Healthcare Records revealed each youth received a general orientation within twenty-four hours of admission to the center. The healthcare topics included access to medical, sick call (use, how to access), what constitutes an emergency and who to notify, medication process and side effect monitoring, the right to refuse care and how it is

documented, what to do in the case of a sexual assault or attempted sexual assault, the non-disciplinary role of the healthcare providers.

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

A review of five youth Individual Healthcare Records (IHCR) found three were applicable for designated health authority (DHA) notification. The DHA received an immediate notification when youth were identified as possessing a medical concern or chronic condition. There was documentation of the DHA being notified within twelve hours of admission. The notifications were documented in the youth's IHCR.

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

A review of five youth Individual Healthcare Records (IHCR) found each youth had a Health-Related History (HRH) completed within seven days of admission. All of the HRH were new. All five HRH were completed by a licensed nurse or practitioner and reviewed by the designated health authority (DHA) or the advanced practice registered nurse (APRN). Each of the HRH forms were completed before the Comprehensive Physical Assessment.

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

A review of five youth Individual Healthcare Records (IHCR) found one contained a current Comprehensive Physical Assessment (CPA). The other four IHCR contained a new CPA. Each of the CPAs were reviewed, initialed and dated by the designated health authority. Three of the five were completed within seven days of admission. The other two were completed four days late and one day late. There was documentation of when any part of the exam was refused of the clinician writing "Youth Refused." Four of the youth had a medical grade ranging between two and five. Each of the four youth were placed on the center's alert system. There was documentation of the youth signing a refusal form to reflect the refused portion on the CPA exam and matched the date of the exam. The Department's Problem List was updated for each youth.

Each of the youth had at least one verified Tuberculosis Skin Test (TST) test documented in the IHCR and on the Infectious and Communicable Diseases form. The Tier 1 TB screening was completed within seventy-two hours. None of the youth had a positive TST or symptoms of Tuberculosis requiring them to be transported to the nearest hospital for further evaluation.

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

A review of five youth Individual Healthcare Records (IHCR) found each youth were screened and evaluated for sexually transmitted infections (STI). None of the youth were tested for STIs. All five youth were offered human immunodeficiency virus (HIV) testing. One of the selected youth gave consent to HIV testing. Additional records were requested, and none were applicable for the review. There was documentation of the youth consenting to HIV testing. There was documentation of the youth being offered counseling and testing for HIV. The results were found in the youth's record filed in a confidential manner. The nurse stated youth are offered HIV testing at the time of the youth's admission to the center and if consent is given they will be given pre-testing, post-testing, and counseling by the advanced practice registered nurse (APRN), as well as, have their blood drawn. Five youth were interviewed and four stated they could request an HIV test, the other youth stated no.

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

The center has a policy and procedures in place defining the process for requesting and conducting sick calls at the center. A review of five youth Individual Healthcare Records found three youth requested sick calls. All Sick Call Request forms and narrative progress notes conformed to the professional standard to include all elements of the subjective, objective, assessment, and plan (SOAP) format. Two of the youth presented a similar sick call complaint three or more times within a two-week period and the youth was referred to the designated health authority (DHA).

Sick calls are conducted in the medical clinic by licensed medical staff at the center. When there is no licensed nurse on-site, the center has procedures in place for the shift supervisors to review all sick call requests no longer than four hours after a request is submitted. Sick calls are provided every day from 7:00 a.m. until 8:00 p.m. and as needed. There were no youth complaints of any severe pain with which were unfamiliar by medical staff.

Three youth interviews revealed they could be seen immediately once a sick call request is made. The other two youth revealed they could be seen within one day of making the sick call request. Youth interviews revealed the nurse, doctor and staff conducts sick calls. The medical department was rated poor by one youth and good by four youth interviewed. Five staff interviewed revealed nurses and staff review sick calls. The staff interviews reveal the nurses and supervisors conduct sick call. During the annual compliance review, a sick call was not observed due to no youth requesting a sick call.

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

The center has a policy and procedures for the provision of episodic care, first aid, and emergency care. A review of five youth Individual Healthcare Records found none of youth received episodic/first aid care by a non-healthcare staff. Additional records were requested, and none were applicable. The documentation on the progress notes contained all required elements. One of the five youth were seen by medical staff for episodic/first aid. Additional records were requested and two were provided for review. There was evidence of the center maintaining an Episodic Care Log to document the provision of episodic care and first aid treatment.

A review of the logs indicated episodic care was administered by the nursing staff. The center has a total of twenty-one first aid kits, which are monitored monthly by medical staff and superintendent or designee. Documentation and interviews confirmed the nursing staff review inventory and restock all first aid kits monthly and maintained on a log located on each first aid kit. First aid kits were found located throughout the center.

The program has a total of two automated external defibrillators (AED). One is located in the medical clinic and the other one is in administration. Both AEDs were tested and functional during the annual compliance review. There was documentation of the AEDs being checked monthly by medical staff. The pads expire on March 28, 2021. The batteries expire on August 23, 2023. A review of the center medical drills confirmed, the center conducts mock emergency medical drills monthly on each shift. The program had a mock emergency drill including cardiopulmonary resuscitation/automated external defibrillator (CPR/AED) demonstration once a quarter. Five staff interviewed and all reported they are able to call 9-1-1 if they feel necessary. All of the licensed health care staff had a current CPR/AED certification. A review of pre-service and in-service training found all staff had current CPR/AED first aid certification.

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

The center has a policy and procedures in place in reference to off-site care for youth. A review of five youth Individual Healthcare Records (IHCR) found two were applicable. Additional records were requested, and one additional record was provided. The Summary of Off-Site Care form was filed in the IHCR. There was documentation of the designated health authority (DHA) being notified of the event. There was documentation of the DHA reviewing the paperwork for each youth. Information was documented on the episodic care log. Each of the three youth required follow-up testing referrals, or appointments. There was evidence of referrals being tracked and youth receiving appropriate, timely follow-up care as needed. The IHCRs contained a Summary of Off-site Care form and discharge instruction documents for each youth.

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

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 five youth Individual Healthcare Records (IHCR) found four youth were identified with a chronic medical condition and/or taking prescribed medications. Each youth were classified with Medical Grade two through five. One youth was identified as pregnant and two were morbidly obese. Each of the four youth were placed on a chronic conditions list. There was documentation of each youth receiving periodic evaluations at no greater than three-month intervals. For three of the applicable youth, there was a periodic evaluation conducted prior to a renewal of prescription medication. The treatment orders were found to be written so they are clearly distinguishable for clinical staff. There were no indications of lapses in care or missed periodic evaluations for any of the youth. The Department's Problem Lists were updated as required for each youth.

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

The center has a written policy and procedures to ensure medication is received, stored, inventoried and provided in a safe and effective manner. A review of five youth Individual Healthcare Records (IHCR) found three youth were prescribed medication prior to their admission to the center. In each of the three IHCRs, the medication was brought to the center by the parent/guardian, verified by medical staff, and the youth was continued on medications. The center used the standard Department's Medication Administration Record (MAR)/Electronic Medical Record (EMR), to document consumption and refusal of medications. The MAR documented all of the required information including demographic information of youth, medication start and stop dates, and staff and youth initials of medication received. There were no lapses or errors in medication administration. The medical staff documents weekly side effect monitoring on the MARs. There were no refusals documented; however, the program's practice is to clearly document refusals on the MAR and Refusal form, when applicable. None of the youth required parenteral medication. None of the youth were prescribed psychotropic medication upon admission.

A medication pass was observed during the annual compliance review, after the youth gave verbal consent for Monitoring and Quality Improvement Staff to observe. The registered nurse (RN) verified the Six Rights of Medication Administration (Right youth, right med, right dose, right route, right time, and right documentation). After the RN gave the youth the medication, the RN verified the youth consumed the medication by checking their mouth. The center has a total of eleven trained non-healthcare staff to assist in the delivery of medications when licensed staff are not on-site. Five staff were interviewed, and three of the staff stated they give medications and two do not give any medications to youth. Five youth were interviewed, three reported the nurse or supervisor gives them medication. The other two stated they do not take medications. The registered nurse (RN) is responsible for the disposal of medication in conjunction with the pharmacy consultant. According to the policy, controlled and non-controlled medications for disposal are inventoried prior to disposal and disposed in the presence of the pharmacy consultant. The medications are disposed of by utilizing the Drug Enforcement Administration

(DEA) approved Drug Buster disposal system in accordance with state board of pharmacy and DEA disposal plan.

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

The center has a written policy and procedures ensuring medications and sharps are secured and inventoried by using a perpetual inventory. The medications and sharps were found stored and locked in designated areas inaccessible to youth. Medications are stored in a locked medication cart, cabinets, and in the locked refrigerator in the medical clinic. All controlled medications were found stored behind two locks. A shift-to-shift inventory count of all controlled substances was documented on the youth's individualized Controlled Medication Inventory Record.

An inventory of three different sharps, three prescribed medications, three over-the-counter (OTC) medications, and three controlled medications revealed each count was accurate and documented by licensed nursing staff correctly. A review of the past six months medications revealed, all counts, and inventories matched medications on available. If there is an inventory discrepancy is detected the department's Central Communications Center (CCC) is contacted. The nursing staff completes the Error Reporting form and faxes it to the Diamond Pharmacy Services. The superintendent is notified as well.

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

The center has a written policy ensuring all staff and youth receive education on infection control. A review of the center's Exposure Control Plan was conducted and confirmed the plan included all required elements outlined in the Department's standards. The plan was reviewed and signed by the superintendent. Five youth reviewed Individual Healthcare Records (IHCR) confirm 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 was maintained in each reviewed IHCR. All training and education were 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.

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

The center has a written policy and procedures in place which discusses prenatal care for all pregnant youth and health education is provided to both youth and staff. An evaluation of the staff's training roster verified the center's registered nurse 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. A review of five youth Individual Healthcare Records revealed one was applicable prenatal care education. Additional records were requested, and the center did not have any applicable records. There was documentation of the youth receiving prenatal care beginning immediately upon determination of the youth's pregnancy. The designated health authority (DHA) or designee conducted focused medical evaluation at least every thirty days. There was documentation of the youth being provided health education on alcohol and drug usage, smoking, nutrition, sexually transmitted diseases, contraception, prenatal care, birthing process, postpartum care, basic baby care (feeding, diapering, bathing), child/infant development, and parenting skills.

Standard 5: Safety and Security

5.01 Active Supervision of Youth (Critical)	Satisfactory Compliance
Staff are aware of the location of youth assigned to their supervision at all times. Staff monitor the movement of youth in their direct care from one location to another. *Youth are in sight of at least one juvenile justice detention officer (JJDO) at all times (with the exception of sleeping hours or time secured in rooms).* *Officers are responsible for the care of youth at all times. At no time shall another youth be allowed to exercise control over or provide discipline or care of any type to another youth.* *When a youth leaves the group or program area of the center for any reason, all staff assigned to supervise the youth are informed.* *Master control authorizes all movement of youth prior to the actual movement, and no movement occurs until cleared by master control.* *Staff moves youth from one area of the center to another in accordance with Florida Administrative Code.*	

The center has a policy and procedures which requires staff to be aware of the location of youth assigned to their supervision. During the annual compliance review, youth supervision was observed during the entire four days. The center had a total of three females who was supervised by two officers. There were two groups with six male youth each being supervised by a minimum of two male officers. Youth were observed involved in education, meals and outside activities. Staff and youth interactions were always appropriate and professional while actively supervising youth. At no time was it observed of a youth exercising control or discipline over another detained youth. Counts were conducted three times a shift. All counts and youth status change were documented in the logbook. Master control authorized all movement and no movement occurred until cleared by master control. All movement was in accordance with the Florida Administration Code. All officers were provided an alert list of all youth in the center during briefing as a method of tracking the daily census. Five staff interviewed all reported there is enough staff to provide safety and security of staff and youth.

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

The center provides a system of rewards, privileges, and consequences to encourage youth to fulfill the center's expectations. During the annual compliance review and walk through of the center, it revealed postings of the behavior management system (BMS) in all living areas which

clearly specified appropriate and inappropriate behaviors, rules, norms and expectations of youth. Postings and calendars included rewards for positive behavior and consequences for inappropriate behaviors. Youth point cards were reviewed and documented daily in accordance with the BMS. Five youth were interviewed and stated they understand the BMS and are rewarded accordingly. Five staff interviewed all reported they believe the center's BMS is effective and youth are youth given an opportunity to explain their behavior.

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

The center's behavior management system (BMS) restricts certain types of penalties on youth who demonstrate negative behavior. Five youth were interviewed, and indicated youth are not allowed to punish each other, group punishment is not used, nor are drugs used to control a youth's behavior. There were no instances of corporal punishment reported to the Florida Abuse Hotline or Central Communications Center (CCC) during this annual compliance review period. Five staff interviewed report never observing any staff encouraging youth to punish another youth.

5.04 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 conduct observations in a manner ensuring the safety and security of each youth and documents each check in real time, manually or electronically. Documentation must include the actual time of each visual observation and initials of the staff conducting the check; preprinted times are not acceptable.* *There shall be no obstructions (e.g., clothing, memos, pictures) over windows and areas where direct line of sight is needed.* *If an officer, in the course of completing visual observation, is unable to see the youth or any part of the youth's body, the officer shall, with the assistance of another officer, open the door to verify the youth's presence.*	

The center has a policy and procedures requiring staff to 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. The center has sixty-four cameras of which fifty-six are operational. Video recordings are stored for thirty days. A review of ten-minute checks conducted on September 27th, 28th and 30th of 2020 for various shifts.

All checks were conducted in real times due to the centers use of the wand system. Checks were completed within the required time frame with the exception of three checks which were late due to a code blue in the area. Five staff were interviewed, and all stated checks are conducted at a minimum of every ten minutes for standard supervision youth. While conducting the facility tour there was no obstruction observed to the youth rooms.

5.05 Census, Counts, and Tracking	Satisfactory Compliance
Officers must know the exact number and location of all youth under their supervision at all times. Census counts of youth shall be taken, called into Master Control, and documented, at a minimum: • *At the beginning and end of each shift.* • *Following any emergency to include power outages, evacuation due to emergency drills, and any code called outside the secure walls. In the event a code is called in any location outside the main walls of a facility, it is critical all youth counts are reconciled prior to the movement of any group of youth.* • *Prior to and following routine group movement.* • *Any time a population change occurs.* • *Randomly, at least once on each shift.* *Staff should not include youth in the count who are not physically present with the staff person at the time of the count (e.g., court, clinic, confinement).*	

The center has a policy and procedures which requires staff to maintain an accurate count of youth in their care. Census counts are conducted throughout each shift and called into master control and documented in the logbook. Observations during the annual compliance review confirmed, staff called in counts three times a shift beginning, mid-shift and ending of the shift. Master and mod logbooks were reviewed, and all counts were documented. Following any emergency, drills and any code called outside the secure walls, counts were documented. Five staff were interviewed and reported counts are conducted three times each shift. In addition, courts are conducted during a major disturbance, codes, and drills.

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

The center maintains a chronological record of events, incidents, and activities in logbooks maintained at master control and in each living area in accordance with Florida Administrative Code. Master control and module logbooks were reviewed from the past six months. The center maintained a separate logbook for each living area and one for master control. Each logbook was bound with numbered pages. Each logbook entry included the date and time of the event, the names of staff and youth involved, a brief description of the event and the initials of the person making the entry with date and time. All entries were made in black and blue ink. Entries regarding medical, special needs, and mental health issues which impacted the center were highlighted. Incidents, Central Communications Center (CCC) calls, Florida Abuse Hotline calls, and drills were documented in the master control and module logbooks. All errors were struck through with a single line and initialed by the person making the correction.

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

The center maintains a policy and procedures requiring the superintendent or designee to reviews all logbooks weekly and the juvenile justice detention officer supervisor (JJDOS) reviews the center logbook maintained at master control when accepting responsibility for the center. Review of the logbook confirmed the superintendent and the JJDOS reviewed the logbooks as required. The center maintains a chronological record of all events, incidents and activities in their logbooks which are maintained in master control and in each living area. Each logbook was bound with numbered pages with the dates written on top. According to the superintendent, logbooks should be reviewed by management and signed off on by management.

5.08 Key Control	Satisfactory Compliance
Each center is responsible for maintaining inventory and control of all facility keys. *All keys shall be placed on a tamper-resistant key ring designed to inhibit the removal of keys.* *Emergency key rings shall be maintained separately from other facility keys, in master control, in a secure location designated by the Superintendent. These keys shall be notched or otherwise identifiable by touch.* *The key(s) on these rings shall provide egress through facility exterior doors providing access to evacuation areas.* *A key inventory shall be maintained by the Superintendent or designee at all times.* *(For the entire indicator statement, please reference the Monitoring and Quality Improvement FY 2020-2021 Detention indicators.)*	

The center has a policy and procedures which requires center to maintain inventory and control of all center keys. The superintendent provided a copy of the master key inventory, in review of the key inventory it revealed all keys were accounted for. All keys were numbered, placed on a tamper resistant ring with a label indicating the total keys on each ring. Keys were secured in a box in master control. Shift briefing was observed, supervisors assigned floor keys to staff during shift briefing. All keys are placed on a tamper-resistant key ring designed to inhibit the removal of keys. Supervisors document what key is assigned to each staff on the shift report in SharePoint. Floor keys are kept in the supervisor's office in a secure locked cabinet. Some staff were observed turning in their personal keys to master control and other staff placed their keys in a locker.

Five staff interviewed reported they always carry the center key on their person. Emergency keys were kept in master control in a secure locked box. Youth do not have access to center keys. Master control operator was interviewed and explained if staff mistakenly leaves the center with keys, staff shall contact the shift supervisor immediately and shall be required to return the keys within two hours. Master control operator was able to explain the procedure for addressing missing or lost keys. There have been no instances of lost keys six months in the last. Five staff interviewed all reported they are only provided keys which would grant them access to common area in the center.

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

The center maintains a policy and procedures which ensures all vehicle used to transport youth are properly maintained, as well as maintains documentation on the use and maintenance of each vehicle. Four vehicles were observed. Each vehicle was observed to be locked. All vehicles contained a window punch, seat belt cutter, first aid kit and fire extinguisher which was up to date. Four of the five vehicles were operational and in good condition with one van

receiving maintenance. Each vehicle has a vehicle log, enough gasoline, seatbelts anchored properly, cages tested and secured, all registrations were present, copies of transportation procedures, keys, gasoline card, and cellular phones are provided for transports. Vehicle weekly and monthly inspections were documented in SharePoint. A transport was not able to be observed due to the COVID-19 pandemic. During the annual compliance review, the center was unable to provide invoices from an automotive shop indicating any of vehicles received an annual safety inspection; however, the superintendent scheduled the annual vehicles inspection prior to the conclusion of the annual compliance review.

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

The center maintains a written policy and procedures to ensure all tools and equipment related to maintenance are properly maintained, stored, and inventoried. The center utilized a locked storage room located in the sally port. The kitchen maintains sharp tools in a locked cabinet. Each tool was inspected monthly. The results of the inspections are reviewed by the superintendent. There was no evidence of broken tools upon observations. The center maintains a perpetual inventory of all tools and the superintendent reviewed each tool. Kitchen staff inventoried each tool daily during shift change. There was no evidence of discrepancies upon observations. There were no documented instances of lost tools by the center. After interview of the superintendent, there has been no instances of missing tool.

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

The center maintains a policy preventing youth from use or access of any tools, including kitchen or medical equipment. Five youth were interviewed, four youth stated they can use brooms and mops for cleaning purpose, and they are not permitted to use cleaning agents. The remaining youth reported not using tools. Observations during the annual compliance review confirmed youth only use mops and booms.

5.12 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 maintains a policy requiring all flammable, toxic, caustic, and poisonous items to be inventoried and secured when not in use. The use of hazardous material is required to be consistent with the manufacturers' instruction and all safety precautions are required to be followed. During the annual compliance review, chemicals were observed stored in a locked shed away from the center. The center has a safety plan addressing proper use, storage and disposal of chemicals. The center maintained a Safety Data Sheets for all chemicals. Maintenance staff maintained an inventory of all chemicals in the facility.

5.13 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 maintains a policy and procedures requiring flammable, toxic, caustic, and poisonous fluids and other dangerous substances to only be drawn or acquired by authorized personnel. Observation of all flammable, toxic, caustic, and poisonous fluids were found to be securely stored and inaccessible to youth. Five youth were interviewed, indicated they do not have access to flammable, toxic, caustic and poisonous items.

5.14 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 maintenance mechanic or other trained staff who have the safety equipment for diluting, handling, and disposing of hazardous waste and/or solid waste are 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 maintenance supervisor indicated there have not been any instances of chemical spills or a need to dispose of any hazardous waste since the last annual compliance review. According to staff, the center does not use grease for cooking. The maintenance mechanic indicated all hazardous liquids are disposed in accordance with the manufacturers Safety Data Sheets (SDS).

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

The center has a policy and procedures requiring staff to use behavioral confinement as an immediate, short term response strategy during escalated situations in which a youth's sudden or unforeseen onset of behavior imminently and substantially threatens the physical safety of others or self. During the tour of the center, rooms were observed, and windows were free of obstructions so youth can be visually observed. A review of the last six months confinements was conducted. Documentation confirmed all rooms were searched prior to youth entering the rooms. Five confinement reports were reviewed and found to be completed within the hour. The supervisor reviewed all reports within two hours and on three occasions the supervisor failed to speak with three youth in confinement at the three-hour mark to determine the need to remain in confinement or if the youth should be released from confinement. One of the five confinements, the superintendent or designee failed to review the confinement report within twenty-four hours to determine whether the confinement was appropriate or inappropriate. Five youth records were reviewed concerning ten-minute observation logs were reviewed with officers documenting five-minute checks for the first hour and ten-minute checks thereafter. Five staff interviewed, two reported youth have access to educational materials while in confinement, the remaining three reported youth are not having access to educational materials.

5.16 Confinement Over 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. *Confinements should not exceed twenty-four hours; however, if a youth continues to exhibit behavior which poses a risk to him or herself, staff, or others, a Confinement Review must be conducted.*	

According to the center's policy, confinements should not exceed twenty-four hours; however, if a youth continues to exhibit behavior which poses a risk to him or herself, staff, or others, a Confinement Review must be conducted. A review of confinements was conducted, the center did not have any occasions when a youth's confinement exceeded twenty-four hours. According to the superintendent interview, the center has not had any confinements over twenty-four hours during this annual compliance review period.

5.17 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 Continuity of Operations Planning (COOP) drills were reviewed. The center is required to conduct a COOP drill quarterly, the center conducted a total of six drills within the last year covering severe weather. Drills were conducted on each shift as required. Three drills were conducted prior to hurricane season as required. All COOP drills were placed in a binder. All staff on duty stated they participated in the COOP drills and is satisfied to how they were conducted. Each drill documented all the required information, including but not limited to, the type of drill, date and time, and participants.

5.18 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 center shall conduct and document quarterly mock escape drills.*	

The center has an Escape Prevention Plan and procedures which are incorporated with the Departments policies and procedures. The center utilizes a drill reporting form for all drills. The drills were completed quarterly as required on each shift. Drills were documented in the master control logbook. Five staff were interviewed, and all reported they participated in the drills and are aware of the procedure for the drills. The center did not have any escapes during this annual compliance review period.

5.19 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 utilizes a drill reporting form for all drills. Fire drills were reviewed for the past six months. All drills were completed for each shift and documented in the center's logbooks. Fire drills were conducted on each shift monthly as required. The center's fire procedure has been approved by the local fire marshal. All fire extinguishers were inspected annually. Five staff interviewed and indicated fire drills are conducted on a monthly basis.