STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Marion Regional Juvenile Detention Center

Department of Juvenile Justice
(State-Operated)
3040 NW 10th Street
Ocala, Florida 34476

Review Date(s): July 23-26, 2019

Promoting Continuous Improvement and Accountability
in Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Katina Horner, Office of Program Accountability, Lead Reviewer (Standard 1)
Renette Crosby, Office of Education, Education Specialist (Standard 2)
Lissette Godfrey, North Region Detention Services, Government Operations Consultant II (Standard 5)
Amy Hutto, Office of Program Accountability, Regional Monitor (Standard 3)
Jennifer Schad, Office of Program Accountability, Regional Monitor (Standard 4)

Program Name: Marion Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: Marion County / Circuit 5
Review Date(s): July 23-26, 2019

MQI Program Code: 094
Contract Number: NA
Number of Beds: 60
Lead Reviewer Code: 170

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
5.02 Ten-Minute Checks *	
5.07 Vehicles and Maintenance	

Standard 1: Management Accountability
Detention Rating Profile

Indicator Ratings

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

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

Standard 2: Youth Management
Detention Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Detention Rating Profile

Indicator Ratings

Standard 4 - Health Services		
4.01	Designated Health Authority/Designee*	Satisfactory
4.02	Facility Operating Procedures	Satisfactory
4.03	Authority for Evaluation and Treatment	Satisfactory
4.04	Parental Notification/Consent	Satisfactory
4.05	Healthcare Admission Screening & Rescreening Form	Satisfactory
4.06	Youth Orientation to Healthcare Services/Health Education	Satisfactory
4.07	DHA/Designee Admission Notification	Satisfactory
4.08	Health-Related History	Satisfactory
4.09	Comprehensive Physical Assessment/TB Screening	Satisfactory
4.10	Sexually Transmitted Infection Screening & HIV Screening	Satisfactory
4.11	Sick Call Process	Satisfactory
4.12	Episodic/First Aid Care/Emergency Care	Satisfactory
4.13	Off-Site Care/Referrals	Satisfactory
4.14	Chronic Conditions/Periodic Evaluations	Satisfactory
4.15	Medication Management	Satisfactory
4.16	Medication/Sharps Inventory and Storage Process	Satisfactory
4.17	Infection Control/Exporsure Control/Education	Satisfactory
4.18	Prenatal Care/Education	Satisfactory

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Standard 5: Safety and Security
Detention Rating Profile

Indicator Ratings

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

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Program Overview

The Marion Regional Juvenile Detention Center is a state-owned detention facility, operated by the Department, located in Ocala, Florida. The center serves youth in Citrus, Hernando, Lake, Marion, and Sumter Counties in Circuit 5. Male and female youth who are detained pending adjudication, disposition, or placement in a residential commitment program are housed in the sixty bed center. Youth are provided services which include youth orientation, behavior management, safety and emergency procedures, transportation, mental health, and healthcare services. The center's educational services are provided by the Marion County School Board. The center's management team includes the superintendent, two assistant superintendents, one administrative assistant, seven juvenile justice detention officer (JJDO) supervisors, and forty-six JJDOs. Mental health and healthcare services are provided through the contracted provider, Maxim. Mental health services are provided by a licensed mental health counselor (LMHC) who acts as the designated mental health clinician authority (DMHCA) and one unlicensed mental health counselor. A psychiatrist is also on-site weekly. Clinical services provided by the center include mental health and substance abuse evaluations, mental health treatment planning, individual, group, and family therapy, mental health crisis intervention services, on-site psychiatric services, and availability for substance abuse services for youth with co-occurring disorders. Medical services are provided by contracted provider Maxim Healthcare Services. The following positions are provided: a medical doctor who serves as the center's designated health authority (DHA), an advanced registered nurse practitioner (ARNP), a registered nurse (RN) who serves as the clinical manager, two full-time and two part-time licensed practical nurses (LPN). The medical clinic maintains nursing coverage seven days a week, from 7 a.m. - 5 p.m., and on weekends, from 7 a.m. - 3 p.m. Food services are provided by Department staff and include menus, meal planning, meal schedules, special diets, nutritional analysis, daily allowance, food preparation, health certifications, food product standards, sanitation, and cleaning. Staff are responsible for the custody and control of youth in their care, providing youth supervision twenty-four hours a day, seven days a week. The center has four living modules which are divided by male and female. There are eighty-nine security cameras at the center, of which all were operational at the time of the annual compliance review. The center was clean and free of any noticeable graffiti, odors, or pests. At the time of the annual compliance review, the center had four vacancies, which included one juvenile justice detention officer and one food service worker.

Standard 1: Management Accountability

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

Since the last annual compliance review, twenty-five staff, four volunteers, and six contracted staff required an initial background screening. All thirty-five screenings were completed prior to each staff's hire date and each volunteer's start date, as required. A pre-assessment tool was administered to twenty-five direct care staff, of which twenty received a passing score. The remaining five direct care staff received additional training and were approved to hire by the Assistant Secretary of Detention Services. All six contracted staff were added to the Clearinghouse employment roster. The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to the Background Screening Unit (BSU) by the center on January 10, 2019 for detention center staff and on January 7, 2019 for all teachers.

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.	

Five staff and one volunteer were applicable for a five-year background rescreening. All five staff rescreenings were completed prior to their anniversary hire date, as required. The volunteer has not been on site since January 2018 and the center attempted to contact them on multiple occasions without success to complete the rescreening. The center will move the volunteer to the inactive list until contact is made.

1.03 Staff Code of Conduct	Satisfactory Compliance

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

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

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

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

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

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

Seven staff were reviewed for code of conduct. The center uses an online system called "Onboarding" where electronic versions of detention center forms are maintained. This system was reviewed, and all seven staff electronically signed the Code of Conduct Form. None of the staff had any record of discipline and seven additional staff were reviewed for this practice. In all seven violations of staff conduct cases, management responded with oral or written reprimands. None of the violations were related to abuse towards youth.

Seven youth were interviewed and none of the youth said they have ever been stopped from reporting abuse. One of seven youth said staff are disrespectful when speaking to them or other youth. Two of seven youth said they have heard staff use profanity on occasion. One of seven youth said they have heard staff threaten youth occasionally. Two of five youth said they do not feel safe in the program. One youth said he does not feel safe anywhere except home and the remaining youth said he does not feel safe because even with five staff being present, youth still try to attack him physically. This was addressed with the center and staff have taken measures to protect the youth.

Seven staff were interviewed and asked if they have observed a co-worker using profanity when speaking to youth. Two said they have heard staff use profanity once, one said occasionally, one said often, and three said never. All seven staff said they have never observed a co-worker using threats, humiliation, or intimidation when interacting with youth. In the past year, five of seven staff said the working conditions at the center have been fair and two said good.

The superintendent reports the code of conduct ensures all communication and interaction between staff and the public or youth are professional and respectful in nature. It provides directions for behaviors not acceptable, and lists all standards of conducts for staff. If there are allegations of threats, abuse, or profanity, the allegations are investigated and if founded, the staff can face disciplinary action up to, and including, dismissal. If it is believed a staff abused a youth, the Florida Abuse Hotline is notified.

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

During the past six months, the center reported thirty-seven incidents to the Central Communications Center (CCC). All incidents were reported within a two-hour timeframe and documented in the master control logbook, as required.

Seven staff were interviewed all were able to explain the process for allowing youth to call the Florida Abuse Hotline or CCC to report suspected abuse. All staff said to notify the supervisor and allow the youth to make the call. Five staff said notify the superintendent, six said the supervisor makes the call, and four said staff are allowed to the make the call.

The superintendent states, youth have the right to contact the Florida Abuse Hotline at any time. If staff observe abuse, as mandatory reporters, they are obliged to report any instances of suspected abuse. The superintendent further stated, the CCC is contacted within two hours by a supervisor or administration when incidents occur and meet reporting guidelines.

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

The center had ninety-two Protective Action Response (PAR) incidents in the past six months, of which nine were reviewed. In all nine instances, a PAR report was completed by all staff involved by the end of the staff's work day. None of the PAR incidents included use of mechanical restraints or resulted in serious injury to a youth or staff. None of the youth alleged abuse during these incidents. All nine reports were reviewed by a supervisor and PAR instructor to determine if policy was followed. All nine reports included a Post-PAR interview conducted with the youth by an administrator or designee within thirty minutes after the incident occurred. There were findings in one instance and they were placed in the youth's individual healthcare record. After all other reviews were completed in all nine cases the superintendent or designee reviewed the PAR report and made comments within seventy-two hours, as required. The center's PAR rate during the annual compliance review period was 11.75, which is below the statewide Detention PAR rate of 11.75.

Seven staff were interviewed, and all said staff try to talk to youth prior to using physical restraints. The superintendent was interviewed and stated a video review is completed for all PAR incidents. Corresponding reports are reviewed in the Department's Juvenile Justice Information System (JJIS) to ensure documentation supports the actions that occurred and the PAR was reasonable and necessary when physical interventions occur. The regional office also provides oversight and verifies completed reviews of all PAR and confinement reports monthly.

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

Seven staff training records were reviewed for pre-service training requirements. All seven staff were certified within 180 days of hire and received all required essential skills training prior to being in the presence of youth. All seven staff were Protective Action Response (PAR) certified, with passing scores in the performance tests and written exams within ninety days of hire, as required. The Department's Learning Management System (SkillPro) documented Phase One and Phase Two Academy Training for all seven staff.

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

Seven training records were reviewed for in-service training requirements, including three supervisors. Each staff completed between sixty-five and 122 hours of training, exceeding the annual twenty-four hour requirement. All staff had current Protective Action Response (PAR) certification updates, cardiopulmonary resuscitation (CPR), first aid and automated external defibrillators (AED) certifications. Documentation for all seven staff included suicide prevention, professionalism and ethics, and active shooter training. All three supervisors exceeded the annual eight hour requirement receiving ten, nineteen, and fifty-five hours of training in management, leadership, personal accountability, employee relations, communication skills, and fiscal matters. The program has an annual in-service training calendar which is updated as changes occur. All in-service training was documented in the Department's Learning Management System (SkillPro).

The superintendent was interviewed and stated he received the following management training: Certified Public Management (CPM), leadership training provided during superintendent meetings; annual Equal Employment Opportunity (EEO), workman's compensation (WC), and Family Medical Leave Act (FMLA) retraining. The superintendent stated staff must complete eight hours of PAR, and annual CPR, AED, and first aid update, along with all in service trainings required by the center's annual training calendar.

1.08 Entering Alerts (JJIS) and Sharing of Alert Information (Critical)	Satisfactory Compliance
Superintendents shall ensure Critical and Special Alerts are reviewed and responded to appropriately. *Upon completion of the Admission Wizard, the officer shall ensure all Critical and Special Alerts are listed in JJIS.* *The JJIS alert report shall be reviewed daily by supervisors and administrators to ensure it correctly reflects the status of youth.* *If the electronic system is inoperable, for any reason, the JJDO Supervisor shall ensure the last hard copy of the alerts shall have a written notification or update of the recent admissions or changes to existing alerts on the alert sheet and distribute to all staff within the center immediately.* *Medical and mental health staff shall review alerts to ensure each alert is correctly tracked and managed.* *The responses and updates by medical, mental health and other staff should be documented in JJIS alerts as they pertain to the specific alert.* *JJDOS's shall inform staff of alerts during shift briefing. When a JJDOS receives changes to the alert list, he/she shall notify the staff affected by changes and add the information to the shift briefing for the oncoming shift upon receipt of the information.*	

Seven youth management, mental health, and healthcare records and the Department's Juvenile Justice Information System (JJIS) were reviewed for alerts. The center verifies and documents all youth alerts in JJIS. All seven youth were medically graded two through five and had a corresponding alert in JJIS created by nursing staff. All seven youth had mental health alerts initiated and discontinued by a mental health professional. Four youth had security alerts initiated by detention staff. Youth alerts were entered into JJIS, as required, for all seven youth. During detention reviews, youth alerts are reviewed with administration, medical, and mental health staff.

Seven staff were interviewed and all seven stated they are informed of alerts regarding youth and about information from management through shift briefings. Three staff additionally stated alerts are also provided by email. A shift briefing was observed during the annual compliance review and confirmed alerts were reviewed and provided to staff.

Standard 2: Assessment and Performance Plan

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

The center has written procedures to address the admission process, and all youth are admitted to the center in accordance with Florida Administrative Code. Seven youth records were reviewed and contained all appropriate paperwork, to include arrest affidavit/custody order, Detention Risk Assessment Instrument (DRAI), and Suicide Risk Screening Instrument (SRSI). All admission wizard documentation indicated youth were frisked, allowed to make a telephone call, offered a snack or meal, electronically searched, stripped searched, and had medical, mental health, and substance abuse screening. An admission was observed during the annual compliance review. The youth received orientation verbally and watched the video on Prison Rape Elimination Act (PREA). The youth received a meal and was offered a telephone call during the observation.

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

Seven youth records were reviewed for orientation documentation. Each record included the center's rules, regulations, grievance procedures, visitation, telephone calls, youth's rights, how to access the Florida Abuse Hotline, how to request access to mental health and medical care, the behavior management system, and consequences for criminal acts while detained, with a signed orientation acknowledgment form. Each record indicated orientation was completed within twenty-four hours and was documented according to facility operating procedures. Seven

youth were interviewed and all seven advised they were provided information on rules, regulations, schedule, education, visitation, abuse reporting, and the behavior management system upon arrival. An admission was observed during the annual compliance review, which included the orientation video.

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

Seven youth records were reviewed and indicated each youth was appropriately classified upon admission and assigned to a room based on their classification. The center has written classification procedures to ensure all youth admitted to the center are classified by the admitting officer to provide the highest level of safety and security. All areas of the admission wizard were completed, including a review of information concerning the youth's history, sex, height, weight, age and level of aggressiveness, identified special needs, history of sexual offenses, the Victimization and Sexually Aggressive Behavior (VSAB), medical, suicide risk identified or suspected, escape, and security. Youth with a history of committing sexual offenses or have been a victim of a sexual offense are placed in single rooms. The youth were also screened to determine gang affiliation or membership, if suspected, an alert is entered into Department's Juvenile Justice Information System (JJIS).

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

The center has identified a juvenile probation officer (JPO) designated as the circuit gang representative to communicate suspected gang activity. A review of seven youth records indicated all youth were screened for gang affiliation. Two of the seven reviewed youth were identified with gang affiliation, which was documented. One additional closed record was reviewed for gang affiliation. In all three applicable records, a special alert was entered into the Department's Juvenile Justice Information System (JJIS). A review of additional documentation indicated the sharing of gang information by email with the circuit gang representative by the designated center representative.

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

Seven youth records were reviewed and each had a personal property form signed by the youth and the juvenile justice detention officer (JJDO). Personal property, including clothing, is placed in an assigned locker/bag and documented on the Property Receipt Form and stored in a secure room. Two of the seven reviewed records contained documentation of valuable property. All valuable items were inventoried and placed in a clear and tamper-resistant sealed bag, which included a date, youth's name, Department identification number (DJJID), and a listing of items in the bag. The sealed bag is placed in a drop safe which is under camera surveillance with limited access. The drop safe logbook included the date, time, youth's name, DJJID, printed name of the officer who secured the property, and the officer's initials. All seven records contained a signed Letter of Acknowledgement regarding unclaimed property and personal Property Receipt. Seven youth were interviewed and all seven advised staff checked their personal property and they signed a property receipt upon admission.

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

The program safeguards each youth's personal property until it can be returned to the youth or parent/guardian. The youth's personal property is inventoried upon their admission and stored in an individual property bag and contains a completed inventory form. The property is stored in a secure area. Seven records were reviewed, of which two records contained documentation of valuable property, which was inventoried and in clear tamper-proof bags. The sealed bags were placed in a drop safe, which is under camera surveillance with limited access. The sealed bag is

collected by a supervisor with property permission, and it is locked in a file cabinet located in a secure room also under video surveillance. The youth's valuable items are documented in the property logbook. A review of Central Communications Center (CCC) reports for the past six months indicates no incidents regarding youth property being reported.

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

Two closed records were reviewed and one release was observed during the annual compliance review for proper release. In each record and during the observation, the on-duty supervisor reviewed all paperwork related to release prior to the youth's release. The youth's identification was verified prior to release and the identification of the parents/guardians were verified prior to release and a copy was placed in the records. The youth and the parents/guardians were reminded of future court dates. All required parties signed all release forms. Dates of admission and dates of termination documented in each record correlated with the Department's Juvenile Justice Information System (JJIS). A review of Central Communications Center (CCC) reports for the past six months noted no unauthorized releases.

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

Two closed records were reviewed and one release was observed during the annual compliance review, for release of personal property. Both youth records and the observed release determined the youth signed a receipt of property upon release. Two of the three Property Receipt Forms were signed by the youth's parent/guardian upon release. If the items of the youth's personal property remain unclaimed for more than thirty days, the superintendent or designee shall arrange for their disposition. Property held over thirty days, is taken to the sheriff's office for destruction. Money left unclaimed for thirty days is sent to Bureau of Unclaimed Property, Department of Finance.

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

One release was observed during the annual compliance review and two closed records were reviewed for release of medication, aftercare instructions. All three reviewed records contained documentation verifying the youth was released to an appropriate person with a copy of their identification in the file. A receipt of medications signed by the parent/guardian receiving the youth (OHS Form 053) was in all both closed records, and available for the observed release. The records and observation included a reminder to the youth and the person to whom the youth was being released to of any health or welfare issues, including medical, mental health, and/or substance abuse needs and any pending appointments. A review of the records included receipt forms with signatures of parent/guardian, nurse, and staff and included the date the medication was returned.

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

Detention reviews are conducted by the center on a weekly basis to ensure proper management of youth placed in secure detention and appropriate sharing of information. The superintendent has appointed a detention review specialist to coordinate detention reviews weekly on Thursdays at 3:00 p.m. A weekly detention review was observed for youth in secure detention. In attendance were the superintendent, assistant chief probation officer for the circuit, juvenile detention review specialist, juvenile probation officer supervisor, medical representative, mental health representative, and assistant detention superintendent. A weekly sign-in page was available for each meeting during the past six months.

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

Youth are provided the opportunity to participate in constructive activities benefiting the youth and the program. The daily activity schedule is posted in each living area and outlines the days and times for each youth activity. A review of the logbook, interviews, and observations during the annual compliance review indicated the center follows the daily activity schedule. The schedule includes times for personal hygiene, meals, visitation, education, recreation, indoor activities, shift change, bed time, groups, and open program time. Seven youth were interviewed of which six youth confirmed the center has a daily activity schedule.

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

Center staff adhere to the daily activity schedule. A review of the logbook, observations, and interviews indicated the center adheres to the daily schedule. Seven staff were interviewed and indicated the center follows the daily schedule. Seven youth were interviewed and six of seven indicated the scheduled is followed. One youth indicated the schedule may be changed if there is not enough staff.

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

The center integrates educational instruction (career and technical education, as well as academic instruction) into the daily schedule. A review of the logbook, observations, and interviews indicated the center provides educational access. Each youth attends school for five hours each day. The center provides education on a 250-day calendar over twelve months. The teachers have teacher training and planning days up to ten days a year. Youth enrolled in the center's educational programs have the opportunity to earn course credit for completion of the education and training experience. Seven youth and seven staff were interviewed and confirmed minimal interference of educational instruction.

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

The center provides career education to each youth. The center provides Type 1 programming which includes life skills groups, activities, and instruction. The youth at the center receive instruction in the areas of communication, interpersonal, and decision-making skills.

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

The center provides a system of rewards, privileges, and consequences to encourage youth to fulfill the program's expectations. There is an implemented and maintained behavior management system (BMS) to meet the needs of the youth and the center and it includes utilization of positive rewards. The BMS includes rewards for positive behavior and consequences for inappropriate behavior. The behavior norms and expectations are posted in all living areas and specify appropriate and inappropriate behaviors. Observations of daily activities revealed implementation of the BMS. Seven youth were interviewed and three of seven ranked the BMS as fair, two stated it was good, and two stated it was poor. Seven staff were interviewed and seven stated the BMS is effective.

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

The center's behavior management system restricts certain types of penalties on youth who demonstrate negative behaviors. Group punishment is not used as a part of the center's behavior management plan. Policy prohibits group punishment, unauthorized use of punishment, and corporal punishment. Seven staff were interviewed and all of the staff advised consequences for inappropriate behavior does not include loss of meals, snacks, sleep, or school. Seven youth were interviewed and two advised they never received any consequences, four advised none were ever taken away, and one advised snack was taken. Each of the seven youth advised they are not allowed to punish other youth. All interviewed staff advised no youth are encouraged to beat up other youth.

2.17 Grievances	Satisfactory Compliance

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

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

The center has policy and procedures regarding each youth's right to grieve and to be treated fairly, respectfully, without discrimination, and their rights are protected. The process includes an informal phase, a formal phase, and an appeal phase. Grievance forms were available in the living areas for the youth. During the past year, no grievances were filed for review. All seven interviewed staff were able to explain the grievance process. Each of the seven interviewed youth indicated they had never filed a grievance. Superintendent interview results explained the phases of the grievance process and any grievances would be entered into the Facility Management System (FMS) system on behalf of the youth.

2.18 Trauma-Informed Care	Satisfactory Compliance

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

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

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

The center has a policy and procedures in place regarding trauma-informed care. The center is incorporating trauma-informed practices into current operations to deliver services and to provide care to youth in custody. An interview with the superintendent revealed the center has a soft room and murals throughout the center and within the rooms to soften the aesthetics. Seven staff training records were reviewed and found all of the staff received training in trauma-informed care, as documented in the Department's Learning Management System (SkillPro).

Standard 3: Mental Health and Substance Abuse Services

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

The center has a licensed mental health professional designated as the mental health clinical authority (DMHCA), whose license is clear and active and expires March 31, 2021. The DHMCA is on-site for forty hours a week, Monday through Friday. The DMHCA is a licensed mental health counselor under Chapter 491. The DMHCA confirmed she provides oversight of the department to ensure services are provided to include Assessment of Suicide Risk, development of treatment plans, individual and group sessions, discharge summaries, psychosocial evaluations and crisis evaluations, and communicating with detention administration about any mental health needs of youth in the center.

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

The center's clinical staff includes a psychiatrist and licensed mental health professional. The psychiatrist has a clear and active license with a specialty in child and adolescent psychiatry. Based on the contract, the psychiatrist is to be on-site two hours each week. A review of the contracted provider sign-in log noted three exceptions which included the week of February 26, May 21, and July 2, 2019. The psychiatrist was on vacation during these dates.

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

The center employs one non-licensed mental health professional who started August 6, 2018. The non-licensed staff has a master's degree in mental health counseling. Documentation reflected the non-licensed staff has received twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. This training included administration of five Assessments of Suicide Risk or crisis assessments conducted on-site in the presence of the licensed mental health professional. The non-licensed staff also received one hour a week of on-site face-to-face supervision by the designated mental health clinical authority (DMHCA), with the exception of three weeks (January 28, April 22, and July 10, 2019). The non-licensed staff was on scheduled leave these weeks and did not provide services at the center.

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

The center has a policy and procedures regarding mental health and substance abuse admission screening which was signed by the superintendent and designated mental health clinical authority (DMHCA) on August 6, 2018. Seven youth records were reviewed regarding mental health and substance abuse admission screening. Each youth had a Suicide Risk Screening Instrument (SRSI) and Massachusetts Youth Screening Instrument – 2 (MAYSI-2) completed at intake by a juvenile probation officer. Documentation reflected a review of these instruments were completed by detention staff. These documents were completed in the Department's Juvenile Justice Information System (JJIS). In six of seven records, documentation reflected mental health staff completed their required section of the SRSI. In one record, this section of the SRSI was blank due to an oversight of the mental health staff. The completed forms included summaries and recommendations in the "Screening Results" section. All of the youth had a positive response on the SRSI and were, therefore, placed on suicide precautions, and a mental health referral was completed which documented the youth's need for an Assessment of Suicide Risk (ASR). All screenings were completed by trained staff. In all seven records, the results of the SRSI and/or the MAYSI-2 indicated a need for further assessment. In each of the records, a mental health referral was made and the superintendent or designee was notified of the youth's status. Four of the seven youth had an elevated suicide risk sub-scales based on the MAYSI-2 and were placed on suicide precautions. The results of six youth's MAYSI-2 indicated a need for a Comprehensive Assessment and this was reported to mental health clinical staff by detention staff.

The superintendent stated the suicide risk screening instrument is started by the juvenile probation officer (JPO) screener, it is then sent to the juvenile justice detention officer completing the admission, reviewed by the supervisor, and then completed by mental health staff. JPOs also complete the MAYSI-2.

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

Seven records were reviewed for completion of a mental health and substance abuse evaluations. Three youth received a Comprehensive Assessment through a community provider. The remaining four youth are scheduled for evaluation within two weeks. All seven will be completed within thirty days of the referral date.

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

Three of the seven youth records were applicable for mental health and substance abuse treatment. Each of the three youth were assigned to a mini-treatment team which consisted of mental health clinical staff, a staff from a different service area, the youth, and the parent/guardian, if possible. The three youth were each determined to be in need of mental health treatment and, therefore, received individual and group counseling provided according to the frequency of their plan. The youth each had a proper consent for treatment. Treatment notes were documented on the Counseling/Therapy Progress Note. Mental Health staff have adequate access to youth to provide treatment services. Group therapy is limited to ten or fewer youth with mental health diagnoses for mental health treatment groups and fifteen or fewer youth with substance abuse diagnoses for substance abuse treatment groups.

Seven youth were interviewed and five reported they are not receiving mental health services. The two which reported receiving services rated services were good and very good.

The designated mental health clinical authority (DMHCA) stated she provides individual counseling sessions, group sessions, assessments of suicide risk, psychosocial evaluations, and develops treatment plans, as needed.

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

Three of the seven reviewed youth records were applicable for requiring a treatment plan. The initial treatment plan was in place within seven days of the initiation of treatment. In each of the three records, the initial treatment plan was developed on the Initial Mental Health/Substance Abuse Treatment Plan form. The treatment plan contains the reason for the referral for treatment, the initial DSM-5 diagnosis and symptoms, initial treatment methods, initial treatment goals, psychiatric services including psychotropic medication and frequency of monitoring, the signature of the mental health professional, youth signature, and the signatures of the mini-treatment team members involved in the development of the initial treatment plan. For each of the three youth, the individualized treatment plan was developed prior to the thirty-first day of the youth’s admission. A licensed mental health professional signed each plan within ten days

of completion. The plans contained symptoms which are treatment focused, treatment goals, strengths/abilities, preferences/needs, and psychiatric services including psychotropic medication and frequency of monitoring, and pharmacological interventions. Progress notes for each of the three youth validated they are receiving treatment services as stipulated on the treatment plan. Each of the individual treatment plans were signed by the youth, mental health professional, and the treatment team members. The parent/guardian was contacted by phone and a voicemail was left regarding the individual treatment plan in each instance. The treatment plans included treatment and services provided by a licensed psychiatrist. None of the youth were alleged to be victims of a Prison Rape Elimination Act. One of the three individual treatment plans were due for a review. The review occurred on time and modifications were documented on the review form. The review was signed by clinical staff, the youth, and the licensed mental health professional. Reviews of the other treatment plans were not due, as thirty days had not yet passed.

Three of the seven reviewed youth records were applicable for review of mental health treatment discharge summaries. In each record, the form was completed upon the youth's discharge. In two records, it was documented on the form it was mailed to the parent/guardian, one form did not have signatures to verify if it was provided to the youth, parent, and juvenile probation officer as the document was sent with the youth's chart and the center was only able to provide a printed copy.

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.	

Three of the seven reviewed youth records were for youth who entered the center on psychotropic medication. The initial psychiatric interview for each youth included the following information: reason for the referral, history (medical, mental health and substance abuse history), mental status examination, DSM-IV-TR or DSM-5, treatment recommendations, prescribed medications, explanation of the need for psychotropic medication, and frequency of medication monitoring/management. For each youth, an in-depth psychiatric evaluation was conducted within thirty days of admission.

The in-depth psychiatric evaluation included all of the following elements: the stated reasons and factors leading to the referral, social history, history of psychiatric illness, mental status examination, diagnostic formulation, treatment recommendations and interventions, prescribed medication, explanation of the need for psychotropic medication, and the signature of the practitioner conducting the evaluation. The CPPN, page three, was completed when a new psychotropic medication was prescribed or there were any changes to the existing prescription. The psychiatric evaluation included the following when a new psychotropic medication was prescribed/dispensed/administered by the psychiatrist: identifying data, diagnosis, target symptoms of each medication, evaluation and description of effect of prescribed medication of target symptoms, side effects, youth's adherence to the medication regimen, height, weight, and blood pressure, whether there was telephone contact with the youth's parent/guardian to discuss the medication, the signature of the psychiatrist and date of his signature. Each youth had a completed Authority for Evaluation and Treatment (AET).

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

The center has a written plan detailing suicide prevention procedures. This plan includes 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.*	

All seven youth records reviewed were identified as being at risk for suicide during the admission screening process. Each youth was put on precautionary observations as a result. An alert was automatically generated in the Department's Juvenile Justice Information System (JJIS) as a result of the Suicide Risk Screening Instrument (SRSI) assessment. A suicide risk assessment referral was also completed for each youth on their admission date as a result of the SRSI assessment. The Assessment of Suicide Risk (ASR) was completed for each youth using the Department's form. Each ASR form documented the assessment of the youth in real time. Each youth began on constant supervision as a result of the SRSI and after the completion of the ASR, were placed on standard supervision. The ASR was completed within twenty-four hours for each of the seven youth. There was a documented conference held with the licensed mental health professional and superintendent or designee to reduce the youth's level of supervision. The suicide precaution observation logs were all completed in their entirety to include documented "safe housing areas." A qualified mental health professional was involved in each of the seven records reviewed. In each of the seven reviewed records, documentation reflected the superintendent, or a designee, was notified immediately of the youth's suicide risk. A referral for each youth was made during the intake process to the mental health professional.

Seven suicide risk assessments were reviewed. Two were completed by the licensed mental health professional. The remaining five were completed by non-licensed clinical staff working under the supervision of the licensed mental health staff. The non-licensed staff completed the required twenty hours of ASR training. The center's logbooks and suicide risk assessment reflected administrative or supervisory staff provided instructions related to the suicide risk assessment findings; the logbooks also reflected beginning and end times for youth placed on suicide risk. None of the youth reviewed were placed on secure observation.

The superintendent has an established review process for every serious suicide attempt or serious self-inflicted injury. The multidisciplinary review includes: circumstances surrounding the event, facility procedures relevant to the incident, all relevant training received by involved staff, pertinent medical and mental health services involving the victim, possible precipitating factors, and recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and/or operational procedures.

Seven staff members were interviewed and all seven reported if a youth expresses suicidal thoughts staff are to notify the mental health authority; additionally, five reported they are to search the youth and the youth's room for sharp objects, document supervision, and provide constant sight and sound supervision.

The superintendent confirmed secure observation is used for youth who pose a risk of harm to themselves or others. A staff is posted outside the room and maintains constant supervision of the youth. A mental health referral is completed, and mental health is notified. A secure observation log is maintained which documents the youth's behavior in thirty-minute intervals. Youth in secure observation remain on secure observation until they are stepped down by a mental health professional.

Five youth who have been on suicide precautions were asked if staff watched them at all times and each youth reported yes.

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

Each of the seven youth records reviewed had Suicide Precaution Observation Logs maintained for the duration the youth were on suicide precaution. For each record, the appropriate level of supervision and observations of the youth's behavior were documented in real time and did not exceed thirty-minute intervals. Each Suicide Precaution Observation Log was reviewed and signed by each shift supervisor and by mental health clinical staff. Five of the youth who were on suicide precautions were interviewed and all reported staff were with them at all times while they were on precautionary observation. A review of the seven completed Suicide Precaution Observation Logs confirmed supervision, supervisory reviews, response to warning sings, and safe housing requirements were met.

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.	

Seven pre-service training records and seven in-service training records were reviewed. Each staff completed training in the Department's Learning Management System (SkillPro), as well as an instructor-led training which totaled over six hours. Training for staff also included mock suicide drills which were held no less than quarterly on each shift, for all staff who come in contact with youth. A review of the mock suicide drills confirmed the drills are typically completed monthly on each shift, but no less than quarterly. Each of the reviewed staff participated in quarterly drills with a minimum of one quarterly drill semi-annually.

Staff members who are not present during a quarterly drill have the opportunity to review each drill scenario and procedures in an effort to understand the process and receive the necessary training to respond to an incident of a suicide attempt or incident of serious self-inflicted injury in the center.

Seven staff were interviewed; all seven reported the suicide response kit is located in master control and sub control, three reported in medical, five reported in the shift supervisor office, and two stated in the vehicles.

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

The program has a written mental health crisis intervention plan which details crisis intervention procedures. The plan includes the notification and alert system, means of referral, including self-referral, communication, supervision, documentation and review.

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

The center has an emergency care plan which includes immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment under Chapter 394 Baker Acts, transport for emergency substance abuse assessment and treatment under Chapter 397 Marchman Acts, documentation, training, and review. The plan was signed by the superintendent and designated mental health clinician authority on August 6, 2018. The plan is located in the superintendent office, medical clinic, mental health office, and the briefing room. The plan is accessible to all staff.

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

The program has not completed any crisis assessments at the program since the last annual compliance review. The program has a policy and procedures to address crisis assessments which includes all required elements.

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 center has a policy and procedures for Baker and Marchman Acts. None of the seven youth reviewed were applicable for Baker or Marchman Acts. Three additional youth records were reviewed. Each of these three youth were placed on suicide precautions upon re-admission from the Baker Act. The youth were maintained on a minimum of constant supervision until properly transitioned to a lower level of supervision. The youth's supervision level was not lowered until an appropriate assessment was conducted and mental health staff conferred with the superintendent or designee. The discontinuation of the suicide risk alert and suicide precautions was based on the Assessment of Suicide Risk.

Standard 4: Health Services

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

The center has a licensed medical doctor who holds an unrestricted license and meets all requirements for independent and unsupervised practice in Florida to serve as the designated health authority (DHA). The DHA has a specialty in family medicine with a license which expires on January 31, 2020. The DHA delegates clinical duties to an Advanced Practice Registered Nurse (APRN), as a designee. The APRN holds an unrestricted license to practice in Florida with a clinical specialty in family medicine. The APRN license expires on July 31, 2020. The protocol is maintained on-site at the center. The hours the DHA is on-site are posted in the medical clinic. The DHA is on-site weekly and is on call twenty-four hours a day, seven days a week. A review of the sign-in log found the center ensured there was DHA coverage for each week during the annual compliance review period. The center also ensured no more than nine days passed between visits. The DHA is responsible for communication with the center's staff regarding youth medical needs, and electronically available for acute medical concerns, emergency care, and coordination of off-site care. The DHA performs comprehensive physical assessments, conducts sick call when on-site, conducts periodic evaluations for youth with chronic conditions, reviews currently prescribed medications, and reviews and updates policy and procedures. The role of the DHA at the center was confirmed during an interview with the DHA. Tele-medicine is not utilized at this 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.	

There are facility operating procedures (FOPs) for all health-related procedures and treatment protocols at the center. An annual review of the FOPs last occurred on July 5, 2018. The new FOPs were received by the center from detention services on July 25, 2019, during the annual compliance review. The superintendent was newly assigned and started at this center on July 22, 2019. The review of the FOPs related to psychiatric services was signed by the designated health authority (DHA) when reviewed in 2018. An annual review of all treatment protocols by the DHA and the superintendent is documented. The DHA and superintendent signed and dated all respective treatment protocols. Approval of medical treatment protocols or standing procedures are written and authorized by the DHA and are not delegated to any other person. Nursing staff review, sign, and date a cover page on which all FOPs, treatment protocols, and other procedures, at least annually. All newly employed health care personnel receive a comprehensive clinical orientation to the Department's Healthcare policies and procedures, by a registered nurse.

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

Seven youth individual healthcare records were reviewed for Authority for Evaluation and Treatment (AET). Each youth record had a current signed AET filed with the word “copy” legibly stamped on it. No parent/guardian refused to sign the AET. All seven AETs were obtained prior to providing medical services with the exception of routine medical intake screenings. One of the AETs was a Limited Consent for Evaluation and Treatment for a youth who is in the custody of the Department of Children and Families due to the parental rights being terminated.

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

Seven youth individual healthcare records (IHCRs) were reviewed for parental notification and consent. Four youth were applicable for parent/guardian notification. One youth IHCR required notification of over-the-counter medication beyond those covered by the Authority for Evaluation and Treatment (AET). Two youth IHCRs required notification for changed in medication for youth with chronic conditions. None of the youth IHCRs required a notification to be sent for emergency care. Three youth required notification for new medication. All three IHCRs had documentation of the parent/guardian notification by telephone and followed by a written notice regardless of the telephone notifications. Two youth required parental notification regarding psychotropic medication. In both IHCRs, verbal consent was documented followed with written notification being sent. The written notification included the Clinical Psychotropic Progress Note (CPPN). None of the youth IHCRs required notification regarding vaccinations.

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

Seven youth individual healthcare records (IHCRs) were reviewed for healthcare admission screening. All seven IHCRs had a Medical and Mental Health Admission Screening form for the most recent admission. All seven IHCRs had documentation the screening date was the admission date. All seven were completed by a juvenile justice detention officer (JJDO) and reviewed by a licensed nurse within twenty-four hours. The notification was documented in the youth’s IHCR for all seven youth. None of the youth had a change in physical custody since the youth’s most recent arrival. Two of the seven youth were female. One youth received a qualitative urine pregnancy screening test at the time of admission. The other youth received the pregnancy test five days after admission. During an interview with the superintendent, it was confirmed the center’s practice at admission of the JJDO completing the form which is reviewed within twenty-four hours by a licensed nurse.

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

Seven youth individual healthcare records (IHCRs) were reviewed for youth orientation to healthcare services. All seven youth IHCRs had documentation the youth received general healthcare orientation within twenty-four hours of admission to the center. The healthcare topics included access to medical care, sick call, what constitutes an emergency, medication process, right to refuse care, Prison Rape Elimination Act (PREA) information, and the role of the healthcare providers. Youth orientation to healthcare services was documented for each admission into the center, regardless of how recent the date of the last admission.

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

Seven youth individual healthcare records (IHCRs) were reviewed for designated health authority (DHA) admission notification. None of the seven youth were identified as in need of emergency care. Four of the youth were identified as possessing a medical concern or chronic condition. The DHA was notified at the time of admission and documented in the youth's IHCR. Youth with known or suspected chronic conditions were referred to the DHA or Advanced Practice Registered Nurse (APRN). Three youth were taking psychotropic medication upon admission for which the DHA and psychiatrist was notified.

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

Seven youth individual healthcare records (IHCRs) were reviewed for health-related history (HRH). Each youth IHCR had a HRH completed within seven days of the youth's admission. Three of the HRHs were new and four HRHs were updated. All seven HRHs were completed by a licensed nurse. Each of the seven HRHs had documentation they were reviewed by the Advanced Practice Registered Nurse (APRN) before or at the time of the Comprehensive Physical Assessment. All HRHs were documented on the Department's most recent form.

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

Seven youth individual healthcare records (IHCRs) were reviewed for a Comprehensive Physical Assessment (CPA) and Tuberculin Skin Test (TST). Four youth IHCRs had documentation of a current CPA on file at the time of admission. The current CPA was reviewed, initialed, and signed by the Advanced Practice Registered Nurse (APRN). A current CPA was used for the four youth and a focused evaluation was documented within seven days of admission. Three youth had a new CPA conducted within seven days of admission. The medical grade was noted on each CPA and appropriate alerts were entered or verified as required. All seven CPAs were completed in full with no missing or incomplete elements. All

seven youth IHCRs had documentation where part of the exam was refused or deferred and documented as required. For any refusal, the youth signed a separate refusal form. The Department's Problem List was updated as needed for six applicable youth.

At least one TST test was documented on the CPA and the Infectious and Communicable Disease (ICD) form for all seven youth. All seven youth IHCRs had documentation the Tier 1 Tuberculosis (TB) screening was completed on the Medical and Mental Health Admission Screening form. None of the youth required further evaluation as a result of the TST test.

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

Seven youth individual healthcare records were reviewed for sexually transmitted infection (STI) and human immunodeficiency virus (HIV) screening. A STI screening was completed by the advanced practice registered nurse (APRN) within seven days of admission. Four youth required further evaluation. Two youth IHCRs had documentation of the results on the Infectious and Communicable Disease (ICD) form. Two youth IHCRs had not yet received the testing results. All seven youth were offered counseling, testing, and treatment referral for HIV. Four of the seven youth consented for a HIV test. Two youth received testing and two are pending the testing. Documentation of the pre-test counseling is documented on the Individual Health Education Record for each of the two youth who were tested. The youth HIV results are in a sealed envelope, marked confidential in each healthcare record. Five of the seven interviewed youth stated they could ask for an HIV test and two youth stated no.

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

Seven youth individual healthcare records (IHCRs) were reviewed for the sick call process. One youth IHCR was applicable. Two additional IHCRs were requested and reviewed. All three youth IHCRs sick call request forms conformed to professional standards and documentation. The documentation included all elements of SOAP (Subjective, Objective, Assessment, and Plan) found in each youth's IHCRs. For each youth, if the licensed practical nurse (LPN) conducted sick call, it was reviewed by the designated health authority (DHA) or the advanced practice registered nurse (APRN) within twenty-four hours. Each sick call was documented on the sick call index. None of the youth presented a similar sick call complaint three or more times in a two-week period. None of the youth complained of any severe pain in which staff were unfamiliar. There are approved treatment protocols appropriate to the level of the provider conducting sick call. The LPN provides sick call and the DHA and APRN will conduct sick call when on-site. Sick call is conducted daily during the medical clinic open hours. When there is no licensed nursing staff on-site, there are procedures in place for the shift supervisor to review all sick call requests after a request is submitted. Youth privacy is ensured during sick call encounters with a curtain to separate the youth. Youth have the ability to request sick calls and report it as a private matter, if necessary. A sick call was observed with the youth's permission. The youth was escorted to the medical clinic by the direct care staff. The LPN clarified why the

youth was there and had the youth initial they was being seen, prior to the exam. The youth was seen in a private area with no other youth present to hear or see the examination. The youth was examined by the LPN. The direct care staff was in the room but at a distance away in order to maintain privacy. Seven youth were interviewed regarding how quickly a youth can be seen once the youth makes the sick call request. Three interviewed youth stated immediately and one youth stated within one day. Three interviewed stated they had never requested a sick call. Three interviewed youth stated the nurse conducts sick call and three interviewed youth stated they had never requested a sick call. One youth stated they did not know who conducted sick call as the youth put in a sick call the previous day and still had not been seen. A review of the youth's record disputed the youth's response. Two youth stated the medical care is very good and three youth stated the medical care is good. Two youth stated they had not received medical

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

Seven youth individual healthcare records (IHCRs) were reviewed for episodic care. Three youth IHCRs were applicable. The three youth had a total of seven episodic care incidents. None of the episodic care incidents were conducted by non-healthcare staff. The documentation included all elements of SOAP (Subjective, Objective, Assessment, and Plan) found in each youth's IHCRs. Six of the seven incidents were logged in the episodic care log. One incident was not found documented in the log. The center has seven first aid kits located inside the building and seven additional first aid kits designated for the center's transportation vans. Three first aid kits were reviewed and no expired contents were found. The first aid kits were fully stocked with approved contents. There was documentation the first aid kits are monitored monthly and replenished, as needed. The center has two Automated External Defibrillators (AEDs) located in the building. One in the administrative conference room and one in the subcontrol/supervisor's office on the main hallway. The instruction guides are attached to the AEDs. The AED batteries and pads are checked monthly by the nursing staff. The AEDs were new AEDs to the center in January 2019. The monthly check occurs on the computer with a printout of the date and time provided. The AED batteries were installed in August 2018 and expires four years from the date. The AED pads were installed in September 2018 and expires four years from the date. A test was conducted on each AED. Mock emergency medical drills are conducted quarterly. Mock emergency medical drills were reviewed for the past four quarters. Cardiopulmonary resuscitation (CPR)/AED were not demonstrated during the July to September 2018 quarter. There was one drill which included a demonstration of CPR/AED for one of the two shifts for the quarter of October to December 2018. Each shift had drills which included a demonstration of CPR/AED for the last two quarters of January and June 2019. A list of emergency numbers is maintained by master control and in the medical clinic. The numbers are inaccessible to youth. Seven pre-service and seven in-service staff training records were reviewed for CPR and AED certification. Each staff had training in CPR and AED. All licensed healthcare staff maintain current CPR and AED certification. Seven interviewed staff stated they are able to call 9-1-1 if they feel it is necessary.

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

Seven youth individual healthcare records (IHCRs) were reviewed for off-site care. One youth IHCR was applicable. Two additional IHCRs were requested and reviewed. All three youth IHCRs had documentation the Summary of Off-Site Care form was utilized for the off-site care. The designated health authority (DHA) was notified of the off-site care for each youth. Two of the off-site care instances were for emergency care and both were documented on the episodic care log. The DHA or the advanced practice registered nurse (APRN) initialed off-site findings, instructions, and information. Two of the youth required follow-up appointments. One was released prior to the next appointment. The remaining youth was referred and attended follow-up appointments, as needed.

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

Seven youth individual healthcare records (IHCRs) were reviewed for chronic conditions or periodic evaluations. Four youth (IHCRs) were applicable. None of the youth had been in the center for more than ninety days. There was documentation of periodic evaluations prior to the renewal of medication. All periodic evaluations were documented on chronological progress notes. Treatment orders were written so they were clearly distinguishable for clinical staff. There were no indications of lapses in care or missed periodic evaluations. The Department's Problem List was up-to-date for all four youth.

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

Seven youth individual healthcare records (IHCRs) were reviewed for medication management. Three youth were applicable for being on medication at the time of admission. None of the youth arrived with medication. All three youth IHCRs had documentation the designated health authority (DHA) and/or psychiatrist was contacted in order to resume the specified medications the youth was prescribed. The medical clinic ordered the current prescribed medication from the pharmacy for each youth. Over-the-counter (OTC) medications not listed on the Authority for Evaluation and Treatment (AET) form are administered according to approved protocols. The standard Department Medication Administration Record (MAR) is used to document all medication and treatment. The MAR contains the youth name, Department identification number, date of birth, youth allergies, precautions, medical grade, medical alerts, and a current picture of the youth. The MAR clearly indicates medication start and stop dates. Staff initial each administered medication entry. There were no lapses or errors in medication administration. The youth initials each medication administered. At a minimum, the nursing staff documents side effects weekly on the MAR. None of the youth required parenteral medication. Only trained non-healthcare supervisory staff may assist in the delivery of medications only when licensed staff are not on-site. The six rights of medication administration are maintained. Refusals are clearly

documented on the MAR and a separate refusal form. There are no standing orders or pro re nata (PRN) orders for psychotropic medications. For youth prescribed psychotropic medication upon admission, the DHA and psychiatrist were notified upon admission. The psychotropic medications were ordered to continue until an initial diagnostic psychiatric review. For the two applicable youth receiving psychiatric medications over thirty days, there was a review by the psychiatrist every thirty days. One youth was referred to psychiatrist subsequently to admission and placed on psychotropic medications.

Medication administration was reviewed. Medication administration is the sole responsibility of the nurse during the administration. Nursing staff are not expected to supervise any other activities during this time. Youth are escorted to the medical clinic by direct care staff. Youth approach the nurse individually, there were no other youth in the medical clinic at the time. The six rights to medication administration are verified.

Nursing staff observed youth to make sure medication is swallowed. There was no pre-pouring of medications. All medications are in a separate locked area designated for medication storage, inaccessible to youth. Medications are stored separately by type or form. Medications requiring refrigeration are stored in a secure refrigerator used for medication only. Syringes and sharps are secured in a cabinet inaccessible to youth. The center destroys medication when the pharmacy representative is on-site. Seven youth were interviewed regarding who gives the youth medication. Six youth stated the nurse gives them medication, one youth stated staff give the medication, and one youth stated they did not take medication. One youth has asthma and stated they can ask anyone for their inhaler. Seven staff were interviewed regarding providing medication to youth. Three staff stated they do give medication to youth and four staff stated they do not give medication to youth.

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

Any medical equipment classified as sharps are securely stored. A perpetual inventory and a weekly inventory of all sharps is conducted. A perpetual daily running inventory of medication utilization for all prescribed and over-the-counter (OTC) medications is maintained. The center destroys medication when the pharmacy representative is on-site. Controlled substances are maintained in a locked container inside the locked medication cart. Shift-to-shift inventory counts are conducted on all controlled substances and documented on the youth's Individualized Controlled Medication Inventory Record. Only trained non-healthcare supervisory staff may assist in the delivery of medications only when licensed staff are not on-site. There are weekly inventory counts for all opened OTC medications. Random inventory counts were conducted on three sharps, three prescribed medications, and three OTC medications. One sharp count did not match the inventory. Two prescribed medication counts including one controlled substance, did not match the inventory. All three discrepancies which were off by one, were corrected immediately after being reconciled with other documentation confirming the counts were accurate.

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

Seven youth individual healthcare record (IHCRs) were reviewed for infection control, exposure control, and education. All seven youth IHCRs had documentation the youth received infection control training within seven days of admission. Training topics included hand-washing techniques, universal precautions, prevention/transmission of communicable diseases, vaccinations, and guidelines for infection control. The center's exposure control plan includes risk assessment, methods of compliance, and engineering and work practice controls. The exposure control plan is reviewed and signed annually by the superintendent. The center's infection control procedures include prevention, containment, treatment, and reporting requirements. Seven pre-service and seven in-service staff training records were reviewed. Each staff had training on the center's specific exposure control plan. There was no documentation of an instances in which the local county health department, Centers for Disease Control and Prevention, or the Central Communications Center (CCC) should have been notified of an infectious disease.

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

Seven youth healthcare individual records (IHCRs)were reviewed for prenatal care and education. One youth IHCR was applicable. Two additional IHCRs were requested and reviewed. All three IHCRs had documentation prenatal care began immediately upon determination of the youth's pregnancy. The advanced practice registered nurse (APRN) or designated health authority (DHA) conducted an initial focused medical evaluation. Only one of the three youth were applicable for a focused evaluation after thirty days. The evaluation was completed as required. Each youth had daily monitoring of the danger signs of pregnancy complications. Each youth received pregnancy education which included topics of alcohol and drug use, smoking, nutrition, sexually transmitted diseases, contraception, prenatal care, and birthing process. Additional topics were postpartum care, infant development, and parenting skills. Each youth received nutritious food in quantities appropriate for a pregnant youth. Each youth had weekly monitoring of weight and youth's nutritional status. All pregnancy education was documented in the youth's IHCR. Seven staff training records were reviewed and confirmed staff receive education on pregnant youth. Seven youth were interviewed and only one was applicable for prenatal, obstetrical, or gynecological services. The youth stated they had received those services since being in the center.

Standard 5: Safety and Security

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

The center has a written policy and procedures addressing the active supervision of youth. Youth were observed throughout the week in various areas of the center through the closed-circuit television (CCTV) system from master control. Observation determined the staff were appropriately supervising the youth in their care. Youth were accompanied by staff at all times. Master control authorized all movement of youth prior to the youth being moved. A review of the center's logbooks documented counts were conducted at the beginning and end of each shift, as well as periodically during the shift. Tracking of youth daily census is collected and documented within the master control logbook and within the Department's Juvenile Justice Information System (JJIS), as well as a white board in master control. Three of the seven interviewed staff responded counts are conducted at the beginning and end of each shift. Three staff responded counts are conducted before and after school, and before and after meals. If the count is incorrect a re-count is conducted. Five of the seven interviewed staff reported they feel there is enough staff at the center to provide for the safety and security of the youth and staff.

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

The center has a written policy and procedures to ensure ten-minute checks are conducted when youth are in their rooms. The center has eighty-nine cameras, which all are operational and store video recordings for up to thirty days. The center utilizes the Guard One Electric System (Wand). The checks are downloaded to a computer and are documented electronically. Ten-minute checks were reviewed for five different days in June and July 2019. One ten-minute check was conducted thirty-one minutes late on June 27,2019, for the time period of 12:00 a.m. through 12:31 a.m. One check was conducted twenty-four minutes late and another was twenty-five minutes late on June 29, 2019, for the time period of 12:00 a.m. through 12:25 a.m. On July 2, 2019, for the time period of 6:00 a.m. through 6:20 a.m., one check was conducted two minutes late. There were issues with checks reviewed on July 6, 2019. On July 18, 2019, two checks were conducted three minutes late for the time period of 11:01 p.m. through 11:14 p.m. Six of the seven interviewed staff reported room checks are conducted every ten-minutes.

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

The center has a written policy and procedures in place to track all youth placed in the center. Master control logbooks and logbooks which are maintained on each module were reviewed for the past six months. Youth counts are routinely completed multiple times throughout the day

following releases, new admissions, and after group movement. Observations were made of counts being conducted during the course of the annual compliance review. During an interview with seven staff, it was reported emergency counts were conducted when a youth is believed to be missing, when visibility is hindered, after a major disturbance, and after a drill.

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

The center has a written policy and procedures regarding logbook maintenance. The center has separate logbooks for master control, each youth module, contracted staff, and visitors. All observed entries were made in real time and no military time was used. Logbook entries contained chronological record of events including the date and time, names of youth, staff involved, and a brief description of the event. All entries were documented in black or blue ink and errors were struck through with a single line. Logbook entries regarding medical, special needs, and mental health alerts were highlighted. Master control logbook captures emergency situations, incidents involving youth, drills, counts, confinements, and all other important information.

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

The center has a written policy and procedures in place addressing logbook reviews. A review of the center's logbooks for the previous six months revealed the superintendent or designee reviews all logbooks on a weekly basis. Module logbooks are reviewed on a daily basis by the supervisors. There was documentation of the superintendent or designee touring the youth living areas at least once during each shift. Observation revealed all required staff including the superintendent or designee and supervisors, reviewed and signed the logbooks as required.

During an interview with the superintendent, it was stated the supervisors are expected to review the logbooks daily and administration is expected to review them weekly.

5.06 Key Control	**Satisfactory Compliance**
Each center is responsible for maintaining inventory and control of all facility keys. *All keys shall be placed on a tamper-resistant key ring designed to inhibit the removal of keys.* *Emergency key rings shall be maintained separately from other facility keys, in master control, in a secure location designated by the Superintendent. These keys shall be notched or otherwise identifiable by touch.* *The key(s) on these rings shall provide egress through facility exterior doors providing access to evacuation areas.* *A key inventory shall be maintained by the Superintendent or designee at all times.* *(For the entire indicator statement, please reference the Monitoring and Quality Improvement FY 2019-2020 Detention indicators.)*	

The center has a written policy and procedures regarding key control. An inventory of all keys is maintained and includes all required information and matches observation made of the centers keys. Key inventories are maintained and stored by the assistant superintendent. Emergency keys were located in master control. Youth in the center do not have access to keys. Staff keys are secured in a shadow box or staff's personal locker. The issuing of keys is documented on each shift with the date and time of issue, name of staff issuing the key ring, and to whom. This is maintained in the Juvenile Justice Information System (JJIS) shift report. Key rings were inspected and all had a tamper-proof key set with a tag label and number of keys. The center did not have any reports of lost or missing keys for the past six months. Seven interviewed staff were able to describe and identify the restricted keys within the center as medical and the kitchen. Six of the seven staff stated their center keys cannot access youth property. Three of the seven staff stated their center keys cannot access mental health records or case management records.

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

The center has a policy and procedures for vehicles and maintenance. The center has a total of six vehicles which are used for transportation. Four available vans were inspected during the annual compliance review. Each vehicle had the appropriate number of seat belts, seat belt cutters, window punches, fire extinguishers, and first aid kits. First aid kits are not left in the vehicle but are taken on each transport. Observation of a transport indicated the youth were searched upon their return to the center. All weekly and monthly vehicle checklists were in compliance and completed for the past six months. Documentation further revealed the annual maintenance inspections have been completed, as required. 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 securely anchored, test the security screen, confirm the vehicle folder contains all required information, and ensure all youth are searched prior to being placed in the vehicle. This information is required for documentation in the vehicle logbook. A review of the vehicle logbook and master control logbook found staff were not documenting inspections as required.

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

The center has a written policy and procedures for tools. Tools are stored in a building which is separate from the center and requires authorized key pad access. Maintenance staff maintain a tool inventory binder which is inspected monthly. Tool inventories are signed off monthly by the superintendent. Service vendors are always accompanied by a designated center staff at all times when in the secure area of the center. The maintenance staff described the policy for lost tools. Seven interviewed staff stated if a tool is damaged or missing, the center will stop all movement and conduct a search of the youth. Kitchen knives and other hazardous kitchen sharps are stored in a locked cabinet. An itemized inventory of all kitchen tools is documented three times a day. Kitchen staff were familiar with the procedures regarding kitchen tools, stating youth are not authorized in the kitchen.

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

The center has a written policy and procedures addressing youth's access and use of tools and cleaning items. Youth are prohibited to use tools except for mops and brooms under staff supervision. Seven youth were interviewed and six stated they only use mops and brooms. One youth stated they do not use any tools.

5.10 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 which addresses the inventory of all flammable, toxic, caustic, and poisonous items. The center's hazardous chemicals are stored in locked areas not accessible to the youth. The center maintains an inventory of all chemicals. Safety Data Sheets (SDS) were reviewed and contained a sheet for all chemicals present. Seven interviewed youth stated they do not clean with any cleaning agents.

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

The center has a written policy and procedures which addresses access to all flammable, toxic, caustic, and poisonous items. All hazardous chemicals are stored in secure areas inaccessible to youth. All items are labeled as required. Seven interviewed staff stated youth are not allowed to clean with substances identified as toxic, flammable, or poisonous.

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

The center has a written policy and procedures addressing the disposal of flammable, toxic, caustic, and poisonous items. The center has a grease trap in the kitchen. Mop sinks are located throughout the center. The maintenance staff is responsible for diluting, handling, and

disposing of hazardous waste. The center reported no chemical spills, or disposal of flammable, toxic, caustic, or poisonous items in the past six months.

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

The center has a written policy and procedures regarding the use of confinement under twenty-four hours. Six under twenty-four hours confinement reports were reviewed. All reports documented the room was searched prior to youth being placed in the room, the rooms were clear of obstruction, the confinement report was completed within one hour, and the juvenile justice detention officer supervisor (JJDOS) reviewed the report within two hours. The superintendent or designee reviewed confinements within forty-eight hours and the confinements were communicated with school personnel. Seven interviewed staff reported when a youth is placed in confinement, they must complete a confinement report, conduct and document ten-minute checks, and search the confinement room.

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

The center has a written policy and procedures regarding the use of confinement over twenty-four hours. Six over twenty-four hours confinement reports were reviewed. Five of the six reports documented the confinement room was searched. All six confinements were approved by the superintendent or designee. Confinement was approved every twenty-four hours after placement by the regional director, and the juvenile justice detention officer supervisor (JJDOS) conducted the three-hour evaluation. All medical and mental health reviews were conducted as required. There were no confinements exceeded seventy-two hours.

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

The center has a Continuity of Operations Plan (COOP) to ensure the center is prepared to manage emergency and disasters. The center had a weather drill the beginning of the hurricane season on May 16, 2019. Seven interviewed staff reported they have participated in a weather, major disturbances, bomb threats, hostage situations, chemical spills, flooding, terrorism, escape, and fire drills.

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

The center has a policy and procedures addressing escapes. Drills were completed on a quarterly basis and signed by staff. Documentation supported all staff participated as required. Seven interviewed staff indicated they participated in an escape drill.

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

The center has a policy and procedures addressing fire drills. The center maintains documentation of all fire drills. A review of these drills confirmed the center conducted monthly fire drills on each shift. The center's evacuation plans are documented throughout the center indicating primary and secondary evacuation points. Seven interviewed staff indicated drills take place on monthly basis. Five of the seven interviewed youth stated they have been instructed on what to do in case of a fire.