STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

PROGRAM REPORT FOR

Manatee Regional Juvenile Detention Center

Department of Juvenile Justice
(State-Operated)
1803 5th Street West
Bradenton, Florida 34205

Review Date(s): September 25-28, 2018

PROMOTING CONTINUOUS IMPROVEMENT AND ACCOUNTABILITY
IN JUVENILE JUSTICE PROGRAMS AND SERVICES

Rating Definitions

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

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

Review Team

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

Toni Del Regno, Office of Program Accountability, Lead Reviewer (Standard 1)
Marvin Bliss, Office of Program Accountability, Regional Monitor, (Standard 5)
Christine Calvert-Joyner, Office of Program Accountability, Regional Monitor, (Standard 4)
Felicia Goldstein, Office of Program Accountability, Regional Monitor, (Standard 4)
Stephanie Lobzun, Office of Program Accountability, Regional Monitor, (Standard 3)
Joey Nice, West Region Education Coordinator (Standard 2 - Indicators 2.14 & 2.15)
Louise Quick-Hill, Orange Regional Juvenile Detention Center-Assistant Superintendent, (Standard 2)
Paul Sheffer, Office of Program Accountability, Regional Monitor, (Standard 5)

Program Name: Manatee Regional Juvenile Detention Center
Provider Name: State-Operated (DJJ)
Location: Manatee County / Circuit 12
Review Date(s): September 25-28, 2018

MQI Program Code: 298
Contract Number: N/A
Number of Beds: 60
Lead Reviewer Code: 147

Methodology

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

Persons Interviewed

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

Documents Reviewed

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

Surveys

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

Observations During Review

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

Comments

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

Standard 1: Management Accountability
Detention Rating Profile

Indicator Ratings

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

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

Standard 2: Youth Management
Detention Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Detention Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Detention Rating Profile

Indicator Ratings

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

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Overall Rating Summary for Standard 5

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

Standard 1: Management Accountability

Overview

Manatee Regional Juvenile Detention Center (MRJDC) is a sixty-bed hardware secure facility, maintained and operated by the Florida Department of Juvenile Justice (DJJ), located in Bradenton, Florida. The center's primary objective includes the provision of safe housing and essential services (medical, dietary, psychological and educational) for youth who are detained pursuant to court order awaiting disposition, delinquency adjudication, or placement in a residential commitment program. Historically, the center has primarily served youth who reside in Manatee, Sarasota, and Desoto counties; however, particularly in recent months, youth from neighboring counties primarily in Highlands and Polk counties are transported and detained at MRJDC. At the time of the annual compliance review, the center had five female and thirty-five male youth. The population of the center changed throughout the annual compliance review. The center administration team consist of a superintendent and two assistant superintendents to ensure the safe, efficient, and effective operation of the center and delivery of the essential services. The superintendent maintains the responsibility for the leadership and successful functioning of the center. The center's current superintendent was transferred from another detention center to MRJDC in May 2018. Additionally, one of the assistant superintendents recently returned to work after an extended leave and remains limited in the duties they can perform. The remaining assistant superintendent position became vacant during the week of the annual compliance review. A maintenance manager and food-service manager are additional members of the administration team. Other staff positions at the center include a fiscal secretary, an administrative assistant, a training coordinator, a detention review specialist, three food service workers, seven juvenile justice detention officer supervisors (JJDOS) and forty-six juvenile justice detention officers (JJDO). Due to significant staff turnover during the past year, many of the detention officers are new to their current positions. On the first day of the annual compliance review, the superintendent reported twelve staff vacancies consisting of an administrative assistant, one JJDOS, six JJDO II and four JJDO I positions.

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

The program has a written policy and procedures in place to ensure background screenings are conducted on all new staff, volunteers, and interns who will have access to the youth and/or their confidential information at the center. The policy was reviewed and found to be consistent with the Department standards requiring the screening to determine if the individuals meet established statutory standards. A review of twenty-one applicable background screenings found all individuals employed by the center since the last annual compliance review, were appropriately screened prior to their date of hire. These staff also completed pre-employment

assessments and obtained passing impact scores. Additionally, four contracted staff were also hired to provide services at the center. A review of the background screening process indicated three of the contracted staff were screened prior to hiring and one staff's screening was completed three days after hire, but prior to the staff interacting with youth or having access to youth confidential records. One volunteer was screened before permitted access to the youth and/or information about the youth in the center. The center did not have new mentors or interns since the last annual compliance review in August 2017. All twenty-six reviewed background screenings indicated the new staff and the volunteer received eligible ratings following the background screening process and none required consideration for exemption. The center provided documentation for review indicating, both the Annual Affidavit of Compliance with Level 2 Screening Standards and the Annual Affidavit of Compliance with Level 2 Screening Standards for School Board Personnel were submitted to the Department's Background Screening Unit (BSU) prior to the January 31, 2018 deadline.

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 program has a written policy and procedures for conducting a background rescreening for all applicable staff, volunteers, and interns every five years from the date of hire. The center had three staff and one contracted staff eligible for a five-year rescreening during the annual review period. All four required rescreens were completed within twelve months of the original hire date. Each of the applicable re-screens yielded results indicating eligibility for continued provision of services for the center.

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

The center has a policy requiring staff adhere to a code of conduct which prohibits any form of abuse, profanity, threats, harassment, intimidation, personal relationships with youth. A review of seven randomly selected staff personnel records found there was either a signed code of conduct form or a statement of personal responsibility, which referenced the staff's review of the code of conduct in six of the reviewed records. The exception was a new employee whose start date was August 31, 2018, after the Department implemented a computerized hiring process which completes documents with an electronic signature. The reviewer was able to access confirmation of the electronic signature of the code of conduct by contacting the human resources staff. One of the seven originally reviewed records documented disciplinary action. The staff received a verbal reprimand in January 2018 for violation of agency rules and demonstration of a lack of professionalism. In July 2018, the staff received another disciplinary referral related to the breach of confidentiality involving a youth at the center. The recommendation was for a three-day suspension. The center was able to provide two additional records for review. One of the three reviewed records documented an oral reprimand in April 2018 due to the staff's poor performance, inefficiency/inability to perform assigned duties, and violation of law or agency rules. The third reviewed record contained two separate disciplinary actions which included an oral reprimand in June 2018 for insubordination, conduct unbecoming of a public employee, negligence and poor performance. A second disciplinary action in July 2018, for allowing a detained youth unsupervised access to the Internet which resulted in the staff's termination of employment in August 2018. Each disciplinary action was observed to a prompt response from administration to the identified inappropriate behavior of staff. Two additional records were provided for review reflecting staff who were recognized by the Department during this review period. One staff was recognized as the Food Service Manager of the Year and was also selected for the Above and Beyond Award by the Assistant Secretary for Detention Services. The second reviewed personnel record documented a staff recognition as the central region employee of the second quarter of 2018. The superintendent also provided documentation for review indicating the nomination of three staff for employee of the month in June and July 2018. During the annual compliance review, interviews were conducted with seven randomly selected youth and seven staff. When asked regarding their experiences/observations of staff/youth interactions in the center, all seven youth indicated staff are consistently respectful when talking with youth and have never been threatened by a staff member, or observed another youth being threatened by staff in the center. None of the youth reported having been denied access to the abuse hotline. Two of the seven interviewed youth indicated they heard staff curse when speaking with another youth on a single occasion, both describing the curse word as not directed toward a youth in an abusive manner. All seven interviewed youth stated they feel safe in the center. Seven staff were interviewed and were able to explain the process for allowing youth access to the Florida Abuse Hotline or, if applicable the Central Communications Center (CCC) to report abuse and none reported any co-workers refusing a youth access to report abuse. Four of the seven interviewed staff indicated they heard staff use mild profanity in the presence of youth. Two reported hearing staff verbally use profanity on one occasion and two reported hearing staff use of profanity occasionally. None of the staff indicated the profanity they heard was intentionally abusive or humiliating for the youth who heard it but rather an unintentional conversational slip. During the staff interviews, five of seven staff described recent working conditions in the center as fair to poor, relating morale issues to staff shortages, feeling physically unsafe, and lacking the support of administration. Two staff rated the working conditions as good.

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

The center maintains a written policy and procedures addressing incident reporting to the Department's Central Communications Center (CCC) in accordance with Florida Administrative Code (F.A.C.) 63F-11. There were thirty-one CCC reportable incidents in the six months prior to the annual compliance review. A review of the center's logbooks, incident reports, and youth grievances did not reveal any additional CCC reportable incidents which were not reported. A sample of five reports was randomly selected for review. A review of the CCC reports confirmed it is the center's practice to contact the CCC to report incidents in a timely manner. Four of five of the reviewed reports were reported to the CCC within two-hours of the occurrence or the program becoming aware of the incident. One reviewed CCC report dated June 19, 2018 related to a Prison Rape Elimination Act (PREA) incident was found to have an incorrect incident time of 7:30 p.m. The incident as related in the body of the report states a youth made the allegation of the incident to center staff at 6:00 p.m. Subsequently, the CCC was contacted at 9:29 p.m. eighty-nine minutes beyond the required two-hour time frame. Three of the five reviewed CCC reports were observed documented in the master control logbook. Two of the five reviewed CCC reports dated July 16, 2018 and September 7, 2018 were not documented in the master control log.

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

The center maintains a written policy and procedures outlining the use of physical intervention techniques as indicated under the Department's approved Protective Action Response (PAR) matrix in accordance with the Florida Administrative Code (F.A.C.) 63H-1. A minor deficiency related to documentation of PAR reports was identified on August 31, 2018. During the past six months, PAR techniques were utilized at the center on seventy-two different occasions. The review team did not find any other incidents when PAR physical intervention techniques were used during their review of the center logbooks, incident reports, or grievance forms. There was a significant decrease in the number of PAR incidents compared to the number (138) reported during the last six months of the annual compliance review period for 2017-2018. A review of PAR reports verified the center's practice of maintaining all PAR reports in the Department's electronic database. A random sample of eight PAR reports was reviewed for compliance with Department requirements. None of the reviewed PAR incidents involved the use of mechanical restraints. Neither did any of the reviewed PAR reports reference allegations of abuse by the program staff or youth injury related to the PAR incident. One report indicated a staff injury occurred during the PAR. A review of reports to the Central Communications Center (CCC) verified this injury was promptly reported. One of the reviewed PAR reports did not include the required narratives of the incident by the two staff listed as actively involved and did include a narrative of the PAR by a staff not listed as involved. Two PAR reports indicated a medical review was necessary after the youth interview; however, the report documented no injuries to the youth occurred and there was no subsequent medical review. Two PAR reports did not

document review of the incident by either the acting supervisor at the time of the incident or the PAR certified staff. Neither was the youth post-PAR interview section completed on these reports. One PAR report was reviewed by administrative staff 2 hours and fifteen minutes late and one youth post-PAR interview occurred four minutes late. The administrative staff or designated reviewer did not document the needed corrections or inquire about missing information upon their review of the reports. All seven interviewed staff stated verbal interventions are consistently implemented prior to the initiation of a PAR. An interview with the superintendent confirmed the center's process for monitoring PAR incidents and use of use. The superintendent stated, all PAR incidents are reviewed and signed by a supervisor, PAR instructor, and an administrator within the designated timelines.

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

The center has a written policy and procedures in place which communicates the requirements of pre-service training staff to ensure all new staff are trained in accordance with the Florida Administrative Code within the first 180 days of hire. The policy states each staff must complete two phases of training including training in the workplace for on-the-job experiences and training at the Department of Juvenile Justice Academy. Phase One training includes training in essential skills which must be completed prior to the new staff having direct contact with youth or confidential youth records. Additionally, Phase One training includes a curriculum of coursework accessed through the Department's web-based Learning Management System (SkillPro) and through attendance in a standardized course of more experiential, instructor-led seminars. The coursework completed is documented on the annual pre-service training calendar approved by the Department's Office of Staff Development and Training. Phase Two training includes the completion of the training curriculum at the Academy. Seven applicable pre-service staff training records were reviewed to assess staff compliance with both the Department and the center training requirements. The hire dates of the staff records ranged from September 2017 to July 2018. All seven records contained documentation which indicated the completion of the essential skills component of phase one training. One staff lacked documentation in SkillPro regarding completion of first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator training (AED); however, a review of the training roster verified the training was completed within the required ninety days of hire. Six of the seven reviewed records documented staff completed all Phase One training with one minor exception. One staff did not have documentation of human trafficking training in SkillPro; however, the training coordinator verified the training was completed, but not recorded due to a glitch in SkillPro on the date of the training. Five of the seven reviewed training records were applicable for the required completion of Phase Two training within 180 days of hire. Each of these five records documented timely completion of Phase Two training and certification of the officers. There were two staff who must complete Phase Two training which have hire dates of June 22, 2018 and July 6, 2018, and appear to be on track to complete the training and earn certification within the 180-day timeframe.

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

The center has a written policy and procedures in place and maintains an annual training calendar to ensure staff are trained annually in mandatory topics Protective Action Response (PAR) update, cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), suicide prevention, and professionalism/ethics as specified in the Administrative Code and the Department's approved Detention Services Training Plan. Training opportunities are provided on the Department's web-based Learning Management System (SkillPro) as well as, more experiential instructor-led courses. A review of seven randomly selected staff training records for the calendar year of 2017 confirmed the completion of the required twenty-four hours of in-service training. The sample included one assistant superintendent, two shift supervisors, and four detention officers, all who have been employed at the center for three years or longer. A review of SkillPro documents and/or training records in each of the seven staff records reflected more than forty-five hours of completed training in 2017 for each staff member, almost double the required twenty-four hours. All training was inconsistently documented in SkillPro, the center was able to provide documentation indicating six of seven reviewed staff records met the requirement of twenty-four hours of in-service training in the mandatory topics specified in the Florida Administrative Code. The exception was the assistant superintendent, who had not completed the four hours of instructor-led suicide prevention/intervention training, and the two required hours of training on SkillPro on the same topic before going out on extended leave from the latter months of 2017 to summer 2018. All four detention officer staff completed all required in-service trainings, as well as, trainings on various elective topics. Supervisory staff are required to complete eight additional hours of training each year to enhance supervisory skills including leadership, personal accountability, management, employee relations, fiscal principles/practice, and/or communication skills. The review of the three training records of staff in supervisory positions indicated the assistant superintendent completed six of the eight hours of supervisory training prior to the extended leave. The two remaining reviewed records of supervisory staff found no documentation of completed supervisory training in 2017.

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

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

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

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

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

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

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

The center has a written policy and procedures for entering youth alerts into the Juvenile Justice Information System (JJIS). The policy outlines upon completion of the Admission Wizard, the detention officer conducting the admission shall ensure all critical and special alerts are posted in JJIS. Subsequently, the superintendent is to ensure all alerts are reviewed, and appropriately addressed and documented. Medical and mental health staff are also to review alerts related to their discipline and ensure each alert is tracked and managed correctly. Medical and mental health staff, as well as, detention staff, are to add alerts and update previously assigned alerts during the youth's stay in the center as appropriate. Six of the seven randomly selected sample of reviewed youth records were applicable for having at least one open alert identified in JJIS at some point during the youth's current detention stay. There was a total of ten open alerts for the six applicable youth. All medical alerts including those relating to allergies, were verified by the parent/guardian at intake. Documented alerts included one youth who were determined at risk for suicide upon admission, one youth with a vision deficit, one youth who is in foster care, two youth with a chronic medical condition (asthma), one youth with a no strenuous activity alert due to a suspected hernia, two youth prescribed medication, one youth who presented with a food allergy, one youth identified as requiring single room placement, and one youth who was placed on medical isolation for twenty-four hours were among the six youth applicable for alerts. A review of the center's Admission Wizard in JJIS, internal alert forms and module logbooks found each identified alert for the six reviewed youth was documented appropriately. Two of the eleven alerts required updating. One mental health update was completed by the licensed mental health clinician (LMHC) immediately following the completion of a suicide risk assessment. The other alert related to medical isolation was completed by the registered nurse (RN) once the youth's medical condition was treated. The responses and updates by medical, mental health and other staff who manage the alert information are documented by the appropriate staff address the alert in JJIS. The center's written policy and procedures also address how identified security risk, safety, and special needs alerts regarding youth are addressed and effectively communicated to the center staff. Reviewed shift briefing minutes, interview reports by seven staff, and the observation of a shift briefing, verified the open alert

report is reviewed before the start of each shift by the shift supervisors and all present juvenile justice detention officer staff. The supervisors then distribute copies of the alert list to the detention officers. A member of the review team attended a shift briefing during the annual compliance review and observed this practice. Additionally, when each of seven detention officers was interviewed, the reviewer requested a of the alert form staff receives at shift report for the day of interview, and each staff was able to do so.

Standard 2: Assessment and Performance Plan

Overview

The Manatee Regional Juvenile Detention Center staff use a standardized intake process utilizing the Department's Juvenile Justice Information System (JJIS) Detention Admission Wizard each time a youth is detained regardless the number of times the youth has been previously detained or the time of day/night the youth is admitted to the center. The center's release process has uniform procedures in place to ensure all essential tasks are completed before a youth is discharged from the center. After a youth is searched, their personal property is collected, inventoried, and secured. The youth is interviewed using specific screening tools, to obtain pertinent demographic, family contact, medical, mental health data, as well as, any issues/needs specific to the youth. The information accessed during this interview and during subsequent collateral contacts with parents/guardians, and on occasion, assigned juvenile probation officers (JPOs) is used to facilitate the classification process to determine the appropriate living unit and room assignment for a youth. Specialized alerts related to medical, mental health, substance abuse, dietary and/or other issues/needs are also documented once the information is obtained, and if applicable, confirmed by the youth's parent/guardian. All information obtained during the intake interview is entered into the JJIS through the Detention Intake Wizard. The intake process at the center also includes a comprehensive orientation to the facility and the services provided to the youth. The youth are educated about their rights and the grievance system, the program schedule, and the behavior management system (BMS) used in the center, as well as, how to access medical, mental health, and religious services during their detention stay. Educational services are available to all youth detained at the center through the Manatee County School Board. Teachers and classes are provided year-round and youth are able to earn credits for their school attendance and credits toward academic advancement/high school graduation for their involvement in school activities while in the center. The center conducts detention review hearings, with various staff weekly to assess the youth's adjustment and needs while in secure detention and to address updated information regarding the youth's behavior, needs, legal status, or anticipated release. Youth are released from detention pursuant to a signed court order. Once all of the requisite release procedures are completed and documented in the JJIS Detention Release Wizard, the youth is released. All youth who are younger than eighteen years old, are released to a parent or legal guardian whose identification is verified prior to granting access to the youth.

2.01 Admission	Satisfactory Compliance

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

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

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

Manatee Regional Juvenile Detention Center operates under the Facility Operating Procedures (FOP) for all juvenile detention centers in the state of Florida. The FOP's detail standardized admission procedures formulated in accordance with the Florida Administrative Code. All admissions take place in a designated intake area of the center which is separate from where the youth are housed. One of the initial tasks the juvenile justice detention officer (JJDO) conducting the admission is to complete a review of the required paperwork from the court, law enforcement, and the screening staff. Previous inactive records, if applicable, are also reviewed. The reviewer requested to observe an admission from start to finish during the week of the annual compliance review; however, the intake process had already started when the reviewer arrived to observe, and the JJDO already completed the admission procedures. A review of seven youth records revealed all seven contained an admissions packet which included copy of an arrest affidavit/custody order, a Detention Risk Assessment Instrument (DRAI), and a Suicide Risk Screening Instrument (SRSI); although, one youth record did not document review of the DRAI. It was evident the Detention Wizard was completed in each of the seven reviewed records. Documentation of three separate searches of the youth by a JJDO of the same gender, including a frisk-search, an electronic search, and full body search was observed in each of the seven reviewed records. All seven youth were offered the opportunity to make an intake telephone call; however, two youth were unable to complete the call after the JJDO attempted to contact the parent/legal guardian and was unable to do so. One record indicates an electronic message was left. Reviewed documentation in all seven youth records indicated each of the youth was offered a meal, regardless of the time of their admission. Each of the seven youth were screened by the JJDO for medical, mental health, and substance abuse needs. Each of the seven records also contained a Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) screening. Four of the seven reviewed records contained documentation the youth had been identified as being at risk of suicide upon their admission. All four youth at risk of suicide had documentation in their record if a referral for further assessment was made and each youth was placed on suicide precautions during the intake process until they were assessed by a licensed clinician or a non-licensed clinician under the supervision of a licensed clinician.

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

A review of the facility operating procedures indicates the provision of a comprehensive, documented orientation to each youth within twenty-four hours of arrival to the center is to occur after every admission. A review of seven youth records suggests it is center practice to provide the orientation as part of the admission process. All seven reviewed records confirmed each youth was oriented to the center within twenty-four hours of their admission. The orientation process is an interactive discussion between the youth and the juvenile justice detention officer (JJDO) which is documented on an orientation checklist and orientation review forms. The JJDO reviews facility rules, regulations and behavioral expectations with the youth, as well as, related positive and negative consequences for pro-social or misconduct describing the behavior management system (BMS) in detail, and the possibility of incurring new law violations related to aggression or destruction of property. All seven reviewed records documented the orientation process addressing verbally, and in writing, youth rights, the grievance procedures, how to access the Florida Abuse Hotline or Center Communication Center (CCC) to report any perceived abuse, youth access to medical and mental health services, and visitation and telephone calls with family members. The reviewer observed a JJDO providing an orientation to the youth. The orientation contained all the elements of the process as outlined in the facility operating procedures. The reviewer also observed the facility orientation videotape which reiterated the orientation information while also addressing other topics including the levels and level privileges of the facility BMS. Seven youth were interviewed regarding the orientation process they had upon admission to the center. Four youth recalled the orientation addressing all the required topics, while three youth stated they did not.

2.03 Classification	Satisfactory Compliance

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

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

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

The center's facility operating procedure outlines a classification process which takes place upon a youth's admission to ensure each youth is provided the highest level of safety and security during their detention stay. The classification determines the youth's room and whether or not the youth is assigned a roommate. The facility has procedures in place to reclassify any youth if their behavior while in the center or if new information is accessed which warrants change. Seven youth records were reviewed for documentation of the classification procedures. Each youth's record contained a copy of the individual booking classification form, and documentation in the Juvenile Justice Information System (JJIS) Detention Admission Wizard to facilitate the classification process. Each record also contained the Victimization and Sexually Aggressive Behavior Scale (VSAB) which assesses a youth's vulnerability to victimization and risk for sexually aggressive behaviors through self-report and contact with collateral sources. Detention policy requires significant information is considered before a youth is assigned to a room including the youth's age and physical characteristics, such as: weight, height, and the presence of any overt physical or developmental disabilities or abnormalities which might provoke bullying/ridicule by other youth. Also considered during the classification process is the youth's known history of aggression and/or violent behavior, criminal behavior and types of offenses, including sexual offenses or hate crimes against a particular group of people, the youth's escape history, and gang affiliation, the youth's intellectual concerns, mental health issues, and/or any indication of suicide risk. Each of the seven reviewed records documented the classification process was conducted and each youth was assigned a room based on their classification. One youth had a history of committing a sexual offense was placed in a single room. All seven reviewed youth records documented the shift supervisor signed the bottom of the Admission Wizard form including the youth's room assignment based on the classification process. One reviewed record documented a change in the youth's classification during their stay in the center due to aggressive behavior, substantiating the process to reclassify a youth.

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

The center's facility operating procedures addresses the need to identify street gang members and/or youth claim affiliation with a gang or who engage in gang-associated behaviors. The Detention Intake Wizard and other screening tools, utilized during the admission screening process seeks to identify youth who are involved in gang activities or engage in gang-related behaviors. A review of seven youth records documented each of the youth were screened for gang affiliation/membership during the admission process. None of the seven youth records reflected the youth was associated with any street gang or suspected of engaging in gang-related activities. All youth are observed during their detention stay for gang-related behaviors, including flashing signs, making drawings, or attempting to modify their clothing. If a youth is suspected of gang involvement, a reclassification process is in place to have the youth interviewed by the facility gang representative and, if applicable, document the suspected gang involvement in the Juvenile Justice Information System (JJIS). The review team found the center had no new youth identified as a gang member or suspected of gang affiliation during the annual compliance review period. Youth who are admitted with gang alerts on their Department of Juvenile Justice Face Sheets are monitored for gang-associated behaviors while in the center. All information regarding a youth's suspected or confirmed gang involvement is shared internally, through entries in center logbooks, the facility alert report which is reviewed with detention officers at every shift change, and the youth management/conduct card maintained by staff who are made known of the youth's potential to engage in gang-related behaviors while in the center.

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

Review of the center's facility operating procedures supports the detention center staff will notify a youth's suspected street gang activity or gang membership to the designated circuit's gang representative juvenile probation officer by email, copying the shift supervisor, and the superintendent. Any indications of a youth participating in gang activities while at the center to include presenting with gang tattoos, flashing gang signs, or creating gang-related drawings or graffiti should be detailed in writing, photographed, and emailed to the identified circuit gang representative. The detention staff are to then document the suspected gang member alert in the Juvenile Justice Information System(JJIS). A review of seven youth records documented none of the seven youth was suspected of being affiliated with any street gang or a documented

gang member. The review team found the center had no new youth identified as a gang member or suspected of gang affiliation during the annual compliance review period. Therefore, there was no documentation to review to verify the program practice of making notification of a youth's gang involvement. There is a policy in place which communicates all required procedures. All seven interviewed staff indicated their awareness in monitoring youth for gang-related behavior. Additionally, a review of all seven staff in-service records documented staff completion of gang awareness training during the last full calendar year.

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

The center's facility operating procedure addresses the handling of youth's personal property during admission ensuring staff accountability for the security and proper handling of a youth's personal property. As part of the admission process, all youth personal property including clothing is taken from the youth prior to the youth showering. All surrendered items are recorded on the Property Receipt Form. This form documents the youth's name, identification number, the date and time the item is surrendered, an item description, the number of each item, and the total number of items placed in a mesh bag. The youth and the juvenile justice detention officer (JJDO) sign the property receipt and the JJDO will place the receipt in the bag. Seven youth records were reviewed for the inclusion of a personal property receipt form itemizing all personal property surrendered to the JJDO by the youth at admission. All seven records contained the form, each signed by the JJDO who completed the form; however, only five of seven personal property receipt forms were signed by the youth. There was no documentation indicating why the two youth did not sign the form or clarifying a youth refusal to sign. All valuable items, including electronic devices such as cellular phones, cash and/or jewelry are verified, placed in a clear tamper-proof plastic bag, which also includes the valuable Property Receipt Form, which lists each item in the bag and placed in the center safe. All bags placed in the safe are logged into the safe logbook with the appropriate staff credentials. Only one youth was applicable for the surrender of valuable property. All required procedures regarding valuable property was documented in the youth's record. Each of seven reviewed records also contained the required letter of acknowledgement regarding unclaimed property signed by the youth. All seven interviewed youth indicated upon their arrival at the center, their personal property was checked, they signed a form which correctly listed their personal property, a copy was placed in the bag with their belongings, and a copy in their record.

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

The center has a written policy and procedures pertaining to the maintenance of inventory and the safekeeping of a youth's valuable and personal property upon admission to the center. Each youth's property is kept safe and secure, until it is returned to the youth and/or their parent/guardian. The reviewer observed the storage and security of youth personal property. Observations found all youth property deemed non-valuable such as clothing, shoes, and documents, stored in bags along with a copy of the personal Property Receipt Form, which serves as an inventory of the items. Each bag is placed in a secure locker, located in a locked room accessible only to juvenile detention officer supervisors (JJDOS) and the center

administrators. Valuable property (electronics, cash, jewelry, cell phones) are securely stored in clear tamper- proof bags which contain an inventory of property documented on the valuable Property Receipt Form. The bags are placed in a drop safe in a room accessible only to designated staff where there is video surveillance monitoring entry. A log of items in the drop safe is maintained and upon review, found to accurately document the contents of the safe. The center did not have any incident or Central Communications Center (CCC) reports during the annual compliance review period which involved reports addressing missing or stolen youth property or improper release of a youth's property.

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

The center has a written policy and procedures to ensure all youth are released from the detention center appropriately and promptly once the court authorizes the release while safeguarding against the negligent release of a youth. A review of seven closed records verified the juvenile justice detention officers (JJDO) are consistently adhering to the required procedures regarding a youth release. Each of the seven reviewed records indicated the on-duty juvenile justice detention officer supervisor (JJDOS) reviewed all paperwork related to the release to start the release process. This paperwork included the court order, or in absence of a written order, documentation of a verbal order in open court and photographic verification of the youth's identity. Furthermore, the JJDOS is responsible for ensuring there are no holds, active court orders or other legal reasons not to release the youth. Any questions concerning the release is addressed with the superintendent prior to the release. All seven reviewed closed records indicated the youth's identification was verified prior to each youth's release and the identification of each parent/ guardian of each youth was also verified prior to the youth's release. There was a photocopy of the parent/guardian identification card in each reviewed closed record. The reviewed sample of closed records did not include any youth over the age of eighteen years. Additional documentation in each record indicated the parent/guardian and youth signed all applicable release forms. The youth and parent were reminded of upcoming court hearings in all five of the five applicable records. There were no future court dates related to the two remaining records. A review of the dates of release in the seven youth records matched with the Department's Juvenile Justice Information System (JJIS). There were no reports to the Central Communication Center (CCC) involving an unauthorized release from the center.

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

The center's facility operating procedures documents a policy and procedures in place regarding the release of a youth's personal property upon their release from the center. A review of seven closed youth records confirmed each contained property receipts (personal and/or valuable) completed when the youth was admitted to the center. Each form was signed by the youth on the date of release in acknowledgement of receipt of all property surrendered during the admission process. All of the youth represented in the reviewed closed records were under the age of eighteen, the reviewed forms were signed by the youth's parent/guardian, indicating all the youth's personal property was returned to the parent/guardian upon the youth's release. Normally, when a youth is release, the release occurs at court. the youth does not return to the center to be released. All property is brought to court for relinquishment to the youth and the parent/guardian, in case the court orders the release of the youth If the release is ordered, the youth is provided their personal clothing to change into prior to leaving the court with their parent/guardian. During the week of the annual compliance review, there were no unclaimed youth personal property at the center. During an interview with the training coordinator, the center's practice for purging unclaimed personal property was explored and outlined. All unclaimed property is maintained in secure lockers, or if deemed of value, the safe in the property room. The center mails notices of impending disposal of property to the addresses of the youth whom property is left at the center along with a request for pick-up. No property is held more than thirty days post release. The center did not have to dispose of property since before the last annual compliance review in August 2017.

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

The center's facility operating procedures documents policy and procedures in place regarding the release of a youth's medication upon their release from the center. Three closed youth individual healthcare records, applicable for the release of youth medication and medical/aftercare instructions were reviewed. Each of the records contained a Department's Medication Receipt, Transfer & Disposition form 053 signed by the youth's parent/guardian. Form 053 listed the name of each medication the youth was prescribed and the quantity of each medication being returned upon the youth's release. The parent/guardian signature affirmed their receipt of the medication. The parent/guardian identity was verified upon release and a photographic copy of their identification was found in the youth record. Also observed in each youth individual healthcare record was the completed Department's Health Discharge Summary Transfer Note form 012. This form requires the medical staff to complete a list of medications prescribed to the youth copied exactly as the medication order is written and specific medical/aftercare instructions regarding the ongoing use of the medication and/or any other known health concerns. The form also lists any pending appointments. A copy of this reviewed form was provided to the parent/legal guardian of each of the three youth in the reviewed sample of the closed records.

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

The center facility operating procedures establishes a process for weekly detention reviews to ensure proper management of all youth placed in secure and/or home detention. The reviews are also conducted to serve as a communication forum regarding the youth between detention staff, probation officers, and commitment managers, if applicable. The detention review process was observed for youth in detention and on home detention during the week of the annual compliance review. Present for the review meeting was the detention review specialist, who conducted the meeting, the superintendent and assistant superintendent of Manatee Regional Juvenile Detention Center, and representatives from medical, mental health and education staff at the center. Present by telephone conference was the assistant chief probation officer for Manatee County. An attendance roster was signed by all present and the names listed for all who participated in the review meeting. The observed discussion covered each youth, including youth in Manatee County and one youth from out of state. The discussions involved the projected release dates, court updates, and when applicable, electronic commitment packet needs for youth pending placement to a residential program, alert updates, medical concerns, mental health and substance abuse issues, gang involvement, and education. A review of documentation from the past six months confirmed these reviews are conducted weekly and are well attended.

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

A review of the facility operating procedure for detention services requires each detention center keep youth in their care constructively involved throughout each day with a schedule which incorporates, both structured and free time. The daily schedule includes times for the following activities: sleeping and waking hours, personal hygiene, meals, medical and mental health needs, education, recreational, and other activities which are documented on a daily activity schedule. It was observed during the facility tour a posted copy of the daily activity schedule in each module accessible for youth to review. A review of the program schedule for the center document the times and activities for each day of the week. The schedule was observed to include time frames for all but two of the activities the center is required to provide including personal hygiene, meals/snacks, visitation, five hours of education for five days weekly, recreational/physical activities, and indoor activities promoting educational and problem-solving skills such as life skills training to include reading and audiovisual programming. The center also has designated times on the schedule each day for youth participation in education detention curriculum groups, which address a variety of topics including: anger management, how thoughts generate emotions and behaviors, and active listening; which are designed to help the youth choose to act more responsibly in everyday life situations, including interpersonal relationships. Additional activities including opportunities to attend religious services, module clean-up, outgoing telephone calls, letter writing, and behavior management system (BMS) reinforcement activities are also observed on the reviewed schedule. The following required elements were missing from the schedule which included specific times identified for gender-specific programming for at-risk girls and boys, restorative justice programming to enhance

youth accountability for their actions, community safety, and youth competency development. There was no documentation or curriculum available for review to substantiate if either programming is routinely occurring at the center. The gender-specific programming is to include topics such as the various kinds of abuse, high-risk sexual behaviors, mental health and substance abuse issues and gang activity. Seven interviewed staff were asked about gender-specific programming being offered as part of the daily schedule. Four of the staff responded the programming is being offered, and three either did not know or asserted gender-specific programming was not available to the youth. Four staff responded positively and commented they were not sure on the provisions of gender-specific programming and listed examples of activities the youth participate in within their modules which are separated by gender. The examples provided by the staff included anger management groups, sexual education, and personal hygiene groups. An interview with seven youth confirmed their awareness the facility has a daily schedule and a copy of the schedule is posted in their assigned living module.

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

An observation of the center's daily schedule is posted in all youth modules, and includes the designated specific times and activities for all youth activities from morning to lock down to evening/nighttime. A review of the center's master control and living module logbooks indicated there were significant discrepancies between the posted schedule and the actual experience of the youth, in part, due to the numerous staff vacancies, as well as, the need to adequately staff youth transports during the daytime hours. There has been the need to initiate rolling lockdowns to ensure the safety and security of the youth, staff, and facility. It is clear, many of the daily schedule activity times were not adhered to regularly. A review of master control logbooks indicated the program deviates from the posted youth activity schedule on a regular basis. The logbook review found the staff were not consistently documenting activities for youth within the module, contrary to the center's policy which indicates all activities of hygiene, education, and letter writing are to be documented in the living module logbooks. The logbook reflected activities such as education activities either starting late, ending early, or not occurring at all and there is a failure to consistently document reasons for the change to the schedule. Youth participated in outside recreation and/or indoor large muscle activities four of six scheduled times during the period of July 25-30, 2018 and ten of twenty-nine times during the period of August 1-29, 2018. Additionally, the reviewed logbooks show frequent delays (compared to the designated times on the schedule) in the provision of meals, as youth are served meals in their rooms rather than the cafeteria during rolling lock downs. A comparison of the posted schedule and seven module logbooks for seven randomly selected days found several inconsistencies were noted in each day in regard to actual meal times, classroom times, shower times, and recreation times. There were several instances when a youth or group of youth was documented engaging in one activity when the schedule indicated they were involved in another. Showers were started in the module at various times during the afternoon/evening (4:03 p.m., 3:30 p.m., 4:50, p.m., 3:47 p.m., 5:56 p.m., 3:20 p.m., and one day no showers were documented). The schedule clearly states the modules are locked down and showers are to begin at 8:00 p.m. Group movements were typically documented, several activities were not,

making it difficult to determine from reviewing the log book if the activity occurred or when the activity may have occurred. Reviewed logbooks also did not reflect the daily occurrence of life skill or education detention curriculum groups as scheduled. There was no documentation to indicate why the times of the activities were changed or cancelled. During the annual compliance review, female youth were observed outside on the recreation field when the posted schedule indicated they should be in school. Seven interviewed youth were asked if the daily activity schedule is followed consistently. Six of the youth responded affirmatively, while one youth stated the schedule is not followed when the program is short-staffed. Five of seven interviewed staff responded yes when asked if the daily activity schedule is followed. All seven staff commented on the effect of short-staffing and subsequent lock down of youth in their rooms. The seven interviewed staff continued to report major variances in what actual occurs to the posted schedule, such as reporting the youth only attend school half-days on Fridays when the schedule states youth attends school for five hours.

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

The center provides educational access to detained youth through a written cooperative agreement with the Manatee County School Board. The board provides teachers who offer educational instruction and the opportunity for youth to earn credit for their attendance and performance as if they were attending school within the community. The center operates on a year-round academic calendar, in which educational instruction is consistently available to the youth when admitted to the center. The calendar provides for educational and career related instruction for a total of two hundred fifty days annually and a minimum of twenty-five hours weekly. The posted daily activity schedule in the center designates five hours each weekday to youth attendance in school. Interviews and a review of the center log logbooks indicate the youth in the center are not consistently accessing the required five hours of educational services each weekday. An interview with the lead teacher indicated there is a significant disruption in youth access to education at the facility due to staff shortages. Youth escorted to class is an increasingly common occurrence for the past four weeks and is an intermittent problem during the summer months. A review of the master control and unit logbook documentation presents inconsistencies and illegible writing, making it difficult to fully understand which modules are moving to class and when the movement is occurring. There is; however, sufficient evidence in the logbook which is clear youth are not consistently moving in accordance with the daily activity schedule. Review of the master control logbook indicated youth attended class four times during the week of July 23-27, 2018, three times during the week of July 30, 2018 through August 3, 2018 and two times for the week of August 6-10, 2018. Youth attended class only three of five days for the remaining three weeks of August 2018. The logbook review further indicated the center staff does not consistently ensure youth are available to the teachers for classes as scheduled at 8:30 a.m. or after lunch. This complicates the youth's access to educational services. A review of the sign in/out logs indicated eight of fifteen reviewed instances when the teachers left the facility prior to the 2:30 p.m., the school dismissal time. Staff interviews support these findings. Two of the staff stated during the interviews female youth in the center do not return to class after lunch on Fridays. This statement was consistent with the review team observation on Friday during the week of the annual compliance review. The female youth were outside when the daily activity schedule indicated the youth should be in school. Another interviewed staff indicated only some youth attend class on Fridays when the teachers show movies. Staff indicated the youth in B1 are typically the commitment kids who are there for

extended periods and often miss school on Fridays when the teachers show movies because these youth tend to be disruptive in class. Generally, not the staff module because the male youth in module B1 are prone to being disruptive and the teachers prefer they not attend the movie activity. Four of seven interviewed youth indicated they attend school Monday through Friday at the center. Two of three interviewed youth responded they do not attend school five days a week consistently. The youth also indicated, Friday is movie day in class and Friday their assigned module (B1) doesn't attend school on Friday's. They have attended movie day one time in forty-seven days. The remaining youth indicated they attend school daily Monday through Friday, when not on lock down." Seven of the interviewed youth indicated they attend a history class while at the center, six reported they attend math and reading classes, and two youth indicated they attend science class. Two youth indicated they attended school for one day.

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

The center provides Type 1 career education programming based on the age, assessed educational abilities, the goals of the youth and the typical length of stay to which each youth is assigned. The center's educational program provides an orientation to a broad scope of career choices, based on personal abilities, aptitudes, and interests. The programing integrates personal accountability with the development of competency in requisite skills and behaviors appropriate for youth in all age groups and ability levels to learn. The development of the necessary social, interpersonal, decision-making and problem-solving skills is emphasized to encourage work habits to help a youth access and maintain employment.

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

A review of the facility operating procedure for Detention Services outlines a behavior management system (BMS) which is implemented in all detention centers, statewide. The BMS is designed to foster in youth a sense of accountability for one's own choices, attitudes, and behaviors, while providing predictable rewards, privileges, and consequences to encourage each youth to meet center expectations. All youth are educated on the BMS upon admission and orientation. Additionally, behavioral norms and center expectations regarding youth behavior posted in all living areas. A review of seven randomly selected youth records indicated there is a signed acknowledgement by each youth indicating they were educated about the BMS during the orientation process. Posters regarding the BMS were observed by members of the review team in two of the three open living modules during the annual compliance review. The exception was module B1 where observations of postings regarding the behavioral expectations or the reinforcers of the BMS. Each module was also observed to have a whiteboard listing the name of the youth and their current level. The center's BMS is a three-tier

system for rewarding a youth's positive behavior, ranging from level one to level three. The system's three levels include rewards for positive behavior and consequences for negative behavior. Youth move up and down the levels based on their behavior and responsiveness to staff directions. The BMS is designed to promote youth compliance with the rules and regulations of the center while teaching them alternative pro-social methods of dealing with problems and accessing rewards, privileges, consequences, safety, and security. Consequences have a direct association with the behaviors displayed and are fair and reasonable. As a result of negative behavior, a youth's level may be dropped. The center has developed and use youth management/conduct cards to track the behaviors and levels of each youth. The conduct card also tracks warnings given to the youth by the detention staff regarding their conduct and rationales for level drops and other consequences. Rewards the youth can earn with level advancement are extra phone calls, extra snacks, later bedtime, choice of movies shown to the group, participation in special events including level parties, and canteen. Seven youth were interviewed regarding the BMS. One youth rated the system as poor, two rated the system fair, three rated the system as good, and one youth rated the system as very good. When asked about the fairness of negative consequences they received, four of the interviewed youth stated the consequences were fair. Three youth stated they never earned or received a consequence of the BMS. Seven staff were interviewed and four stated the BMS is effective in encouraging youth to meet behavioral expectations of the center. Three staff disagreed; however, four of the seven interviewed staff commented negatively, emphasizing on the recent lockdowns where youth does not get special privileges. The staff indicated the center does not follow the BMS by enforcing the consequences for negative behavior. "the youth aren't really getting any special privileges," "It (the BMS) would if we followed it, the girls have level three blankets and when we take the level down they keep the blankets." "Yes, but the kids get upset when they don't get the privileges they earned." The youth seem to not care about the BMS, it does not motivate them. "The staff indicated the center need more motivating consequences such as little or no playing time with video games. All seven staff were asked if staff speak to youth to discuss the imposed consequences. All seven staff stated, "yes." All seven staff also confirmed youth are given an opportunity to explain their behaviors and staff speak with youth about alternative, acceptable behaviors. Six of the seven interviewed staff agreed supervisors provide feedback to them regarding their implementation of the BMS, as needed. One staff denied ever receiving supervisory feedback regarding their practices related to the BMS.

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

A review of the center's facility operating procedures regarding the behavior management system fully addresses the concept of types of punishment the centers prohibit including the use of drugs/medications to control a youth's behavior, the use of corporal punishment, and the use of group punishment. During the annual compliance review, there were no documentation indicating any of these prohibited forms of punishment were implemented. Neither did staff or youth interviews indicate unauthorized use of punishment. There were no allegations reported to the Central Communications Center (CCC) or the Florida Abuse Hotline regarding the use of corporal punishment, group punishment, or the use of medication to control a youth's ability to act out or to manage the youth's behavior. Seven interviewed youth were asked if handcuffs or leg irons are used on out of control youth to prevent them from hurting themselves or others. Five youth stated mechanical restraints are not used for those reasons. Two youth stated they never witnessed a youth placed in mechanical restraints. Four interviewed youth stated they were never sent to their room for punishment, three stated they have. Follow-up revealed the three youth were placed in confinement in their rooms rather than a designated confinement room in compliance with detention policy and procedure. The facility operating procedures also prohibit the practice of permitting a youth to impose discipline on another youth. A review of the center's documentation, including logbooks and point cards, along with youth and staff interviews, confirmed only staff have the authority or ability to discipline youth at the center. Seven interviewed youth each reported they never seen a youth allowed to punish another youth. The consequences of a youth's failure to meet behavioral expectations are not to in any way to inhibit a youth's access to food, including snacks, sleep, clothing, or bedding or medical/educational services. Seven interviewed youth were asked when consequences were given and what was taken. Four youth experienced a behavioral management system (BMS) consequence indicating the consequence took away points and a level. None of the youth reported not having food, sleep, clothing or bedding, medical services, or school taken away as a consequence of the BMS. An interview with seven staff confirmed consequences for inappropriate behavior does not include the loss of meals, snacks, sleep, or school. Six of the seven interviewed staff indicated they never observed another staff take meals, snacks, clothing, bedding or education services away from a youth as a form of punishment. The exception was a staff who in describing a youth placed in confinement indicated the ability for the youth to attend school was taken away. None of the seven staff indicated they never heard of other staff encouraging a youth to fight with another youth.

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

The detention center has facility operating procedures addressing a three-phase youth grievance procedure ensuring youth have the right to file a grievance, if they feel their rights have been violated and/or they have been treated unfairly while in the center. Once a youth completes a grievance form, the staff records the grievance onto the grievance form in the Facility Management System (FMS). The process includes the administrative staff escalating

the grievance if not resolved in the informal phase. The center did not have any grievances during this review period according to staff report and review of the FMS. An interview with seven youth indicated they never filed a grievance. All youth are informed of their basic rights during the orientation process. A review of seven randomly selected youth records indicated there was a signed acknowledgement by each youth indicating they were educated of their rights and on the grievance process during their orientation to the center. The review team observed grievance forms available to all youth on the living modules. All staff completed training regarding the center's grievance process during pre-service training. However, three of the seven interviewed staff indicated if received a grievance from a youth, they would give it to their supervisor. These three staff did not seem able to identify the three phases of the grievance process or the timeframes associated with the process.

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

The center requires all staff to complete training regarding the principles of trauma informed care. A review of seven staff pre-service training records verified each of the staff completed the training prior to certification. Additionally, a review of seven in-service training records indicated each of the staff completed training regarding trauma informed care as part of their annual in-service training. There was limited documentation provided to the review team to support the facility is consistently incorporating trauma informed practice into current operations. Trauma informed care is a practice designed to deliver services and provide care to all youth in custody, acknowledging the role violence and victimization play in the lives of most of the youth entering the facility. The review team was unable to find a facility operating procedure regarding trauma informed care outlining how the center implement such care to all youth whether a past trauma was identified for the youth or to eliminate the risk of causing further trauma. During an interview with the superintendent, the question was asked on the implementation of trauma informed practices. The superintended explained, youth with identified trauma issues are treated on an individual basis. As an example, some youth are allowed to sleep outside the room, if the designated mental health clinician authority (DMHCA) or mental health staff deems it necessary to accommodate the trauma related mental health issue. The facility is being painted in non-institutional colors to reduce the intimidation factor. Female youth are provided with pajamas to sleep in. One component of providing trauma informed care is the provision of a "soft room", where youth are able to access a comfortable space to process difficult news received from home, to discuss intense emotions, or to facilitate relaxation. The center currently does not have a soft room for trauma-informed care practices, counseling, and de-escalation of agitated or anxious youth. Another component of trauma informed care is the use of paint in soothing colors

to help promote a feeling of calm. The female module, which was recently repainted/redecorated, is painted in the colors of pink and lavender. The male module which is currently being repainted/redecorated with the inside of the rooms is being painted in vibrant, stimulating shade of yellow-green colors.

Standard 3: Mental Health and Substance Abuse Services

Overview

The Manatee Regional Juvenile Detention Center contracts with Camelot Community Care, Inc. to provide mental health and substance abuse services to the youth at the detention center. The center's clinical team is comprised of a regional mental health coordinator, designated mental health clinician, a part-time licensed mental health clinician, one full time non-licensed clinician, and two part-time non-licensed clinicians. Camelot contracts with two licensed psychiatrists to provide psychiatrist services to the youth at the center. The two psychiatrist's alternate weeks and one of the psychiatrists is on-site weekly. During the review, the team was advised one of the psychiatrists resigned their position and Camelot advised they would provide the center with another psychiatrist to fill in the weeks the psychiatrist is scheduled to be on-site. The clinical team provides weekly life skills groups, individual counseling, mental health and substance abuse evaluations, suicide prevention services, treatment planning and medication management to the youth at the center.

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

The center contracts with Camelot Community Care, Inc. to provide mental health and substance abuse services to the youth at the center. The program has a licensed marriage and family therapist who is identified as the program's designated mental health clinician (DMHCA). The DMHCA has a back-up licensed mental health counselor (LMHC) who provides services during the DMHCA absence A review of the Florida Department of Health Medical Quality Assurance Search website indicated the DMHCA, as well as the LMHC both have clear and active licenses in the state of Florida. The DHMC and the LMHC licenses expire on March 31, 2019. A review of the centers mental health sign-in and sign-out book indicated the DMHCA or the LMHC is on-site weekly, which has allowed for sufficient time to coordinate and implement mental health and substance abuse services. During an interview with the DMHCA, who is a consultant and provide expertise on mental health issues in the facility. The DMHCA complete assessments, crisis assessments, individual counseling, group counseling, and family counseling, and assess youth for suicidal thoughts. The DMHCA is also responsible for the coordination and facilitation of weekly psychiatric treatment team meetings held at the center. The DMHCA collaborates with the juvenile probation officers (JPOs), and case managers to link youth with specific services and resources in the community.

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

Camelot Community Care has two licensed professionals providing services at the center. The first licensed professional acts as the center's designated mental health clinician authority (DMHCA) and are a licensed marriage and family therapist. The second licensed professional is a licensed mental health counselor (LMHC). According to the Florida Department of Health Medical Quality Assurance Search website both licensed professionals have clear and active licenses in the state of Florida.

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

Camelot Community Care, Inc. contracts with three non-licensed professionals to provided mental health and substance abuse services to the youth at the center. Camelot is currently not licensed for substance abuse services under Chapter 397; however, they are currently in the application process with the Department of Children and Families (DCF) to gain licensure under Chapter 397. The licensed professionals are the only clinicians providing substance abuse services to the youth at center. A review of the three non-licensed clinician's personnel records revealed one of the clinicians holds a master's-level degree in counseling psychology, one holds a master's-level degree in mental health counseling, and the third non-licensed clinician holds a master's-level degree in rehabilitation counseling. A review of each non-licensed clinicians training records revealed each had twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. The training also included the administration of at least five assessments of suicide risk conducted under the supervision of a licensed professional. A review of the program's clinical supervision logs for the six months prior to the annual review indicated all three non-licensed clinicians received weekly supervision. All supervision was provided to the non-licensed clinicians by the designated mental health clinician authority (DMHCA) or the licensed mental health counselor (LMHC) every week services were provided to the youth at the center. Weekly documentation included the date the supervision was held, time and hours supervision were provided, names of clinicians in attendance, signatures of the attendees, and the signature of the licensed professional who provided the supervision. There were five instances where one attendee did not sign the weekly supervision log; however, the DMHCA had the non-licensed staff sign the supervision logs during the review. The weekly supervision documentation also contained a summary of the supervision session, instructions and directions to the clinicians and a review of sample treatment or summary notes.

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

The center has facility operating procedures in place outlining the center's process for completing mental health and substance abuse screening on all youth upon their admission to the center. A review of seven mental health and substance abuse records revealed all youth were presented to the detention center with a completed positive achievement change tool (PACT) mental health and substance abuse screening form, suicide risk screening instrument (SRSI), the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2), and the screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB), which were all completed by the juvenile assessment center staff. Each of the seven records revealed the designated mental health clinician authority (DMHCA) conducted a review of all the above listed forms upon each youth's admission to the center. Four of the seven reviewed records contained documentation on one or more of the above listed forms in which the youth were identified as being at risk of suicide upon their admission. All four youth at risk of suicide had documentation in their record, a referral for further assessment was made, and were placed on suicide precautions. An interview with the centers superintendent indicated each youth who enters the center are initially screened on the SRSI by a juvenile detention officer (JDO) and then the mental health staff complete a portion of the SRSI. The superintendent also indicated each youth is assessed by mental health staff using a variety of instruments including an assessment of suicide risk, follow-up assessment of suicide risk, and crisis assessment forms.

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

The center has facility operating procedures in place outlining the center's process for obtaining or completing a mental health and substance abuse evaluation on youth at the center. A review of seven mental health and substance abuse records revealed five youth were applicable for the completion of a mental health and substance abuse evaluation. Four of the five records contained a copy of a current evaluation completed by a community provider. All four records contained a chronological note documenting the designated mental health clinician authority (DMHCA) received and reviewed each of the community evaluations. The fifth record contained a completed mental health and substance evaluation completed by the DMHCA on the youth's twenty-sixth day in detention. The center provided the review team with copies of three mental health and substance abuse evaluations completed by the center's clinicians. The evaluations were completed on youth who were in the center for a minimum of thirty-one days. Two of the evaluations were completed by the DMHCA and both evaluations were completed prior to the youth's thirty-first day in detention. The third evaluation was completed by a non-licensed clinician and was reviewed by the licensed clinician the same day the evaluation was completed. The evaluation was also completed prior to the youth's thirty-first day in detention.

3.06 Mental Health and Substance Abuse Treatment [Detention Staff/Contract Provider]	Satisfactory Compliance

Mental health and substance abuse treatment planning in departmental facilities focuses on providing mental health and/or substance abuse interventions which will reduce or alleviate the youth's symptoms of mental disorder or substance abuse impairment and enable youth to function adequately in the juvenile justice setting.

Each youth determined to need mental health treatment, including treatment with psychotropic medication, or substance abuse treatment while in a detention center, must be assigned to a mini-treatment team.

The center has facility operating procedures outlining the center's process regarding mental health and substance abuse treatment services. A review of seven mental health and substance abuse records revealed six youth were applicable for receiving mental health and substance abuse services. The six applicable records revealed all youth were assigned to a mini-treatment team, which consisted of mental health clinical staff, education staff, medical staff, the youth, a juvenile detention officer (JDO) and the youth's parent/guardian, if available. Four of the six applicable youth were receiving group treatment, three of the six youth were receiving individualized treatment, and two of the six youth were received supportive services. All seven reviewed records had a properly executed Authorization for Evaluation and Treatment (AET). All seven records had a signed consent for substance abuse treatment and a signed consent for the release of substance abuse treatment records. All six applicable youth who were receiving services had treatment notes from a clinical completed on the Department's Mental Health and Substance Abuse (MHSA) form 018, titled counseling/therapy progress note. A review of sign-in sheets for group treatment revealed the center does not conduct substance abuse groups and the mental health groups are limited to ten or less youth. Seven youth were interviewed about the mental health and substance abuse services in the center. Two of the seven youth indicated the mental health and substance abuse services at the center are good, three rated the services as very good and two youth indicated they are not receiving services. An interview with the designated mental health clinician authority (DMHCA) indicated the clinical staff conduct individual sessions with youth, provide group treatment such as anger management, grief groups and life skills group. The DMHCA also indicated the clinicians provide cognitive behavior therapy (CBT), trauma-focused CBT, and solution focused groups.

3.07 Treatment and Discharge Planning [Contract Provider]	Satisfactory Compliance

The superintendent and DMHCA or mental health and substance abuse clinical staff are responsible for ensuring the development and review of an initial and/or individualized mental health/substance abuse treatment plan for each youth receiving mental health and/or substance abuse treatment in the facility.

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

The center has facility operating procedures which address mental health and substance abuse services provided to the youth at the center, as well as discharge procedures for youth who were receiving mental health and substance abuse services at the center. Seven youth mental health and substance abuse records were reviewed, and five records were applicable for the completion of initial treatment plans. One of the seven reviewed records indicated the youth refused to participate in all mental health and substance abuse services, including treatment,

while in the detention center. The youth signed a refusal for treatment form, which was also signed by the designated mental health clinician authority (DMHCA); however, the form was not signed by a witness. During the debriefing process the DMHCA provided the team with a newly signed refusal of treatment form signed by the youth which was witnessed by another individual. All five reviewed initial treatment plans were developed using the Department's Mental Health and Substance Abuse(MHSA) form 015 and contained the reason for the referral. All five records had a diagnostic statistics manual – five (DSM-5) diagnosis/symptoms, initial treatment methods, initial treatment goals, and psychiatric services. All initial treatment plans were signed by the licensed professional, youth, and mini-treatment team members involved in the development of initial treatment plan within the required timeframe. Three of the seven reviewed records were applicable for individualized treatment plans. The first record had the individualized treatment plan completed by the youth's thirty-first day in the center. The second individualized treatment plan was completed with the mini-treatment team three days after the youth's thirty-first day in detention; however, the youth and the DMHCA met and developed the plan on the youth's thirtieth day and reviewed it with the mini-treatment team three days after the youth's thirty-first day. The third plan was completed four days after the youth's thirty-first day in detention; however, the youth and the DMHCA met and developed the plan on the youth's twenty-eighth day and reviewed it with the mini-treatment team four days after the youth's thirty-first day. All three individualized treatment plans were signed by a licensed professional, had a documented DSM-5 diagnosis, symptoms which were treatment-focused, treatment goals, strengths/abilities, preference/needs, and psychiatric information as necessary. All individualized treatment plans were also signed by the youth, and treatment team members. One of the three records which required an individualized treatment plan required treatment plan reviews. The center provided the review team with two additional records for review of treatment plan reviews. The three applicable records required five treatment plan reviews. There was documentation in the applicable records of the five individualized treatment plan reviews, and they were conducted every thirty days with one exception; one record had a review completed five days late. During the debriefing process the clinical team acknowledged one review was completed late. All individualized treatment plan reviews were signed and dated by a licensed professional, treatment team members, and the youth. Two of the reviewed youth mental health and substance abuse records indicated the youth had substance abuse diagnoses and did not have substance abuse goals on their plans. The DMHCA indicated during the debriefing process both youth declined substance abuse services when they entered the facility; however, there was no documentation to support either youth refused substance treatment until the DMHCA had the youth sign the refusal of treatment form on the last day of the review. The DMHCA acknowledged the refusal form should have been completed when the youth initially refused services and the refusal of services should have been noted in each youth's chronological record. Two mini-treatment team meetings were observed during the annual compliance review. During each meeting the DMHCA, the youth, educational staff, medical staff and the psychiatrist was present. The DMHCA contacted both the youth's parent/guardian by telephone and they also participated in the meeting. The team discussed the youth's progress with treatment, behavioral issues and the youth's status at the center. Three closed records were reviewed for the completion of mental health and substance abuse discharge plans. All three records contained a completed mental health and substance abuse treatment discharge summary on the Department's Mental Health Substance Abuse (MHSA) form 011. None of the three youth were released on suicide precautions or any alert status at the time of their discharge. All three treatment discharge summaries contained mental health and substance abuse treatment recommendations for the youth in the community. All three records contained documentation the discharge summary was mailed to the parent/guardian and electronically submitted to the juvenile probation officer (JPO).

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 has facility operating procedures outlining the center's process for providing psychiatric services to youth residing at the center. The center has two psychiatrist who provide psychiatric services to the youth at the center. One of the two psychiatrist is on site weekly to provide medication management, psychiatric evaluations, treatment planning and to participate in treatment team meetings. A review of the Florida Department of Health Medical Quality Assurance Search website indicated both psychiatrist have clear and active licenses in the state of Florida, expiring on March 31, 2019 and January 31, 2019. The medical quality assurance website also indicated the psychiatrists are board certified in forensic psychiatry and have training in the psychiatric treatment of children and adolescence. A review of the detention centers provider sign-in and sign-out book indicated one of the psychiatrists were on-site weekly to provide services to the youth at the center. During the review, the team was advised one of the psychiatrist resigned their position. The contract provider, Camelot, ensured the team they would provide the center with a new psychiatrist and psychiatric services would not be interrupted. An interview with the designated mental health clinician authority (DMHCA) indicated they meet with the psychiatrist weekly to discuss youth receiving psychiatric services. A review of seven mental health and substance abuse records revealed three youth were applicable for an initial psychiatric interview within fourteen days of their admission to the center. All three initial psychiatric interviews contained the reason for the referral, historical information, mental status examination, diagnostic statistics manual – five (DSM-5), treatment recommendations, prescribed medication, explanation of the need for medication, and the frequency of medication monitoring. A review of seven mental health and substance abuse records revealed five were applicable for an in-depth psychiatric evaluation. All psychiatric evaluations included the reason and factors leading to the referral, historical information, mental status examination, identification of individual, family and environmental factors, DSM-5, treatment recommendations and interventions for youth to assist in stabilizing psychiatric disorder, prescribed medication and frequency of medication monitoring/management, explanation of the need for psychotropic medications related to the youth's diagnosis, target symptoms, potential side effects, risks, and benefits of taking the medication. All evaluations indicated the youth's height, weight, and blood pressure documented on the last page of the evaluation. All evaluations were signed by the psychiatrist. All evaluations contained page three of the clinical psychiatric progress note (CPPN); however, there were no changes to any of the youth's existing medications. Four of the five applicable youth had a properly executed Authorization for Evaluation and Treatment (AET) in their medical record. One of the five youth was eighteen years of age and signed an AET for youth eighteen years of age or older and authorized their own care and release of information.

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

The center has facility operating procedures which encompasses the program's suicide prevention plan. The center's suicide prevention plan was last reviewed and approved by the

facility superintendent and the designated mental health clinician authority (DMHCA) on August 3, 2018. The program's suicide prevention plan includes all required components as listed in the Florida Administrative Code, (F.A.C.) 63N-1. The suicide plan specifically addresses identification and assessment of youth at risk of suicide, staff training, suicide precautions, level of supervision, referral, communication, notification, documentation, immediate staff response, and a review process.

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

The center has facility operating procedures and a suicide prevention plan in place which outlines the center's suicide services. A review of seven mental health and substance abuse records revealed four were applicable for suicide prevention services upon their admission to the center. The clinical team provided three additional records of youth who were applicable for suicide prevention services, which ended up in the three youth being hospitalized under the Baker Act; therefore, a total of seven records were reviewed for various suicide prevention services. Four of the seven reviewed records were applicable for suicide prevention services during the admission screening process. All four records contained precautionary observation forms documenting the youth's placement on constant supervision during the intake process. All four youth were referred to the centers clinical team for an assessment of suicide risk (ASR). All four youth's ASR's resulted in the youth being placed on standard supervision after consultation with the superintendent or designee. Two of the four ASRs were completed by non-licensed clinicians and prior to the youth being released to standard supervision the non-licensed staff consulted with the licensed professional and discontinuation of precautions was approved. There was evidence in the centers' master control logbook three of the four instances where the youth were placed on precautions were documented, along with their discontinuation of the placement. During the debriefing process the center acknowledged one of the youth's placement on precautions and discontinuation of the placement was not documented in the master control logbook. Two of the three youth who were applicable for suicide services which resulted in a Baker Act revealed they were referred to the center's clinical team based on staff observations of the youth. The third youth was screened for suicide upon admission to the center and was recommended for Baker Act after the screening process. All three youth were placed on precautionary observations at the time the staff found the youth to be at risk of suicide. When two of the three youth were determined applicable for Baker Act, they were placed on one-to-one supervision pending their transportation to the Baker Act facility. The third youth was placed into secure observation an hour after being placed on precautions. The secure observation placement was authorized by the designated mental health clinician (DMHCA) and the superintendent/designee. There was a lack of documentation in the youth's record the juvenile probation officer (JPO) and the youth's parent/guardian was notified of the youth's placement in secure observation. The center completed the health status check list on

the youth, searched the youth prior to placement in secure observation, and inspected the secure observation room prior to the youth's placement in the room. The youth was then seen for a follow-up ASR within eight hours of placement in secure observation. The youth was then determined applicable for Baker Act. The youth was then released from secure observation and placed on one-to-one supervision until transported to the Baker Act facility. The center uses Centerstone mental health facility in Bradenton, Florida as their Baker Act facility. Two of the three youth who were hospitalized under the Baker Act returned to the facility and were released prior to the mental health meeting; however, both youth were placed on precautionary observations upon their return. Both records also contained signed Department form 009, entitled Detention Suicide Risk Parent/Guardian Notification. The third youth returned to the center, was immediately placed on precautionary observation and an ASR was completed by a non-licensed clinician. The youth was then stepped down to close supervision after consulting with a licensed professional and the superintendent/designee. The youth remained on close supervision until the following day when a follow-up ASR was completed by a licensed professional and the youth was stepped down to standard supervision after consultation with the superintendent. The center has a process in place for the review of serious suicide attempts or serious self-inflicted injuries. During the review period, the center had one instance of serious self-harm, resulting in the death of a youth. The incident is being investigated by the state of Florida's office of the inspector general; however, the center could show the team they conducted a review of the incident which followed their established suicide prevention plans review process. An interview with the superintendent indicated the center uses secure observation for potentially suicidal youth. The superintendent indicated youth who are placed on precautionary observation and are still exhibiting behaviors which present a danger to themselves or others may be placed into secure observation. The superintendent further indicated youth on secure observation are behind a door with an officer maintaining constant direct supervision and completing regular visual observations. Furthermore, a youth may only be released from secure observation after being assessed by mental health staff. Seven youth were interviewed and asked if they ever been placed on suicide watch while at the center and one of the youth indicated yes. The one youth further indicated staff always watched them. Interviews with seven staff revealed all staff could interpret the center's facility operating procedures for youth who present with suicidal thoughts. All seven staff knew they were required to notify mental health staff of the situation, and document supervision of the youth. Six of the seven staff also indicated they searched the youth and their room for sharp objects, and then place the youth on constant supervision. All seven staff indicated each youth living module has a suicide response kit locked in the desk cabinet. Six of the seven staff indicated there is also a suicide response kit in master control and medical. During the review, the suicide response kit in medical and in one of the living modules was inventoried for all required content. Both kits contained a knife-for-life tool, wire cutters, and needle nose pliers.

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

The center has facility operating procedures and a suicide prevention plan in place which outlines the center's suicide services. A review of seven youth mental health and substance abuse records indicated four youth were applicable for having precautionary observation logs. An additional three records of youth who were hospitalized under the Baker Act were also

applicable for precautionary observation logs. There was a total of sixteen precautionary observation logs, three one-to-one logs and four secure observation logs reviewed for completion. There was one precautionary observation log which could not be located by the mental health staff or the detention center staff. The missing precautionary observation log was for a forty-five minute period prior to the youth being placed into secure observation and should have included one visual observation. Twenty-three logs in total were reviewed and there were minor exceptions noted on several logs and were documented as follow: One log had a visual observation check documented three minutes late. Two logs did not have the facility documented on the logs. Three logs did not have the provider documented on the logs. One precautionary observation log had the section checked indicating the staff conducted a health status check on the youth and searched the secure observation room; however, the youth was on constant supervision and the boxes are only used for secure observation. Three logs did not have the suicide alert box checked on the log indicating the youth was at risk of suicide. One secure observation log indicated the areas of safe housing for the youth; however, the youth was in secure observation and the safe housing box should have not been checked. One precautionary observation log did not have the safe housing area's designated on the log and the suicide alert box was not checked. One precautionary observation log and two one-to-one observation logs indicated the youth was exhibiting warning signs and there was no description of the warning signs indicated in the notification of warning signs boxes on the logs. None of the three logs contained the staff signature in the notification of warning signs box and there was no indication a mental health clinician was notified of the warning signs. During the debriefing process, the designated mental health clinician and the regional mental health coordinator provided documentation indicating the precautionary observation log training was provided to the detention center staff in March 2018 and August 2018; however, the logs continued to have documentation errors. Five youth whom were placed on precautionary observations were interviewed about their time on precautions. All five youth indicated staff always remained with them and never left them alone until a clinician reduced the supervision level to close supervision.

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

The center has facility operating procedures (FOP) which address staff training in suicide prevention services. The FOP indicates all staff who work with youth must receive six hours of annual training on suicide prevention and implementation of suicide precautions. A review of seven in-service training records and seven pre-service training records revealed thirteen staff received the required six hours of suicide training and one staff did not have all required hours. The one staff had four hours of instructor led training in suicide prevention during the last annual training cycle; however, the staff worked only for two months of the training cycle and then was out on extended leave. The staff returned during the new annual training cycle and completed the two hours of suicide prevention training in the Department's Learning Management System (SkillPro). A review of the center's mock suicide drill documentation confirmed the center is conducting drills at a minimum of quarterly on each shift. A review of the mock suicide drills conducted since the last annual compliance review confirmed all staff who have direct contact with youth participated in at least one quarterly drill on a semi-annual basis. The drill documentation revealed all staff participated in a quarterly drill during the third and fourth quarters of fiscal year 2017-2018. The drill documentation also revealed during the first and second quarter of fiscal year 2018-2019, all staff except for one participated in at least one quarterly drill; therefore, all staff but one participated in a mock suicide drill on a semi-annual

basis. During the debriefing process, the center acknowledged the one staff did not participate in mock suicide drill semi-annually. None of the seven interviewed staff indicated they participated in a mock suicide drill; however, the staff are not specifically asked if they participated in a suicide drill and none indicated they had.

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

The center has facility operating procedures which includes the center's mental health crisis intervention plan. The crisis intervention plan addresses how staff shall 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 center. The program's mental health crisis intervention services plan includes all required components as listed in the Florida Administrative Code (F.A.C.)63N-1. The plan specifically addresses notification and alert system, means of referral, including self-referral, communication, supervision, documentation and a review process. The plan was reviewed by the center's superintendent and designated mental health clinician authority (DMHCA) on August 3, 2018.

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

The center has facility operating procedures which includes the center's emergency care plan. The center's emergency care plan includes information about immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment for Baker Act, transport for emergency substance abuse assessment and treatment under Marchman Act, documentation, training, and review process. A copy of the emergency care plan is in the superintendent's office, medical clinic and the mental health clinicians' office. The emergency care plan is also available to all staff on the center's computer system. The center's plan was reviewed and approved by the designated mental health clinician authority (DMHCA) and the center's superintendent on August 3, 2018.

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

The center has facility operating procedures which address the center's process for youth in crisis. The center's designated mental health clinician authority (DMHCA) indicated the program did not have youth in the center during the review period who required the completion of a crisis assessment. The DMHCA further indicated if the center had to conduct a crisis assessment they use the Department's Mental Health and Substance Abuse (MHSA) form 023, titled Crisis Assessment. A review of the center's electronic health services database revealed the center did not have any crisis assessments completed in the system during the review period.

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.	

The program has facility operating procedures, as well as an emergency care plan, which addresses the programs process for handling youth who are believed to be an imminent danger to themselves or others, due to mental illness or substance abuse impairment. During the review period, the center had no instances where the Marchman Act were implemented. During the review period, the center had four instances where implementation of the Baker Act process was utilized. The center only had three of the four youth records available for review. The fourth youth was transferred to another detention center and the youth's record and Baker Act information was transferred to the receiving detention center along with the youth. All three reviewed records indicated each youth was placed on suicide precautions prior being transported to the Baker Act facility and upon re-admission to the center. All three applicable records contained a referral for a mental status examination, which was completed the day the youth were re-admitted to the center. All three youth were placed on constant supervision upon their return to the center. All mental status examinations were completed by a licensed or a non-licensed clinician acting under the direct supervision of a licensed professional.
One of the reviewed Baker Act records indicated the youth was placed on precautionary observation upon their return to the center and an assessment of suicide risk (ASR) was completed; however, the youth was continued on precautionary observations. The youth's supervision level was not reduced to close supervision until a follow-up ASR was completed by a licensed clinician, and the licensed clinician consulted with the superintendent to reduce the youth's supervision level. The licensed professional met with the youth the following day to assess them, and then moved the youth from close supervision to standard supervision, only after consulting with the superintendent. The remaining two youth were placed on precautionary observation upon their return to the center from the Baker Act facility. Both records indicated the youth were released to their legal parents/guardians the same day they returned from the Baker

Act facility. Both youth were still on precautionary observation. There was documentation in both records advising each youth's legal parent/guardian of the youth suicide risk and the need for both youth to receive an ASR. Both records contained the original signed Department's Mental Health and Substance Abuse (MHSA) form 009, titled Detention Suicide Risk Parent/Guardian notification, documenting the notification to the parents. All three reviewed records contained precautionary observation logs, one-to-one supervision logs, and one record contained secure observation logs, and close supervision logs, which were all related to the Baker Act process. A review of the juvenile justice information system (JJIS) alert database revealed each youth had an alert for suicide risk. There was also information regarding each youth's Baker Act and other pertinent information in the alert system.

Standard 4: Health Services

Overview

The Department has a contractual agreement with Maxim Healthcare Services Inc. for the provision of all medical services at the Manatee Regional Juvenile Detention Center. All healthcare staff are employed by Maxim Healthcare Services, Inc. At the time of the annual compliance review, the medical healthcare staff consisted of two medical doctors (MD) serving as the designated health authority (DHA), an advanced registered nurse practitioner (ARNP), one psychiatrist serving as the designated mental health authority (DMHCA), one full-time registered nurse (RN), two licensed practical nurses (LPNs), and one medical records clerk. The center has one vacant LPN position and one psychiatrist position. These positions were vacant less than three weeks and staffing coverage of these positions are being managed by the provider. Additional assistance is provided by the Maxim corporate ARNP, as needed. Medications are procured through Diamond Pharmacy Services and emergency medications may be procured through a local Walmart Pharmacy. The center maintained an agreement with Consultant Pharmacists, Inc. to provide a registered consultant pharmacist, who is scheduled on-site once a month. The Department of Health in Manatee County is utilized for counseling, testing, and education of youth for Human Immunodeficiency Virus (HIV), in addition to gynecological services for detained female youth. Maxim's agreement a Healthcare Services, Inc. also has a contractual agreement with the Department to provide on-site psychiatric services, at least six hours each week, inclusive of evaluation and monitoring applicable youth and conducting psychiatric evaluations of each referred youth, to determine whether psychotropic medications are warranted.

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

The center maintains a written policy and procedures outlining the roles and responsibilities of the designated health authority (DHA). The DHA is clinically responsible for the medical care of all youth at the center. The center also has a policy and procedures to identify credential requirements and additional information with regard to various types of health care providers and disciplines. Both reviewed policies where signed by the superintendent and the DHA, with a revision date of July 5, 2018. The center maintains an executed contract for medical services with Maxim Healthcare Services, Inc. The center utilizes two-part time licensed physicians. Both reviewed licensures showed completion of specialized training in pediatrics expiring in January 2019. Both physicians share in the responsibility of serving as the center's DHA. Maxim Healthcare Services Inc. carries a subcontract with the University of South Florida physicians for DHA services. Additionally, the center has a licensed advanced registered nurse practitioner (ARNP). The license review reflects a clinical specialty of family health expiring in July 2021. The current collaborative practice protocol was signed on September 25, 2018. A review of DHA sign-in logs reflected the DHA signed in twenty-five times in the last six months. The DHA is on site two hours a week with no more than nine days between visits. The DHA sign in sheets reflected two instances when there were more than nine days between DHA site visits. There was an eleven-day service gap from April 7, 2018 through April 19, 2018, and a ten-day service gap from August 1, 2018 through August 12, 2018. An interview with the DHA primarily providing services reflected on-site services are provided weekly for a two-hour minimum. The on-call duties are shared between the two physicians, with occasional delegation to the ARNP.

The DHA further reported communication is conducted by phone and in person between all parties. The DHA interview verbalized compliments for the caring personalities of the nursing staff at the center and commented additional licensed practical nurse coverage is needed. An interview with the ARNP reflected a collaborative practice protocol is maintained and the ARNP is on site weekly. The ARNP reported assisting with training, periodic evaluations, comprehensive physical assessments and referred sick calls at the center.

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

The center maintains a written policy and procedures for facility operating procedures (FOPs) to ensure guidelines are established for the development and implementation of the clinical protocols and procedures used in the center in accordance with Health Services Rule. The policy was revised on July 5, 2018 signed by both the designated health authority (DHA) and the center's superintendent. A review of the FOPs from 2017, in addition to the updated 2018 FOPs, showed clear documentation of signature of each medical staff and the center's superintendent. The facility medical procedures are maintained in the medical clinic. A review of the nursing protocols for 2018 were signed by the DHA on August 17, 2018 and signed, with a note acknowledging August review, by the superintendent on September 25, 2018. The center had two newly employed health care staff at the center since the last annual compliance review. Documentation showed both completed a comprehensive clinic orientation as outlined in each completed medical orientation plan. The reviewed FOP for psychiatric services and psychotropic medication management documented a review by the psychiatrist on September 25, 2018.

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

The center has a policy and procedures to address the scope of the authority for evaluation and treatment (AET) and parental consent and notification. The policy requires the AET form a critical document is completed for every youth in the custody of the Department to ensure the youth's medical and mental health needs are met and services rendered. Seven individual healthcare records (IHCR) were reviewed, and five youth were under the age of eighteen. Two youth turned eighteen after admission. One of the seven youth was in the Department of Children and Families (DCF) system and the authorization for evaluation and treatment (AET) was signed by the mother eight days after the youth's admission. The IHCR contained a limited AET from DCF completed prior to obtaining parental consent and the youth turning eighteen. Three of the seven IHCRs contained an original AET and the remaining four contained a copy which were all stamped as a copy. Four of the seven IHCRs for youth contained a copy of the AET and three contained the original. All four copies forms were clearly marked as a copy except for one which was stamped prior to the review teams exit.

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

The center has a policy and procedures regarding parental notification. Seven individual healthcare records (IHCR) were reviewed and five were applicable for requiring parent/guardian notification to obtain consent for the prescription of new medication or over-the-counter (OTC) medications not covered by the Authority for Evaluation and Treatment (AET). All five records contained appropriate notification to the youth's parent/guardian when a practitioner ordered medication treatment. A total of six parental notifications were reviewed. None of the youth needed invasive dental procedures, vaccinations, discontinuation or changes of medication. Each of the youth were prescribed a new medication, one of which was an OTC medication not covered by the AET, but only one of the six had a documented attempt to contact the parent by phone prior to the mailing of a written notification. Each of the notification forms had the boxed checked indicating verbal consent by telephone was obtained and written consent from the parent was also needed. Attempted or completed verbal contacts were not documented in the nursing progress notes and although the notifications/consents did not come back signed by the parent, none of the medications required parent consent prior to administration.

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

The center has a policy and procedures to address the provision of psychotropic medications. The procedures describe the process for the notification to the parent/guardian and obtaining consent for the prescription of a new, discontinued, or adjustment concerning psychotropic medication. The policy requires the third page of the Clinical Psychotropic Progress Note (CPPN) is mailed to the youth's parent/guardian for the prescription of new psychotropic medications. Three of the seven individual healthcare records (IHCR) reviewed were youth admitted into the center on psychotropic medication. One of the three youth is over the age of eighteen. Each youth had one psychiatric evaluation or medication management review since admission and no discontinuances, changes, additions medications were continued with no changes or additions. The center reported no additional records to review for this indicator.

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

The center has a policy and procedures in place to address the verification of youth's immunization status. Seven individual healthcare records (IHCR) were reviewed. All records had their immunization history verified upon admission by the nursing staff with one exception. On youth was admitted in April 2018 and readmitted on July 11, 2018; however, the immunization was not verified within thirty days of admission. The first attempt to find the immunization history was made during the week of annual compliance review. The history was received and recorded into the IHCR prior to the end of the review. None of the records

reviewed required additional vaccinations or were applicable for religious exemption from immunization.

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

The center has a policy and procedures which require all youth to be screened upon admission for healthcare concerns which may need referral for further assessment. Seven individual healthcare records were reviewed, and each had a Medical/Mental Health Screening form completed on the day of admission which was entered into the Juvenile Justice Information System (JJIS) electronic medical record (EMR). A review of each Admission Wizard confirmed the youth's admission date and each screening was completed by a juvenile justice detention officer (JJDO) and reviewed with the youth and a licensed practical nurse (LPN) or registered nurse (RN) within twenty-four hours. Two of the forms were missing the youth's signature. An interview with the superintendent, indicated the admission process includes the intake officer's role for starting the admission paperwork and concluding with the medical assessment by nursing staff.

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

The center maintains a written policy and procedures to alert staff of medical issues which may affect the security and safety of the youth in the center. Seven records were reviewed for applicable medical alerts. One youth record was applicable for an allergy alert, three youth records were applicable for youth with chronic conditions. Chronic conditions included psychiatric medications, glasses, and/or asthma. Three youth records were applicable and contained alerts for medication side effects. Seven records were reviewed and five had a medical grade of three or higher requiring a medical alert. Each record contained the appropriate alert in the Department of Juvenile Justice Information System (JJIS).
The center's nurse explained the center's practice is to have nursing staff update and verify JJIS alerts daily. Center alerts are discussed during shift meetings and copies of the printed alert sheets are maintained in master control and the kitchen. An interview with the center superintendent reported medical alerts are entered by the center's nurse and intake officers regarding any health concerns presented and verified upon admission. Seven staff were interviewed regarding how they are informed of youth medical alerts. Seven staff reported they learn of youth alerts during shift meetings. Additionally, one staff reported they also learn of alerts from the logbook. One staff reported they learn of alerts from the alert board, and three staff reported they also learn of alerts from the alert sheet. One staff also commented they look at JJIS because the day shift does not always print the alerts forms for the staff to have at shift briefing. Seven staff were interviewed regarding how effective they believe the process for communicating alerts is at the center. Three staff reported the process as very good, three reported as good, and one staff reported as fair.

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

A review of seven individual healthcare records (IHCR) verified each youth had a Suicide Risk Screening Instrument (SRSI) completed by the mental health staff on the day of admission; therefore, this indicator rates as non-applicable. A copy of each form was recorded in the mental health document section of each IHCR.

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

The center has a policy and procedures in place to address the provision of healthcare orientation to the youth. All admitted youth are oriented to the general process and delivery of health care services. Seven individual healthcare records were reviewed, and all contained documentation on the health education record and in the admission progress note to show youth were oriented to the general process of medical services at the center within twenty-four hours of admission. Healthcare topics included but are not limited to; the sick call process, how to access medical services, what constitutes an emergency and who to notify, the right to refuse care and how it is documented, the non-disciplinary role of the healthcare provider, who to notify if an emergency illness occurs, and medication side effects.

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

The center has a policy and procedures regarding notification to the designated health authority (DHA) or designee upon a youth's admission. A review of seven individual healthcare records revealed all were referred to the DHA or designee for further evaluation on the day of admission regardless of health needs. None of the youth required emergency response at the time of admission. Five youth were admitted with a suspected or known chronic condition and three of were taking psychotropic medication. Notification to the DHA was documented on the admission nursing progress note in all reviewed records

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

The center has a policy and procedures addressing healthcare admission rescreening. Two of the seven individual healthcare records reviewed were applicable to this indicator. The center verified their practice by providing one additional record for review. All three records documented a change in physical custody after the youth's admission. Upon each youth's return to the center the Medical/Mental health Screening form was completed by a juvenile justice detention officer (JJDO) and reviewed by a licensed nurse.

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

The center has a policy and procedures addressing the completion of a Health-Related History (HRH) form. Seven individual healthcare records were reviewed. Three of the records had a HRH form completed electronically within seven days of admission and prior to, or at the same time as the completion of the Comprehensive Physical Assessment (CPA). The remaining youth records contained a Department HRH form which was updated within the required timeframe. There was documentation present in all applicable records to show the HRH forms were completed by a licensed nurse and reviewed by the designated health authority (DHA) or advanced registered nurse practitioner (ARNP). The check box on each youth's CPA documented the DHA's review of the HRH.

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

The center has a policy and procedures to address the completion of a Comprehensive Physical Assessment (CPA). A review of seven individual healthcare records confirmed each contained a CPA completed by the designated health authority (DHA) or advanced registered nurse practitioner (ARNP). Four of the seven youth had a current CPA on record and a new CPA was completed in the other three records. Three of the seven records documented a focused evaluation at readmission. All CPAs were completed/updated within seven calendar days of the youth's admission. All applicable CPAs included the medical grade and required marks for each field of the examination. One youth refused parts of the exam and a refusal form was completed. Any areas not completed indicated they were deferred by clinician. The problem list was updated in all applicable records.

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

The center has policy and procedures regarding the completion of gender-specific screening and examination. Two of the seven reviewed individual healthcare records (IHCR) were applicable to this indicator. One additional IHCR was provided for review. The center's policy and procedure indicate all youth in need of a gynecological examination are referred out to the Department of Health in Manatee County. In the three reviewed youth records one was referred for an exam after the youth's pregnancy test was positive. The DHA provided a written order which was documented in the IHCR; however, the youth denied the referral and indicated they will seek services once released. Seven youth were interviewed during this annual compliance review. Only one of the interviewed youth was applicable for female-specific screening. This youth indicated they will receive female specific services when needed.

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

The center has a policy and procedure regarding tuberculin skin test (TST) screening. Seven individual healthcare records (IHCR) were reviewed. Three of the seven had at least one verified TST within the past twelve months, the remaining four had a TST administered by medical staff within seventy-two hours of admission and documented on the Comprehensive Physical Assessment (CPA) and Infectious and Communicable Disease Form, with one exception. One youth's test was completed seven days after admission. None of the youth presented with symptoms suggestive of active Tuberculosis (TB) or in need of further evaluation prior to entering general population.

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

The center has a policy and procedures regarding the screening of all youth for sexually transmitted infections. Seven individual healthcare records were reviewed and upon admission every youth was screened and evaluated for sexually transmitted infections (STI) by a licensed nurse. All youth were referred to the designated health authority (DHA) or advanced registered nurse practitioner (ARNP) for further evaluation; however, the DHA/ARNP decided no further testing was needed. Any prior tests and results were documented on each of the youth's Infectious and Communicable Disease Form and Health-Related History. The center has a policy and procedure requiring a STI rescreening each time a youth reports signs or symptoms consistent with an STI or has been out of the physical custody of the Department for more than thirty days and is sexually active. The center's policy is to rescreen every youth regardless of the time spent out of the physical custody of the Department. Two of the seven youth IHCRs reviewed were for youth who were admitted into the center on prior occasions.

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

At this center all human immunodeficiency virus (HIV) education, counseling, and testing is conducted by the Manatee County Department of Health (DOH). The DOH provides a certified counselor to conduct HIV pre-test and post-test counseling, testing and education monthly. A review of seven individualized healthcare records (IHCR) revealed all youth were offered HIV counseling, testing and treatment; however, three refused testing. One of the four applicable youth's IHCR confirmed they received pre-test counseling, testing and post-test counseling. A copy of the youth's results was sealed in an envelope, marked confidential, and recorded in the youth's IHCR. The remaining three youth are on the list for testing at the next scheduled visit by the DOH on October 1, 2018. One youth consented to a test in July 2018 but was not added on the list for testing until the week of this review. The DOH practice changed to providing all results verbally to youth and eliminating printed results. Seven interviewed youth indicated they could ask for an HIV/Test.

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

The center maintains a written policy and procedures, approved nursing protocols, and non-healthcare protocols for the provisions of sick call. A review of the center's master schedule indicated sick call is scheduled at the center two times a day Monday through Friday. The medical services profile form completed by the clinical director prior to the annual compliance review reported sick call is from 9:00 a.m. to 11:00 a.m. and throughout the day, as needed. An interview with the center's registered nurse (RN) explained sick calls are conducted in the medical clinic by the RN or licensed practical nurse (LPN) from 9:00 a.m. to 11:00 a.m. and in the afternoon, as needed. The RN further explained when youth are presented with repeated similar sick call complaints they are added to the sick list to see the center's doctor. The center maintains a sick call index and the center maintains an approved procedure of sick call procedures for non-licensed staff. The sick call request procedures were signed and approved by the designated health authority (DHA) on June 22, 2018. The clinical director reported there were no instances since the last annual compliance review where the DHA was on site and conducted scheduled sick calls. An informal interview with the on-site RN reported medical staff check the Department's Juvenile Justice Information System (JJIS), Facility Management System (FMS) every few hours for sick call referrals. The nurse explained youth at the center have the ability to submit sick calls as a private matter, if necessary. The RN reported sick call services are provided by the RN. Seven youth were interviewed regarding how long after submitting a sick call they are seen. Two youth reported they are seen immediately, three youth reported within one day, and one youth reported never requiring a sick call. One youth stated medical will see youth more than three days after submitting a sick call. The interviewed youth stated this was not their personal experience, another youth within the same living module communicated this to the youth. When asked for additional information the youth declined. The medical services profile form completed by the clinical director prior to the annual compliance review reported youth are seen on an average of eight to twelve hours following the submission of a sick call. Seven records were reviewed. Four were applicable and contained sick call request forms or narrative progress notes conforming to professional standards in a subjective, objective, assessment, and plan (SOAP) format. There was one instance where a youth presented with a similar complaint three or more times within a two-week period and a referral was made to the advanced registered nurse practitioner (ARNP). One record was applicable for the ARNP immediately notifying the DHA, due to not being able to determine the severity/nature of a youth complaint. There were no youth applicable for complaining of severe pain in which medical staff was unfamiliar. Seven staff were interviewed regarding who conducts the sick call process. Seven staff reported sick call is conducted by the nurse. Four staff also reported the doctor conducts sick call, and one staff also reported the ARNP conducts sick call. Sick call forms were observed on the living module during the center tour and sick calls at the center are entered into FMS by direct care staff.

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

The center maintains a written policy and procedures to ensure all youth have access to regularly scheduled hours for sick call care. Seven youth were interviewed regarding who conducts sick call. Five youth reported sick call is conducted by the nurse and two reported

never participating in a sick call. Seven staff were interviewed regarding who conducts sick call. All seven staff reported the nurse conducts sick call. Four staff also reported the doctor conducts sick call. Seven records were reviewed, there were no youth applicable for a licensed practical nurse (LPN) to conduct sick call. Four were applicable for a sick call requiring documentation for a sick call referral, and each was documented on the sick call referral log, maintained in the Department of Juvenile Justice Facility Management System (FMS). Each of the four sick call logs were initialed by the youth seen for sick call. One of the four records did not document a sick call encounter on the center's sick call index. Observations were made of a sick call during the annual compliance review. Verbal and initial consent was provided by the youth prior to observations. The center's direct care staff escorted the youth to the medical clinic and stood near the entrance of the medical office, ensuring constant supervision, yet providing medical privacy. The registered nurse (RN) identified the youth by name and date of birth and reviewed the reason for sick call. The youth provided written permission by initialing the paperwork acknowledging they were seen and received a thorough exam and interview by the RN. Seven youth were interviewed on the rating of the medical care at the center. Four youth reported the medical care as good, two reported very good, and one youth rated the medical care at the center as fair. The youth who rated medical services as fair declined to offer additional information.

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

The center maintains a written policy and procedures ensuring all youth in the center will be able to access healthcare staff while in restricted housing. Since the last annual compliance review, the center had seventy-one instances of youth who remained in restricted housing for more than twenty-four hours and 201 instances of youth who remained in restricted housing for less than twenty-four hours. Nursing staff are required by policy to make a daily visit to youth in confinement and document the visit for each youth in the chronological progress notes of the individual healthcare record (IHCR). The center's utilized isolation cells are situated directly across the hall from the nurse's station. Three of the seven applicable records contained documentation for daily check-ins conducted by medical staff. One reviewed record showed no medical check-in conducted on August 21, 2018, but two were conducted the following day. The center provided documentation completed by the same nurse on August 21, 2018 for other youth in confinement and a schedule showing the nurse was not working on August 22, 2018. The center explained the youth was seen in confinement and the nurse documented the correct date in error within the Department's Facility Management System (FMS). One record showed the youth was in behavioral confinement from September 22 through September 23, 2018. There was no documented check-in conducted by medical staff during this period. One youth record showed the youth was in confinement from July 27 through July 30, 2018. Documentation showed a check-in was conducted on July 28, 2018, but no medical check-in was completed on July 29, 2018. One youth was in confinement from August 3 through August 7, 2018. Documentation showed a medical check-in was completed with the youth on August 6, but none on August 4, and 5, 2018. This youth was prescribed psychotropic medications. The center requested and received the medication administration record (MAR) from the youth's current placement. The MAR reflected the youth received their psychotropic medications and signed for them on August 4 and August 5, 2018, thus supporting the youth was seen by medical staff for medication administration. Seven youth required thirteen days of medical follow up while in confinement. Ten of the thirteen required confinement checks-ins were completed by medical staff. The center provided five additional records over twenty-four-hour confinement

where the nurse conducted check-ins to support the centers practice of conducting daily medical check-ins with youth in behavioral confinement. An interview with the center's registered nurse (RN) explained youth are checked on and assessed daily while in confinement.

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

The center maintains a policy and procedures regarding the practice of episodic first aid, inclusive of emergency situations. The center maintains sixteen first aid kits and two Automated External Defibrillators (AED) on-site. The two AED's are newly purchased and delivered to the site on September 25, 2018. An observation of first aid kit inventory logs documented monthly monitoring by medical staff. Three first aid kits were inspected during the annual compliance review and each were fully stocked with approved contents. The center maintains an on-site tracking log for episodic care. The episodic care binder is kept in the medical department. Seven records were reviewed and three contained applicable episodic care episodes. None were applicable for off-site care. Each reviewed episodic progress notes documented the time, date, nature of complaint, findings, treatment rendered, printed name and credentials of staff, and the center name. Two episodic events were applicable and documented education and/or instruction to youth. None were applicable for plans of follow up care, being placed on alert list, or parental notification. Each record documented a youth received a follow-up evaluation by the licensed healthcare staff. Three records were applicable for and contained healthcare staff documentation of episodic care. Each conformed to professional standards, contained subjective, objective, assessment, and plan (SOAP) elements, and was entered on the episodic care log. One youth episodic care event was documented as a late entry on the bottom of the log. An interview with the center's registered nurse (RN) explained first aid kits are located on the living modules, in the intake office, in master control, and in the center's vans. It was also reported the kits are checked monthly by the RN and filled, as needed.

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

The center maintains a written policy and procedures for the provision of emergency care. The center maintains two Automated External Defibrillators (AEDs), one in the mail entrance hallway and the other in the medical office. The Office of Detention Services provided the center with two new AED's on September 25, 2018. The batteries in both machines expire approximately five years after manufacturing, or after ten shocks according to the manufacturer inserts. The pads in both machines expire on March 28, 2021. The machines were powered on and off by the nurse during the annual compliance review. The medical drills were conducted at least quarterly on each shift. It was noted the center started two shifts a day starting in approximately April of 2018 due to limited staffing patterns. The drills varied from situation to situation while recording the date, time of drill, persons involved, nature of the emergency, duration of event, and type of equipment used. Drill documentation noted the use of an AED as part of the drill at least once each quarter on each shift. A drill utilizing lifesaving equipment was not observed for the first quarter of 2018; although, the first quarter was not yet completed during the annual compliance review. An interview with the center's registered nurse (RN) explained drills are conducted by the detention staff, quarterly on each shift. A random review of seven medical drills showed five were not documented in the center's master control logbook. The center had a list of emergency contact information posted and accessible to all staff located in medical and

master control. Training records reflected non-healthcare supervisory staff have up-to-date training for the use of EpiPen Auto-Injector, which was provided by the center's RN. Reviewed documentation for seven pre-service and seven in-service training records showed each non-healthcare staff maintains current (cardiopulmonary resuscitation) CPR, AED, and first aid certification and training, annually. Seven center staff were interviewed regarding their ability to call 9-1-1 if necessary. All seven reported they are able to call 9-1-1 if they feel it is necessary.

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

The center has a policy and procedures to address referrals and off-site care. Seven individual healthcare records (IHCR) were reviewed, and none of the youth required off-site medical or emergency care needs. The center verified their practice by providing three additional records for review. Each record documented notification of the event to the designated health authority (DHA)/designee, and each contained the Summary of Off-Site Care Consultation Report form with discharge instructions, which was reviewed and signed by the DHA/designee. Follow-up, referrals, and additional appointments were tracked and completed as documented in the healthcare records.

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

The center maintains a policy and procedures for the provision of treatment for youth identified with chronic medical conditions. Seven individual healthcare records (IHCR) were reviewed, and three youth had a chronic condition; however, only one of the youth was in the center longer enough to be applicable for a periodic evaluation. The center provided an additional two records to verify practice. All five youth were identified as having a chronic condition and were placed on the center's chronic conditions list. Three youth required a periodic evaluation and nursing notes validated each were done on time by the designated health authority (DHA) or advanced registered nurse practitioner (ARNP). Four of the five youth with a chronic condition are taking prescribed medication and classified with a med grade of two or higher. None of the youth have a communicable disease or being treated by anti-tuberculosis medication. All evaluations were conducted on site and prior to the renewal of prescription medication. None of the problem lists were applicable for updates. Evaluation timeframes are documented and tracked on the center's Physical/Sick Call Log maintained by nursing staff.

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

The center maintains a policy and procedures indicating a youth's medication regimen shall be ascertained upon admission. The center only allows medications from a licensed pharmacy with a current, youth-specific pharmacy label on the original medication container. The policy outlines procedures permitting the trained non-healthcare staff to verify the mediations and assist youth with self-administration, if needed. When nursing staff are not on-site, trained non-

healthcare staff verify the medications and assist the youth with self-administration. Seven individual healthcare records (IHCR) were reviewed. A review of each youth's Medical/Mental Health Screening form and admission nursing progress notes revealed three of the seven youth were admitted on medication. Each youth's admission progress notes documented notification to the designated health authority (DHA). One of the three records indicated the youth was not on medication at the time of admission; however, the guardian indicated the youth was on medication and provided the center with all medication seven days after the youth's admission. One of the medications required a refill, the DHA was contacted and the medication was refilled within twenty-four hours. A second youth's record indicated one of the medications provided by the parent could not be verified; therefore, the medication was not accepted by the center. The licensed nurse obtained an order from the DHA to resume medication. In the third record, all medications were verified and documented as required. Documentation of the prescription verification process was present in all three records on the Department's Medication Receipt, Transfer and Disposition form.

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

The center has a policy and procedures to address medication management for orders and prescriptions. Seven individual healthcare records (IHCR) were reviewed and five were applicable. Three youth were admitted on medication and two youth were prescribed medication post admission. One youth was prescribed over-the-counter (OTC) medications not listed on the Authority for Evaluation and Treatment (AET). All youth had current prescribed medications and there was documentation in each of the five applicable records progress notes regarding current medication orders, prescribed, and filled as documented by the psychiatrist, designated health authority (DHA) and/or the advanced registered nurse practitioner (ARNP). There are standing orders approved by the DHA for the administration of OTC medication. Medication Administration Records (MAR) for all reviewed records revealed youth received medications in accordance with orders.

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

The center maintains a written policy to outline the procedures for inventory of medication and sharps. The policy includes provisions for narcotics and psychotropics. The medical clinic was observed and found to be well organized, with no loose equipment or unsecured medication. All medication was properly stored in neatly organized and secured cabinets or in the locked medication cart, inaccessible to youth. The medical clinic maintains a locked refrigerator exclusively for medications requiring refrigeration. Observations showed oral, injectable, drops, liquids, and pills were stored securely by type. The center does not store any over-the-counter (OTC) medications in any location other than the medical clinic. All non-healthcare staff have limited access to medication. Trained and designated supervisors only have access when trained licensed medical staff are not on-site. Expired or discontinued medications are disposed of by the registered consultant pharmacist on-site each month utilizing Rx Destroyer™ medication disposal product. The center contracts with Stericycle for the disposal of sharps and bio-hazardous waste in accordance with federal regulations and the Florida Department of Environmental Protection.

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

The center maintains a written policy and procedures requiring the storage of discarded needles, syringes or any device capable of puncturing or lacerating the skin. Written policy and procedures also stipulate the medical unit's responsibility for sealing, labeling and disposal of any bio-hazardous materials. Documentation review for the last six months showed the inventories were conducted perpetually and weekly for sharps, prescribed medications, and over-the-counter (OTC) medications. Observations of the medical clinic showed medical equipment classified as sharps are securely stored. Observations and inventories for three randomly selected sharps, prescription medications, and OTC medications showed each were accurate. An interview with the registered nurse (RN) validated the center had a method for detecting and responding to any inventory discrepancies.

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

The center maintains a written policy and procedures for the storage and handling of all controlled substances. Controlled substances at the center are stored in a secured storage area, in a locked box, in the locked medication cart, and behind the locked door of the medical clinic. The center conducts shift to shift inventories for controlled substances. At the time of the annual compliance review, there was one youth prescribed a controlled medication. On-site observation was made of the shift-to-shift count of the controlled medications conducted by the registered nurse (RN) with the morning supervisor. Controlled observation inventory records for one youth from August 19, 2018 through September 26, 2018 showed seventy-seven instances were a shift-to-shift counts occurred between first and second shift. The center started working two shifts in April 2018. Twelve of the inventory counts only captured one staff signature. An interview with the registered nurse (RN) explained on the weekends the supervisors count independently and no nurse is scheduled on site. An interview with the Office of Health Services (OHS) explained the center's staff should conduct a shift to shift count prior to the nurse leaving and not documenting an independent inventory. The OHS also reported the Rule and indicator does not specify the need for two signatures; however, the pharmacy manual does. The center provided an additional controlled medication inventory record showing no discrepancies for thirty required shift-to-shift inventoried completed between July 24, 2018 and August 7, 2018. After findings were discussed during the annual compliance review, the center offered two additional youth records documenting controlled inventory shift-to-shift logs from February, March, and April 2018. The provided samples were applicable for 112 shift-to shift controlled medication inventories. Three of the provided shift-to-shift inventories contained only one signature. The center also offered documentation of a training to address the issues resulting in the medication error for "failure to count controlled medications with medical staff and supervisors" completed on September 7, 2018. The center's RN explained the nurse who created the error(s) is no longer employed at the center. Five of the original twelve shift-to-shift inventory deficiencies noted occurred after training on September 7, 2018.

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

The center has a policy and procedures outlining the medication administration process and the use of the Department's Medication Administrator Record (MAR). Each MAR contained the youth's name, Department of Juvenile Justice identification number (DJJID), date of birth, allergies, precautions, medical grade, alerts, and a current photo of the youth. MARs for seven youth were reviewed and there were no lapses or errors in medication. Three of the seven youth were admitted to the center on medication; however, all seven youth had a MAR each month to include standard over-the-counter (OTC) medication and medications prescribed post admission. The current month's MAR is maintained in an active binder within the medical clinic and used during daily medication administration. Start and stop dates for medications were accurately documented. None of the seven youth records indicated they refused medication. Daily monitoring of side effects was documented on each youth's MAR in which both the nurse and youth initialed each dose with one exception. One date was missing the youth's initials indicating the youth received wound care for an injury August 24, 2018.

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

The center maintains a written policy and procedures outlining the method for the safe administration of medications. During healthcare staff hours, medications are administered by licensed healthcare staff. The medication administration process by licensed healthcare staff was observed during the annual compliance review. Seven applicable youth were escorted to the clinic by a juvenile justice detention officer (JJDO) for the administration of medication. The nurse administered the medication in an organized process while the JJDO maintained supervision of the youth and ensuring the medical privacy of the youth by standing outside the medical clinic in the hallway. The medical working space was observed to be clean and organized, with all medical equipment and medication secured. Each youth was brought one at a time to the medical clinic by a direct care staff. The medical cart was placed in the doorway. The Five Rights of Medication Administration were verified for each of the seven youth observed during medication pass. Each youth was asked their name, date of birth, medication name and dosage. Each youth received a visual mouth check and was asked by the nurse to cough after taking their medications. Two of the youth were escorted to the medical clinic by the supervisor and received an additional mouth check by the supervisory staff. Each of the youth were asked to sign the medication administration record (MAR) after receiving their medications. The center's nurse maintains accurate alerts and allergy listings printed from the Juvenile Justice Information System (JJIS) in the medical clinic. During medication pass one youth was asked if they were experiencing any additional symptoms after being administered a pro re nata **(**PRN) Ibuprofen and was asked if feeling better. The youth did not indicate any further distress or adverse side effects from the medication. The remaining six youth were not prompted by the nurse regarding side effects or allergies. Each observed MAR documented side effect monitoring daily by the nurse and side effects are listed on each pre-printed MAR. Two youth were interviewed regarding side effects. One youth could not list side effects, but communicated the benefits of prescribed psychotropic medications. The other youth listed fatigue and weight gain as side effects to prescribed psychotropic medications. Seven youth were interviewed and

asked to identify all staff who administered medication. Two youth reported receiving their medication from the nurse and five youth reported they did not take medication at the center.

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

The center maintains a written policy and procedures outlining the process for non-healthcare staff to assist youth with self-administering oral prescription medications and over-the-counter (OTC) medications. Non-healthcare staff assist youth in self-administration of medication when licensed healthcare staff are not on-site. The process for non-licensed healthcare staff assisting in medication administration was not observed during the annual compliance review. An interview with the clinical director explained non-licensed staff usually administer medications in the evenings on Saturday or Sunday when the nursing staff is not working, or during overnights as ordered by the physician. A review of medication records revealed the nursing staff administer the majority of medications. Three applicable instances of a youth refusing medication was observed and the refusal was documented on the medication administration record (MAR) by the non-healthcare staff and initialed by the youth. Seven youth were interviewed and asked to identify all staff who administered medication to them. Two youth reported receiving their medication from the nurse. Five youth reported they did not take medication at the center. Seven staff were interviewed regarding the administration of medication at the center. None of the interviewed staff reported administering medication to youth. An interview with the center's registered nurse (RN) explained non-healthcare staff attend a medication administration training with the center's RN at least annually. Training sign-in sheets verified all non-healthcare staff (including supervisory staff) on the medication administration list received the necessary training.

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

The center has a policy and procedures to address medication management and psychotropic medication monitoring. Seven individual healthcare records (IHCR) were reviewed and three were applicable. All three youth were admitted on medication, and notification was given to both the designated health authority (DHA) and psychiatrist. Prescription orders indicated medications the youth were receiving prior to admission was continued until an initial diagnostic psychiatric interview was conducted. Each youth received an initial diagnostic psychiatric interview/evaluation within fourteen days of admission. One of the three youth was in the center longer than thirty calendar days and a record review verified the youth received monthly medication management assessments with the psychiatrist to evaluate the medication regime with no recorded lapses. Documentation from the center indicate there were no examples of evaluations which resulted in the prescription of a medication or changes to a youth's existing medication regime; however, a policy and procedure is in place which describes the process when needed. The policy and procedures indicate page three of the Clinical Psychotropic Progress Note (CPPN) would be completed during the psychiatric medication management meeting or at the time of evaluation and mailed to the parent/guardian, regardless of obtaining

verbal consent. Two of the records and CPPNs indicated monthly tardive dyskinesia monitoring was not required; however, one youth's record had two monthly CPPN's which did not indicate if this was required or not.

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

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

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

The center has a comprehensive plan to address infection prevention, control and education. Training records for seven pre-service and seven in-service staff were reviewed and all fourteen records contained documentation of training in infection control. Seven reviewed youth individual healthcare records contained education in hand washing techniques, universal precautions, prevention of transmission of communicable diseases, and vaccinations. Training was provided within seven days of the youth's admission.

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

The center maintains an exposure control plan to address procedures for control, inventory, storage, and disposal of contaminated materials. The center also maintains a written policy and procedures requiring the storage of discarded needles, syringes or any device capable of puncturing or lacerating the skin in puncture-resistant red bio-hazardous containers located in the medical clinic. The written policy stipulates the medical unit's responsibility for sealing,

labeling and disposal of any bio-hazardous materials. The plan was written in accordance with the Department of Labor and Occupational Safety and Health Administration (OSHA) requirements, to include risk assessment and methods of compliance. There were no incidents involving a contagious disease requiring the hospitalization or quarantine of at least ten percent of the total population of youth or staff, since the last annual compliance review. Seven in-service training records were reviewed, and five staff records showed completion of exposure control training. Two supervisory staff training records did not have documentation supporting receipt of exposure control training.

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

The center maintains a written policy and procedures for providing education and prenatal care for pregnant youth. The center had one pregnant youth in population during this annual compliance review. Documentation reflected prenatal care was initiated upon admission, and the designated health authority (DHA) was notified of the youth's status. Documentation supported the youth was seen daily by licensed medical staff and information was recorded in the medical progress notes. An interview with the registered nurse (RN) indicated the center utilizes Manatee County Health Department for obstetrical care for pregnant at the center. The center's clinical director reported there were no other pregnant females at the center since the last annual compliance review. Seven youth were interviewed, and two youth were female. One indicated there was not a need or want of prenatal, obstetrical or gynecological care. The other female youth reported they was able to receive prenatal, obstetrical or gynecological care services at the center. An interview with the center's RN explained education, transportation to off-site prenatal appointments, medication administration and sexually transmitted infection (STI) testing is offered to all pregnant youth.

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

The center maintains a written policy and procedures for providing healthcare education to pregnant youth. The center maintains a pregnancy education binder with information from pregnancy.org, March of Dimes, and Web MD in the medical clinic. The center had one pregnant female in population since the last annual compliance review and no pregnant females in population during the on-site observations. The reviewed applicable individual healthcare record (IHCR) included nursing progress notes to reflect the one applicable youth was seen in the medical clinic daily, where weight and other vital signs were recorded. An interview with the center's registered nurse (RN) explained prenatal and parenting education is provided to all pregnant youth at the center by the licensed medical staff. Additionally, it was reported all youth in the second and third trimester receive an extra snack. The center maintains a standing order for pregnant female youth. The standing order includes daily prenatal vitamins, no ibuprofen, double mats, no strenuous activity, provisions for snacks, and appointment coordination instructions.

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

The center maintains a written policy and procedures ensuring all non-healthcare staff involved in the supervision or treatment of pregnant youth shall receive appropriate education. Reviewed staff training records reflected each non-healthcare staff completed training on pregnancy for monitoring, observation, and emergency care, which included the signs and symptoms of miscarriage. The curriculum is included under the female youth's health training and is included on the annual training plan. An interview with the center's registered nurse (RN) explained all non-healthcare staff receive education on the female youth's healthcare by the registered nurse (RN) or the advanced registered nurse practitioner (ARNP).

Standard 5: Safety and Security

Overview

Manatee Regional Juvenile Detention Center is a sixty-bed hardware-secure facility equipped to supervise detained youth in a safe, secure, and humane environment. The program is comprised of one building which houses administration, a medical clinic, an intake/controlled observation area, a kitchen, dining room, classrooms, and four living modules. There are three living modules for male youth, B1, B2, and B3; and one living module for female youth, G1. One of the male living modules, B2, was closed at the time of the annual compliance review due to painting improvements which were completed. The center was in preparation to move another male living module into the area soon, to begin making improvements to another module. There is a secure sally port area with entry into the intake area. The area for tool storage and the majority of chemicals maintenance area is inside a locked fenced area in back of the detention center. The superintendent, assistant superintendents, and juvenile justice detention officer staff are responsible for ensuring the youth detained in the center are in a safe and secure environment. All staff are responsible for youth safety and the security of the center and provide twenty-four-hour active supervision of all youth directly and/or by digital video recorder (DVR) surveillance cameras. The center uses an electronic wand system to conduct checks on all youth during sleeping hours. The center has a maintenance mechanic who is responsible for ensuring all flammable, toxic, and poisonous items are inaccessible to youth, and all potentially dangerous tools used at the center are always secure.

5.01 Active Supervision of Youth (Critical)	Satisfactory Compliance

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

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

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

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

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

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

The center has written policy and procedures regarding supervision of youth. During the annual compliance review, observations confirmed staff were actively supervising youth at all times. Observations also confirmed consistent communication between staff and master control using a two-way radio to complete head counts and to receive authorization for all movement within the center. The staff were seen supervising youth on living modules, in the classrooms, during

line movement, and recreation. A review of the program's logbooks for the last six months established headcounts are conducted on a consistent basis during the beginning and ending of each shift and randomly through each shift. The logbooks are the centers main tool to keep track of how many youth are in the center. This includes documentation of all trips for youth out of the center (for court, doctors, etc.), in addition to all admissions and releases. Interviews were conducted with seven staff during the annual compliance review. All seven staff indicated youth counts are done at the beginning of the shift, and six of the seven confirmed youth counts are also done at the end of each shift. Four of the interviewed staff indicated counts are also done before and after school, and one staff stated counts are done after meals. All seven of the interviewed staff were able to explain the basic procedure to follow if a count is not correct. All seven staff indicated all movement would stop, and an immediate recount would be conducted. Five staff also indicated they would conduct another count if still not correct. If they could not rectify the count after the second attempt, the staff would then call a code green (for escape) and search the entire facility for the youth in question. All seven interviewed staff indicated there were not enough staff to provide for the safety and security of the youth and staff during recent months. The responses reflected the center had an increased population from other centers, too many holdovers, and a great deal of staff turnover. Three of the staff indicated they feel their personal safety is at risk on the living modules at times, with one staff indicating they feel they are being placed into "dangerous situations" due to staff shortages.

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

The program has a written policy and procedures regarding room checks when youth are placed in their rooms for sleeping or other reasons. The center has cameras on each of the four currently used youth living modules, and in other program common areas recording on a digital video recorder (DVR) system for thirty days. The ten-minute checks conducted from 8:00pm until 7:00am are conducted using an electronic wand system. Staff utilize the electronic wands by tapping them on the check point sensors on the outside of each youth's room. The data from the wand is downloaded every few days to ensure no data is lost. The center utilizes visual observation reports (VOR) to document all checks completed on youth who are in their rooms, or are in confinement, during waking hours. A youth in the center died by suicide on June 10, 2018. Due to this event, it was the unwritten expectation of the Assistant Secretary of Detention Services for staff to complete checks on youth every five minutes. This information was confirmed through an interview with the superintendent. A review was conducted for the ten-minute checks using wand print-outs from the previous six-month period and a review of

recordings from the previous thirty days. The review of wand check documentation and video review for four separate nights found the staff on G1, which is the girls living module, were completing their checks on youth every five minutes, as required by the current expectation. The staff on the other living modules for males were not completing checks every five minutes; however, the staff were conducting them at least every ten-minutes during the majority of the reviewed checks. The following missed checks were found during a review of the Wand Activity Reports and DVR recordings: Video review from September 7, 2018 on living module B1, from 10:57 p.m. until well beyond 12:00 a.m. found only one check was completed by a staff member relieving the assigned staff for a break. The staff assigned to the living module was observed watching television, with a youth on precautionary observation (PO) sleeping on a couch behind the staff, while no room checks were completed. A review of wand check documentation from August 13, 2018 on living module B3 found no checks were completed from 12:46 a.m. to 1:26 a.m. A review of wand check documentation from September 1, 2018 on living module B3 found no checks were completed from 3:10 a.m. to 3:30 a.m. A review of wand check documentation, and video review, from September 2, 2018 on living module B1 found no checks were completed from 1:03 a.m. to2:59 a.m. The video review during this time period found the staff was completing a youth intake on the living module. Once this was complete, the staff was observed watching television on the living module. A review of wand check documentation from September 8, 2018 on B1 found no checks were completed from 2:00 a.m. to 5:46 p.m. The superintendent viewed this lapse in checks, and reported it was the same staff who was watching television during the September 7, 2018 review of living module B1, noted earlier. Another review of wand check documentation from September 19, 2018 on living module B1 found no room checks were completed from 1:54 a.m. to 2:10 a.m. An interview with the field training coordinator (FTC) indicated emails were sent to the superintendent and both assistant superintendents each time the wand documentation was downloaded into their computer system. An interview with the superintendent reflected a review of the video is conducted when emails were received from the FTC. The center was unable to provide documentation to reflect fidelity checks were being done during this review period. These reviews are required to be completed every forty-eight hours at a minimum. Random checks were also completed on VORs for all units on randomly selected days. This review found staff were completing checks on the youth within the ten-minute timeframe. The VOR forms also reflected checks were being done very close to the five-minute expectation currently in place. This was also confirmed through video review and by reviewer observation during the annual compliance review. Seven staff were interviewed to determine their understanding of how often ten-minute checks are conducted on youth while in their rooms for sleep or other non-punishment reasons. Each of the staff indicated ten-minute checks should be done every five minutes according to the policy change since the incident on June 10, 2018. One staff indicated this expectation is almost impossible, another stated they hate the frequency because it is causing problems for their feet, and another felt it has gone on too long.

5.03 Census, Counts, and Tracking	Satisfactory Compliance

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

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

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

The program has a written policy and procedures regarding census counts and tracking of youth. The program keeps track of their census by conducting formal head counts at the beginning and end of each shift, in addition to at least one other time during each shift. During the annual compliance review, a team member observed population counts conducted at various times of the day. Observations also validated staff requesting authorization to master control prior to movement from one location to another. There was documentation in the master control logbook to reflect counts at the beginning and end of each shift, and randomly throughout each shift. Informal interviews with three staff during the review found they were aware of the total number of youth were with them when questioned. The seven interviewed staff indicated counts are completed at least every hour. If there is a discrepancy, they indicated all movement will stop, and an emergency count will be conducted. All seven of the interviewed staff were able to explain the basic procedure to follow if a count is not correct. All indicated all movement would stop, and an immediate recount would be conducted. A few of the staff also indicated they would conduct another count if still not correct. If they could not rectify the count after the second attempt, the staff would then call a code green (for escape) and then search the entire facility for the youth in question. The same seven staff were questioned about when emergency counts are conducted in the center. Seven indicated when a youth is missing, six indicated if visibility was hindered and after a major disturbance. Additional responses were provided by two of the staff. One indicated an emergency count is conducted after a camera disruption, and another indicated another emergency count would be done after a miscount.

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

The program has a master control logbook. This book is maintained by a master control worker, if there is one for the day. A review was conducted on the logbooks from the past six months. The logbooks contained a chronological record of events, incidents, and activities occurring in the program. Each logbook was bound with numbered pages and contained entries regarding admissions and releases, emergencies, incidents, head counts, transports, youth movement, documentation of law enforcement presence, and precautionary observation documentation to include placement information with subsequent step-downs, to include when the placement was initiated and ended. Each logbook entry consistently included the date and time of the event, names of staff and youth involved, a very brief description of the event with the initials of the person making the entry, and the date and time of the entry. There were very few entries found marked through or removed. All applicable incidents for calls placed to the Central Communications Center (CCC) and/or the Florida Abuse Hotline were found documented in the logbook. The logbook was found to indicate head counts were conducted, and accurate information was recorded to reflect the total number of youth in the physical presence of staff during the count. The logbook also documented all youth movement within the master control logbook. The center gathers all pertinent information on a shift report which is maintained with the Facility Management System (FMS) within the Department's Juvenile Justice Information System (JJIS). The review of living module logbooks found all pertinent information regarding occurrences for each module being documented consistently. The center was not consistently documenting the required drill information and confinement documentation, which should include the time confinement was initiated for each youth as well as the time ended for each youth. Drill review found ten escape drills were conducted during the previous six-month period, and nine of these were not documented in the master control logbooks. Ten fire drills were also conducted during the previous six-month review period, and six of the ten were not documented in the master control logbook. Twenty-five confinement youth reports were reviewed from the past six months. Four were not documented as having been placed into confinement in the master control logbook, and there was no entry in the master control logbook indicating when the eleven youth were released from confinement.

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

The center has a policy and procedures in place regarding logbook reviews. The center's policy requires the superintendent or designee to review the master control logbook and all living module logbooks at least once a week and document their review of the logbook. The living unit logbooks had documentation reflecting consistent reviews conducted by the superintendent or their designee. Three master control logbooks were selected for review to determine how frequently the weekly superintendent reviews were occurring for the master control logbook. The review of the logbook for the majority of June 2018 found a superintendent or designee only conducted one review on June 26, 2018. The review of the master control logbook documentation for the eight weeks prior to the annual compliance found a review was conducted only once by the superintendent or designee during this time period. This was during the week of September 2-8, 2018. A review of nine master control and living unit logbooks was conducted. This reflected staff signed to reflect a review of the living unit logbook when reporting for duty, in addition to reviewing the logbook entries for the previous seventy-two hours. Additionally, the review found shift supervisors reviewing and signing the master control logbook when accepting responsibility for the center. A review of the living unit logbooks confirmed the shift supervisors were visiting each unit during their shift and entering a review of each living module logbook during their shift.

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

The center has a policy and procedures regarding key control. All of the center's active keys are housed in locked cabinets located in master control. Observations found the master control has three separate locked cabinets to house staff keys. There is one box for restricted keys, which

are provided to teachers, mental health staff, medical staff, and kitchen staff. This box uses the "keyper" system, which requires staff to provide their key ring for personal keys which is inserted into the cabinet to release their set of keys for the facility. At the time of the review, the cabinet had at least two broken mechanisms for sets of keys within the cabinet. The second key box is for the personal keys turned in by direct care staff. The third locking cabinet holds the sets of keys for the juvenile justice detention officer supervisors (JJDOS) and juvenile justice detention officers (JJDO). There is also an area which is used to store all keys from visitors to the center. The master control area is secure and was observed locked at all times during the annual compliance review. Observations also found the emergency key ring for the facility is stored in a small red locked box with a window in the vestibule leading to the secure area of the center. An interview was conducted with one staff who was in charge of the master control area during the review. The staff indicated they conduct a visual inspection of the keys in the cabinet and compare the keys with the current key assignment log when their shift begins. All keys are accounted for at the beginning and end of each shift. The practice is for staff to turn in their personal keys when entering the building to master control, or for them to lock their personal keys in their personal lockers in the staff break room. If staff turn their personal keys in to master control, the keys are placed into the personal key locker for staff. Observations during the annual compliance review found staff are provided their assignments at the shift briefing. They then go to master control to receive their assigned keys. This distribution is documented by the master control operator in the center's key logbook. The center provided a "Master Key Log" for review. This was last updated on August 16, 2018. The review of this document found seven reviewed key rings had a total of nine keys documented as unknown on the log. Each key is required to have a numbered tag or metal chit on the ring indicating the number of the key ring, as well as how many keys are on the ring. Eleven key rings were checked against the provided master key log. Two of the reviewed key rings had broken keys. They were both removed from circulation, and a work order was submitted for each. Eight of the rings did not match the master key log; however, the number of keys matched the number marked on the stamped chit. The master key log indicated six of these rings should have at least one more key on each ring, and two of the rings should have two more keys on each ring. Even though the number of keys found on the key ring did not match the number stamped on the metal chit, the number of keys did match what was documented in the key inventory log. Two restricted key rings were also checked to see if they matched the inventory. One of the key rings matched while the other did not. A kitchen key ring (Kit #1) was observed to have a chit indicating a total of fifteen keys on the ring, but a count showed sixteen keys on the ring. The master key log reflected this ring should have had twenty keys on it. Further review of the master key log found four keys identified multiple times on the list. A review of the van keys found only the van identification number designated on the log. The review of these key rings found each ring also had an additional key for the anti-theft club which is kept in each of the vans. An informal interview was conducted with one of the assistant superintendents and they presented a key ring which was not found on the master key log. This ring had four keys on it, and there was no identification tag/chit on the ring to identify it or to indicate how many keys should be present. When this was discussed further at a debriefing, it was revealed the assistant superintendent full set of permanent keys are typically kept in the assistant superintendent's desk, unless specific keys are needed. Informal staff interviews were conducted with three staff. Each of these staff did not have their personal keys with them. Two turned their keys into master control, and the other staff keys were in the non-secure area. The key log book kept in master control was also reviewed for compliance with the tracking of key use. All keys are issued by the master control operator. This logbook documented the date and time of issue, the name of the staff who received the key ring, and the time the key rings were returned. A review of twelve randomly selected days of key control logbook entries indicated there were 420 times keys were issued. This review found 168 of the entries were missing one or more of the following items: date, staff

name, time out, key number, time in, initials in, and initials out. The center keeps their backup keys in a locked cabinet within one of the assistant superintendent offices. The assistant superintendent has a key control log which identifies the capability of each key within the box, and which hook each key is kept on within the box. The center was unable to provide a master key inventory which indicates the capability of each key on each ring. This is required for the center. The master key log provided for review, was found to have multiple deficiencies as noted above, only indicated a number or code for each key on the rings. There was not a master inventory in place to reflect where each key will work. Interviews with seven staff indicated the keys for medical records, youth property areas, mental health records, case management/intake records, and the kitchen are restricted. Only staff designated to work in these areas, by their position or assigned permissions, are allowed to access these areas. The staff's responses to the interview questions reflected an understanding of the steps which are to be followed if a key is lost or missing.

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

The center has a policy and procedures for vehicles and maintenance. The center was able to provide annual safety inspection invoices for all ten of the center's vehicles. The center has nine vans, of which only eight are used to transport youth. Random vehicle checks during the annual compliance review found all vehicles were kept secure. Observations conducted on a transport found staff were ensuring youth wore seatbelts for the transport to court. Staff were also observed wearing seatbelts during the transport. Four available vans were inspected during the annual compliance review. Each of the vans were found to contain an emergency roadside kit, jumper cables, a biohazard spill bag, and the appropriate number of seat belts. The program policy requires staff to sign out a first aid kit for each transport. This keeps the contents from breaking down due to the extreme temperatures in Florida. Each of the inspected vans were also found to have a fire extinguisher which was inspected during 2018. Each van key rings also had a tool which was both a window punch and a seat belt cutter. The center's policy requires the maintenance mechanic to complete weekly and monthly inspections on each vehicle. A review of documentation found the weekly inspections were completed for the past six-months, with no exceptions. The center was not able to provide evidence reflecting the maintenance mechanic was completing the required monthly inspection of vehicles during this review period. The center provided documentation reflecting the maintenance mechanic was completing daily vehicle inspections on a vehicle maintenance check list. The center's policy indicates daily inspections are conducted by transport staff and should indicate they have searched the vans for contraband, ensure there is enough gas, verify seatbelts are working properly, test the security screen, confirm vehicle folder has required information, ensure there is a cell phone. This information is required for documentation in the van logbook. A review of van logbooks found staff were not documenting inspections in the van logbooks as required, even though observations during the review confirmed the required contraband checks were being conducted. The documentation in the van logbooks found very limited information to reflect pre-transport information was being completed and documented. The van logs were reviewed for four vans for their trips taken for August and September 2018 (39543, 39542, YF848, and YA908). The trip logs indicated ninety-three trips were taken. Only eighteen of the trips were

documented in the van logbooks, and only ten log book entries reflected a pre-transport inspection check was completed. The reviewer did observe few of the instances when a pre-transport inspection was documented in the master control log book rather than the van log book where required, but when this occurred, the documentation related only to one of several vans transporting youth on the date entered in the log.

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

The center has a policy and procedures regarding tool inventory and management. The center ensures all tools and equipment related to maintenance are properly maintained, stored, and inventoried. Inspections of tool control areas are conducted monthly, and the results of these inspections are submitted to the superintendent or designee for their review. Tools are stored in a locked room which is inside a locked fenced-in area on the back of the detention center. This area is locked when not in use, and inaccessible to youth. This area is off-limits to detention staff as well, with only the maintenance mechanic and center administrators having authorized access to this area. Interviews with administrative staff indicated any broken or defective tools are removed for repair or replacement. Any repairs or replacement of broken or defective tools are immediately reported to the superintendent with a completed incident report. Immediately following the repairs or replacement of a tool, they are returned to the appropriate storage area and properly secured. The center's tools were inspected during the annual compliance review and all were found marked with an identification code identifying the tool as Department of Juvenile Justice property. There were no tools found which were not recorded on the center's inventory.

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

The center has a policy and procedures regarding control and inventory of kitchen tools. All kitchen tools are maintained in a locked box in the back hallway of the kitchen. The kitchen area is inaccessible to youth. An observation of the center's kitchen areas was conducted during the annual compliance review. A physical count was conducted to compare the actual kitchen tools with the inventory during the review, and all knives were accounted for. The tools were visible on a shadow peg board system through the window of the locked cabinet. Kitchen staff signed out a knife for use on a log. The kitchen service manager or another food service worker in their absence conducts inspections and counts of the knives at the beginning and ending of each day. An interview with kitchen staff confirmed youth were not permitted in the kitchen area, and is the center's facility operating procedure to report lost or damaged kitchen tools immediately to

the superintendent or supervisor. The kitchen staff also reported there were no broken or missing knives or other kitchen tools during the review period.

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

The center has a policy and procedures regarding youth access to and use of tools, and cleaning Items. The policy prohibits youth from handling or accessing hazardous materials. Interviews with food service and administrative staff confirmed youth does not have access to areas where tools or toxic items are stored. Youth are only permitted to use mops, brooms and scrub brushes. Observations of cleanup during the annual compliance review found youth cleaning under direct staff supervision. Staff was observed dispensing the cleaning solutions for youth and kept control of cleaning agents at all. An interview with seven staff indicated youth are allowed to use mops and brooms, while four of the seven staff indicated youth can also use scrub brushes. All seven staff indicated they spray chemicals and the youth will clean and wipe down the area. Seven youth were interviewed and five of the seven interviewed youth indicated they have assisted in cleaning while in the center. Each indicated they use mops and brooms to help clean. All five youth indicated staff spray the chemical, and they clean the area and wipe it off. The other two youth have not assisted in cleaning while in the center.

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

The center has a written policy and procedures to address the inventory of flammable, toxic, caustic, and poisonous items. A review of the inventory of flammable, toxic, caustic, and poisonous items was found to be accurate. Cleaning chemicals are stored in a locked cabinet inside a locked fenced-in area behind the detention center and a locked shed. The flammable items are kept in three easily identifiable yellow flammable item cabinets. Safety Data Sheets (SDS) for all flammable, toxic, caustic, and poisonous items were as maintained in a large binder. The SDS binders are maintained near the chemicals, and are accessible, if needed, for reference. Chemical inventory and storage is maintained by maintenance staff, and access to

the shed is limited according to the center administration staff and the maintenance mechanic. The chemical storage shed was organized and free from clutter. These areas are inaccessible to youth.

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

The center has a policy and procedures regarding access to any flammable, toxic, caustic, and poisonous items. The policy prohibits youth from handling or having access to any flammable, toxic, caustic, and poisonous items. All flammable, toxic, caustic, and poisonous items are stored in locked cabinets inside a locked fenced-in area behind the detention center and in a locked shed. Key access to the shed and storage cabinets is restricted to maintenance and administrative staff only. The maintenance shed, fenced-in area, and storage cabinets were observed locked at all times during the review. Five of the seven interviewed youth indicated they have assisted in cleaning while in the center. The youth stated the staff will spray the chemical, and the youth will clean the area and wipe it off. The other two interviewed youth indicated they have not assisted in cleaning while in the center.

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

The center has a policy and procedures regarding the disposal of all flammable, toxic, caustic, and poisonous items. An interview with the maintenance staff confirmed their knowledge of the procedure for disposal of all flammable, toxic, caustic, and poisonous items. The maintenance staff indicated most chemicals are completely used up, and do not require disposal. There were no reported chemicals requiring disposal during the annual compliance review. The center has a contract with EnviroLight & Disposal, Inc. to dispose of all flammable, toxic, caustic, and poisonous items, when applicable. The center does gather grease which is accumulated from the dishes and trays washed in the center. This is disposed of on a quarterly basis. This process was confirmed through a review of contractor receipts from this reporting period.

5.14 Confinement Under Twenty-Four Hours	Failed 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 regarding confinements of youth under twenty-four hours. The center had 201 confinements during the previous six months, and seventeen were selected to review for compliance with this indicator. The review of confinements confirmed staff

are consistently documenting an incident report in the Facility Management System (FMS) within the one-hour time frame after an incident. The center has three confinement cells in the isolation hallway. Cells in the living modules are used if needed. The reviewed documentation reflected female youth are placed within their own cell when placed in disciplinary confinement. All seventeen reviewed confinement reports reflected staff searched the room prior to placing the youth as required. Eight of the sixteen applicable confinement reports did not have documentation to show a juvenile justice detention officer supervisor (JJDOS) completed a review for fairness and appropriateness within the two-hour requirement. Seven of these had an entry by a JJDOS; however, the confinement reports did not address the fairness or appropriateness of the placement itself. Seven of the sixteen applicable reviewed reports had at least one of the required three-hour checks by a juvenile justice detention officer supervisor (JJDOS) conducted outside the three-hour requirement. The center's facility operating procedures (FOP) requires these checks to include a reason for continued confinement. Factors for justification include severity of rule violation, past disciplinary history, and behavior while in confinement. These must be clearly documented in the confinement report. The review found appropriate justification was not documented in at least one three-hour review for three of the fourteen youth which were applicable for continued confinement. These reviews indicated the youth was either sitting calmly or resting during waking hours. All seven interviewed staff indicated they complete a report and complete ten-minute checks when youth are placed in confinement. Only five of the interviewed staff indicated they search the room prior to placing the youth in confinement. Another staff indicated they will search the confinement room once the youth is released from confinement or relocated to their room for confinement since the youth are sometimes confined in their own rooms. The other interviewed staff related they do not search youth rooms prior to confinement because room searches are done daily, and the room should have already been checked for the day. A review of the logbook on the morning of September 27, 2018 found two youth were being held in the isolation hallway. Observations by the review team confirmed the youth were being held in these confinement rooms. A review of confinement reports found both youth were released from confinement the previous afternoon on September 26, 2018. However, there were no new confinement reports documenting the reason the youth were in confinement on September 27, 2018. Video review confirmed the two youth were in confinement from at least 9:00 a.m. on September 27, 2018 until 4:45 p.m. for one youth, and 7:00 p.m. for the other youth. Provided visual observation report (VOR) logs found each of the youth were let out during the day for meals or to help clean; however, both were placed back in their cell after the activity was complete. The center staff could not provide documentation to support the reason the youth were placed back into the cells. The superintendent indicated one of the youth shown aggression towards others and does not want to be in the populated area, but this was not documented. The center also indicated the supervisor from the morning shift forgot to enter the two youth into FMS prior to leaving for the day due to an emergency. No explanation was provided as to why the oncoming supervisor did not enter a report when attempting to enter their three-hour checks into the system. FMS was reviewed on October 4, 2018, and this confinement incident was still not reflected in FMS for either youth. Video review and VOR documentation confirmed staff were checking the youth every five minutes while in this placement.

5.15 Confinement Over Twenty-Four Hours	Failed Compliance

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

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

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

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

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

The center has a policy and procedures regarding confinements of youth over twenty-four hours. A review of the confinements for the past six months found seventy-one confinements in which youth were confined for over twenty-four hours. The average time spent in confinement for these youth averaged a little over fifty-four hours. Seven of these confinements were selected to review for compliance with this indicator. A review of the seven confinements confirmed staff consistently documented an incident report in the Facility Management System (FMS) within the one-hour time frame after an incident. The center has three confinement cells in the isolation hallway. Cells within the living modules are used if additional space is needed. The reviewed documentation reflected female youth are placed in their own cell when placed in disciplinary confinement. All seven reviewed confinement reports reflected the requirement of staff searching the room prior to placing the youth. Five of the seven reviewed confinement reports reflected completion of the review for fairness and appropriateness within the two-hour requirement. Two reports had supervisory reviews documented within two hours of the placement, but the fairness or appropriateness of the placement was not addressed in the report. Three of the seven reviewed reports had at least one of the required three-hour checks by a juvenile justice detention officer supervisor (JJDOS) conducted outside the three-hour requirement. One of the youth had five of their three-hour checks by a JJDOS completed outside of the required timeframe, with one lapse being more than five hours. Another reviewed youth stayed in confinement for ninety hours according to the list of confinements from FMS. The youth placement began on August 3, 2018. The center stated this was an error; however, the center could not provide documentation reflecting when the youth was released from confinement. The youth last documented JJDOS check was August 5, 2018 at 6:00am. The report reflected a nursing check completed on the youth the following morning at 10:00 a.m., even though the center indicated the youth had been released. Confinements for more than seventy-two hours require a hearing. This was not conducted for this youth. The third youth with deficiencies was missing checks on July 28, 2018 from 8:09 p.m. through 7:29 a.m., and on July 29, 2018 from 10:00 p.m. through 5:01 a.m. the next morning. The center's facility operating procedure (FOP) requires the checks to include a reason for continued confinement. Factors for justification include severity of rule violation, past disciplinary history, and behavior while in

confinement. These were consistently being documented in the reviewed confinement reports. The FOP requires extensions beyond eight hours in confinement the approval by the regional director or designee. Documentation indicating extension beyond eight-hours was only provided for two of the seven youth. The FOP also requires e-mails are sent to the regional director to extend confinement beyond twenty-four hours, and every twenty-four hours, thereafter. The center was able to provide evidence reflecting an extension beyond twenty-four hours for the initial period for five of the seven youth. Three of the reviewed youth were maintained in confinement beyond forty-eight hours, and one beyond seventy-two hours. There were no extension requests documented for any of the youth to show an additional request for an extension from the regional office. The FOP also states, "All youth placed temporarily in confinement shall be afforded the same services as youth in the general population." This is to include participation in education and opportunities to have large muscle exercise, among other activities. There was no documentation regarding notification to school personnel documented in each of the confinement reports, and there were no documentation indicating the youth were provided assignments while in confinement. In addition to the lack of documentation regarding education in the confinement reports, the center did not have a process in place to follow in the event a youth is confined during school hours. Only two of the seven reports reflected youth were offered large muscle exercise during the time spent in confinement.

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

The center has a policy and procedures regarding Continuity of Operations Planning (COOP). Copies of the COOP are maintained in the master control area. A review of drill documentation confirmed the center conducted COOP drills in April and May of 2018. Each of these drills were focused on the center preparedness in the event of a hurricane. The reviewed drill documentation included a synopsis of what happened, reviews by supervisory staff, a completed checklist of the steps to follow in an emergency, and signatures of all the participants. No corrective actions were suggested on either of the drills. Three of the seven interviewed staff indicated they participated in a weather drill during the past six months.

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

The center has a policy and procedures in place to address escape drills. A review of escape drill documentation found the center completed escape drills on each of the two shifts from April through September of 2018. Nine of the ten escape drills were not documented in the master control logbook. Six of the ten escape drill reports did not have the required signature pages attached to reflect the identity of each staff who participated in the drills, and six of the ten drills were not signed by the person conducting the drill and were not reviewed by a supervisor. The center's policy also requires all staff are provided with escape prevention training annually. A review of seven staff training records found five completed the training in 2017. Three of the seven interviewed staff indicated they participated in an escape drill during the past six months.

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

The center has a policy and procedures in place to address fire drills. The policy requires the facility conduct a fire drill every month on every shift. A review of documentation from the last six months found fire drills were completed on each of the two shifts from April 2018 through September of 2018. Documentation of the drills included the date and time conducted, the scenario of the drill, and any additional needed follow-up. The review found two drills were missing a signature page for the staff who participated in the drill, and two of the drills were not reviewed by supervisory staff. A review of the center's logbooks found only four of the ten reviewed drills were documented in the master control logbooks, as required. The center's Continuity of Operations Plan (COOP) incorporated a fire prevention and safety plan to ensure the safety of youth and staff. Documentation was provided for an annual inspection by the State Fire Marshal on May 10, 2018. No major fire safety violations were found during the inspection. Five of the seven interviewed staff indicated they participated in a fire drill during the past six months and two did not. Five of the seven interviewed staff also indicated fire drills are conducted monthly. Two of the seven interviewed staff indicated no. Five of the seven interviewed youth indicated they were instructed on what to do in the case of a fire. Two of the seven interviewed youth did not remember receiving this instruction during their stay.

Program Name: Manatee Regional Juvenile Detention Center
Provider Name: Deparment of Juvenile Justicve
Location: Manatee County / Circuit 12
Review Date(s): September 25-28, 2018

MQI Program Code: 298
Contract Number: N/A
Number of Beds: 60
Lead Reviewer Code: 147

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.05 Protective Action Response (PAR)	2.13 Daily Activity Schedule
1.07 In-Service Training	2.14 Adherence to Daily Schedule
2.12 Review of Youth on Home Detention	2.19 Grievances
3.11 Suicide Precaution Observation Logs	5.02 * Ten-Minute Checks
4.30 Medication Management - Controlled Medications	5.05 Logbook Reviews
5.04 Logbook Maintenance	5.06 Key Control
5.07 Vehicles and Maintenance	5.14 Confinement Under Twenty-Four Hours
	5.15 Confinement Over Twenty-Four Hours
	5.17 Escape Drills

Overall Rating Summary for Standard 5

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