STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

PROGRAM REPORT FOR

Monroe Regional Juvenile Detention Center

Department of Juvenile Justice

(State-Operated)
5503 College Road
Key West, Florida 33040

Review Date(s): June 11-14, 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 that do not result in reduced or substandard service delivery; or systemic exceptions with corrective action already applied and demonstrated.
Limited Compliance	Systemic exceptions to the requirements of the indicator; exceptions to the requirements of the indicator that result in the interruption of service delivery; and/or typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery.

Review Team

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

Teves Bush, Office of Program Accountability, Lead Reviewer (Standard One)
Shakela Minns, Office of Program Accountability, Regional Monitor (Standard Four)
Maryann Sanders, Office of Program Accountability, Deputy Regional Supervisor (Standard Three)
Rubin Smith, DJJ Probation, Circuit 17, Juvenile Probation Officer Supervisor (Standard Two)
Daryl Wolf, Miami-Dade Regional Juvenile Detention Center, Assistant Superintendent (Standard Five)

Program Name: Monroe Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: Monroe County / Circuit 16
Review Date(s): June 11-14, 2019

MQI Program Code: 1076
Contract Number: NA
Number of Beds: 10
Lead Reviewer Code: 154

Methodology

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

Persons Interviewed

☒ Program Director
☐ DJJ Monitor
☒ DHA or designee
☒ DMHCA or designee
_____ # Case Managers

1 # Clinical Staff
_____ # Food Service Personnel
2 # Healthcare Staff
_____ # Maintenance Personnel
_____ # Program Supervisors

_____ # Youth
3 # Direct Care Staff
_____ # Other (listed by title): _____

Documents Reviewed

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

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

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

Observations During Review

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

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

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

Comments

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

Standard 1: Management Accountability
Detention Rating Profile

Indicator Ratings

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

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

Standard 2: Youth Management
Detention Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Detention Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Detention Rating Profile

Indicator Ratings

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

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Program Overview

The Monroe Regional Juvenile Detention Center is a state-owned detention facility, operated by the Department, located in Key West, Florida. The center serves youth in Monroe County in Circuit 16. Male and female youth who are detained pending adjudication, disposition, or placement in a residential commitment program are housed in the ten-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 Monroe County School District. The center's management team includes the superintendent, one administrative assistant, five juvenile justice detention officer (JJDO) supervisors, and four JJDOs. Healthcare services are provided by contracted provider, Maxim Mental Health Services, who sub-contracts with Camelot Community Care, Inc., who sub-contracts with Guidance Care Center, Inc., which is a local agency located in Key West, Florida. There is one designated mental health clinician authority (DMHCA), two licensed mental health clinicians, and two non-licensed mental health clinicians. 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 a designated health authority (DHA), advanced registered nurse practitioner (ARNP), and a registered nurse (RN). The medical clinic maintains nursing coverage seven days a week, with varying times. Food services are provided by the Monroe County Sheriff Office which is located on the same grounds. Meals are prepared by the food service workers in the county jail and delivered to the detention center. 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 two living modules which are divided by males and females. There are fourteen security cameras at the center, of which all were observed operational. A tour of the center was conducted by the annual compliance review team during the week of the review. The center was observed clean and free from insects. The youth rooms, day area, bathrooms, classrooms, and cafeteria were clean, neat, and had no graffiti. The youth recreation area was observed to be in an open area without shade located adjacent to the center on the second floor. According to the supervisor, the heat index is monitored daily to ensure youth do not get over-heated during outdoor recreation. It is to be noted there were no youth securely detained in the center during the annual compliance review week.

Standard 1: Management Accountability

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

The center has a written policy and procedures for initial background screening. The center did not hire any new staff since the last annual compliance review. The center also did not have any new volunteers and/or mentors since the last annual compliance review. The center hired one new contracted staff since the last annual compliance review. Documentation confirmed a background screening was completed prior to their start date. The Annual Affidavit of Compliance with Level 2 screening standards was submitted to the Department's Background Screening Unit (BSU) on January 18, 2018, meeting the annual requirement. During a review of the licensed mental health counselor's (LMHC) supervision documentation with the non-licensed mental health counselor, it was determined the LMHC from Guidance Care Center, Inc. who is the sub-contacted provider hired by Camelot Community Care, Inc., has not been background screened by the Department. While the LMHC does not come on-site, she has access to confidential youth information. In addition, the LMHC serves as a back-up in her duties at Guidance Care Center, Inc. but has not been identified as a back-up for the center.

1.02 Five-Year Rescreening	Satisfactory Compliance
Background rescreening/resubmission is conducted for all Department employees, and volunteers and all contracted provider and grant recipient employees, volunteers, mentors, and interns with access to youth and confidential youth records. Employees and volunteers are rescreened every five years from the initial date of employment. When a current provider staff member transitions into the Clearinghouse, the rescreen/resubmission date starts anew and is calculated by the Clearinghouse. (Note: For the new date, see the Retained Prints Expiration Date on the applicant's personal profile page within the Clearinghouse.	

The center has a written policy and procedures requiring the completion of a five-year background re-screening for staff. There was one Department staff requiring a five-year re-screening since the last annual compliance review. Reviewed documentation found the re-screening was submitted, as required. There were no contracted providers, volunteers, educational staff, medical or mental health staff, or interns requiring a five-year background re-screening during the annual compliance review period.

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

The center utilizes the Department's employee handbook, which contains a code of conduct. Three staff personnel records were reviewed, and each contained the acknowledgement, receipt, and review of the Department's code of conduct. The three records were also reviewed for disciplinary actions. One applicable reviewed record contained documentation of disciplinary action. Reviewed documentation validated management took immediate corrective action to address the staff code of conduct when the staff violated policies and procedures. The oral reprimand documented the staff received additional training with no other action required. None of the reviewed incidents were applicable to be reported to Department's Central Communications Center (CCC). Internal incidents and CCC reports for the past twelve months were reviewed and none were applicable for improper conducted by staff. Three staff were interviewed, and each knew the process for allowing staff and youth to call the Florida Abuse Hotline or CCC to report suspected abuse. None of the three interviewed staff ever heard staff use profanity when speaking to youth or observed a co-worker using threats, intimidation, or humiliation when speaking to a youth. The three interviewed staff indicated the working conditions in the center over the past year have been very good. An interview with the superintendent indicated staff are prohibited from any abuse, profanity, threats, harassment, horseplay, or personal relationships with youth, which is included in the center's employee code of conduct. Internal investigation calls are made to the Florida Abuse Hotline or CCC if a staff has been accused of abuse. The types of disciplinary actions given are no youth contact, oral reprimands, written reprimands, suspensions, and may include termination. There were no youth detained in the center during the annual compliance review week; therefore, youth interviews were not conducted.

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

The center has a written policy and procedures addressing reports to the Department's Central Communications Center (CCC). The center had two incidents reported to the CCC since the last annual compliance review. Documentation found each incident was called in to the CCC within the mandatory two-hour time frame and in accordance with the CCC reporting procedures. A review of facility logbooks, grievances, and internal incidents confirmed there were no additional incidents which should have been reported. Each reviewed CCC report was documented in the center's logbook. The center maintains a CCC binder which documents all reports made to the CCC. An interview with the superintendent indicated the process for reporting abuse is to call the CCC within two hours of the incident and when there is alleged abuse, the center will call the Florida Abuse Hotline.

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

There have been no Protective Action Response (PAR) incidents during this annual compliance review period; therefore, this indicator rates as non-applicable.

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

The center has a written policy and procedures regarding pre-service certification requirements. One staff was eligible for pre-service training since the last annual compliance review. A review of the training record indicated the staff was certified within 180 days of hire. Reviewed documentation confirmed the staff received and passed Protection Action Response (PAR) training within ninety days of hire, and the required training which included cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED) certification, mental health and substance abuse, suicide recognition, prevention and intervention, safety, security, and supervision, and the Department's facility operations. All training was completed prior to the staff being in the presence of youth. Reviewed documentation reflected all pre-service training was entered into the Department's Learning Management System (SkillPro).

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

The center has a written policy and procedures regarding in-service training. The center provides in-service training to staff through a combination of the Department's Learning Management System (SkillPro) and instructor-led classes. The center has an annual in-service training calendar, which is updated when changes occur. Three staff training records were reviewed, and determined each staff exceeded the required in-service training hours. All three staff completed the required twenty-four hours of training on Protective Action Response (PAR) update, first aid, automated external defibrillator (AED), and cardiopulmonary resuscitation (CPR). Additionally, each reviewed staff completed escape prevention and fire prevention trainings, professionalism, ethics, suicide prevention, trauma informed care, emergency response, medication management, infectious control, exposure control, and girls' healthcare trainings. Two supervisor training records were reviewed, and documentation found each supervisor exceeded the required eight hours of supervisory training. Each supervisor received training in management, leadership, personal accountability, employee relations, communications skills, and fiscal. All completed training was entered into Department's Learning Management System (SkillPro). An interview with the superintendent indicated he has received training in Certified Public Management (CPM), management, leadership, communications skills, and more.

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

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

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

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

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

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

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

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

The center has a written policy and procedures regarding entering and sharing alerts. Alerts are entered into the Department's Juvenile Justice Information System (JJIS), as well as an internal alert system. Upon review of the alert list, the supervisors distribute the alert list to all working direct-care staff, at each shift briefing. Each staff carries the current alert list throughout their shift. A review of the shift briefings verified alerts are shared with staff. There were no youth detained in the detention center during the annual compliance review. A historical youth alert list from January 1, 2019 to March 12, 2019 was reviewed. Three random youth were reviewed from the historical alert list which verified the youth alerts were entered in JJIS, as required. Any changes to the alerts are updated in JJIS and an updated list is distributed to all direct-care staff. The responses and updates by medical, mental health, and other staff were documented in JJIS alerts as they pertained to each applicable critical alert. A review of the center's Admission Wizard, logbooks, shift reports, and internal alerts found all applicable alerts were documented in JJIS, entered in the appropriate logbook, and noted in the center's shift reports. Three staff were interviewed and stated they are informed of alerts which are specific to youth through the logbook and shift briefings. Three staff indicated management inform them about issues in the center through the logbook, shift briefings, and meetings.

Standard 2: Assessment and Performance Plan

2.01 Admission	Satisfactory Compliance

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

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

The center has a written policy and procedures regarding youth admission. There were no youth detained in the center during the annual compliance review week. Three closed case management records were reviewed and found each included the youth's arrest affidavits, court orders for admission to the center, Detention Risk Assessment Instrument (DRAI), and documented electronic frisk and strip search by an officer of the same gender as the youth. Each reviewed record indicated the youth received a telephone call and meal or snack upon admission to the center. The three reviewed records also indicated the youth were evaluated for medical, mental health, and substance abuse needs.

2.02 Orientation	Satisfactory Compliance

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

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

The center has a written policy and procedures to ensure each youth admitted receives an orientation. The orientation process occurred within twenty-four hours of admission. There were no youth detained in the center during the annual compliance review week. Three closed case management records were reviewed, and each youth signed an orientation acknowledgement form. The form included the center's rules and all required topics. No youth were admitted to the center nor were any youth detained in the center during the annual compliance review week; therefore, an observation of orientation nor youth interviews were conducted.

2.03 Classification	Satisfactory Compliance
All youth admitted to the detention center shall be classified to provide the highest level of safety and security. Considerations shall include, at a minimum: *1. Physical characteristics (e.g. sex, height and weight);* *2. Age and level of aggressiveness;* *3. Special needs (mental illness, developmental disabilities, and physical disabilities);* *4. History of violent behavior;* *5. Gang affiliation;* *6. Criminal behavior;* *7. History of sexual offenses;* *8. Vulnerability to victimization; and* *9. Suicide risk identified or suspected.* *Youth shall be assigned to a room based on their classification and are reclassified if changes in behavior or status are observed. Youth with a history of committing sexual offenses or a victim of a sexual offense are not to be placed in a room with any other youth. Youth with a history of violent behavior shall be assigned to rooms where it is least likely they will be able to jeopardize safety and security.*	

The center has a written policy and procedures regarding classification of youth admitted to the center. There were no youth detained in the center during the annual compliance review week. Three closed case management records were reviewed, and each contained a Department Face Sheet which included the youth's address, gender, height, weight, age, and physical characteristics. The center uses the Secure Detention Admission Wizard form to determine a youth's aggressiveness, mental illness, suicide risk, intellectual and physical disabilities, history of violence, maturity, living arrangements, and gang affiliation. All three reviewed youth records contained a Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB), which was included in the classification process.

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

The center has a written policy and procedures referencing suspected or documented gang members or associates. There were no youth detained in the center during the annual compliance review week. Three closed case management records were reviewed which indicated each was screened; however, none were identified as gang members according to the Department's Juvenile Justice Information System (JJIS). A review of three staff training records showed each received gang awareness training.

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

The center has a written policy and procedures for notifying the juvenile probation officer (JPO) circuit gang representative of any youth suspected of gang involvement. The policy requires the center to notify local law enforcement of youth with suspected gang activity and or membership. The center has designated the shift supervisor as the gang representative. The shift supervisor was interviewed and indicated any on-duty supervisor can communicate information regarding gang affiliation to the assigned JPO. Observations confirmed there were no new youth with undocumented gang affiliation requiring the notification of the circuit gang representative during this annual compliance review period.

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

The center has a written policy and procedures to address the admission of youth personal property. There were no youth detained in the center during the annual compliance review week. Three closed case management records were reviewed. Each contained a property form which was signed by the youth and staff. One youth record documented valuable property was stored. According to the shift commander, the valuables are stored in a clear tamper-proof bag, which is identified with the youth's name, identification number, date, staff name, and signatures of the youth and staff. The property is placed in a drop safe, which is under video surveillance twenty-four hours a day. Each of the three reviewed records contained documentation the youth signed an unclaimed property acknowledgement form. Due to no youth detained during the annual compliance review week, no property was observed; however, the center maintains a supply of clear tamper-resistant property bags and observation of the safe verified it is under video surveillance. Due to no youth detained during the annual compliance review period, no youth interviews were conducted.

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

The center has a written policy and procedures to ensure youth property is stored securely. There were no youth in the center during the annual compliance review week; therefore, no stored property was observed at the time of the annual compliance review. The superintendent was interviewed and stated the superintendent or designee will place the youth's valuables and

personal property in the drop safe, which is under video surveillance. A letter of acknowledgement is sent to the parents/guardians for unclaimed personal property. There were no Central Communication Center (CCC) incidents related to lost or stolen property since the last annual compliance review.

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

The center has a written policy and procedures to address youth releases. The center ensures all youth are released from the center promptly and accurately. The on-duty juvenile justice detention officer supervisor (JJDOS) verifies the release by reviewing the court order and signing the secure detention release form prior to the youth's release. There were no youth detained in the center during the annual compliance review week. Three closed youth case management records were reviewed, and each record contained documentation the on-duty supervisor reviewed the court order, prior to the youth's release. Each of the three closed records verified the youth and the parent/guardian identification prior to release. The parent/guardian signed the applicable release forms and a copy of their identification was maintained in the youth's case management record. The release date in the Department's Juvenile Justice Information System (JJIS) corresponded with the youth's correct release date. Three reviewed closed records indicated the youth and the youth's parent/guardian were informed of future court dates and appointments. The Department's Central Communications Center (CCC) reports for the last twelve months were reviewed and validated there were no unauthorized releases.

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

The center has a written policy and procedures ensuring youth property is maintained securely during admission and returned to the youth or parent/guardian upon release. Three closed youth case management records were reviewed. Each youth admission's record contained a signed acknowledgement from the youth regarding understanding of the unclaimed property process. Upon release from the center, the detention staff, youth, and parent/guardian reviewed

and signed the property receipt form prior to any property being returned. Three staff were interviewed and indicated all property is returned to youth upon release. If property is not claimed during release, it is kept secured and an acknowledgment is sent to the parent/guardian notifying of the unclaimed property.

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

The center has a written policy and procedures to ensure prescribed medication, along with medical instructions, is provided to whomever is receiving the youth at the time of release. A review of three closed youth records indicated there was one youth applicable for the release of medications and medical instructions in the last six months. The program indicated there were no other applicable youth records since the last annual compliance review. A review of the closed youth record contained a signed medication receipt, transfer, and disposition form, with the name and signature of the youth's parent/guardian who took possession of the medication upon the youth's release from the center. The parent/guardian was reminded of any health concerns regarding the youth.

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

The center has a written policy and procedures regarding detention reviews. Detention reviews are conducted on a weekly basis to provide a means to screen all youth who may have physical or behavioral issues, to transfer to a less restrictive placement, or to their designated commitment placements expeditiously. The center maintains a log which documented past detention reviews. A review of the log entries for the past six months indicated reviews were held weekly. The center had no youth securely detained during the annual compliance review week. Observations of the detention review process addressing youth on home detention supported the detention reviews are conducted as required. All staff attending signed a sign-in sheet. Some attendees participate by way of telephone which was reflected on the sign-in sheet. In an interview, the superintendent confirmed the center's practice and stated each detention review is conducted like a mini treatment team.

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

The center has a written policy and procedures to address the daily activity schedule. The observed activity schedule was posted throughout the center and addressed time for personal hygiene, meals, visitation, education, and recreation to promote physical growth and development at least one hour a day. When the heat index exceeds ninety degrees, the center provides indoor recreational activities. The daily schedule also indicated a time for restorative justice and gender-specific programming; however, an interview with the facility superintendent and staff indicated the center does not provide gender-specific programming. There were no

youth securely detained in the center during the annual compliance review week; therefore, no youth interviews were conducted. Three staff were interviewed, and each stated the daily schedule is followed.

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

The center has a written policy and procedures to address a daily activity schedule. There were no youth in secure detention during the annual compliance review week to monitor daily activities. A review of the logbook for the past six months reflected adherence to the activity schedule regarding hygiene, school, physical education (weather and security permitting), meals, and showers. In addition, random observations of video footage validated youth are provided activities according to the schedule.

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

The center has a policy and procedures addressing educational access. Educational instruction is provided by the Monroe County School District and youth can earn credits while they are at the center. At the time of the annual compliance review, there were no youth securely detained in the center. A review of logbook documentation and a random review of video footage indicated youth received educational services. An interview with the lead teacher confirmed the center provides 250 days of educational interaction. The center also provides career education programming which includes communication, interpersonal, and decision-making skills. Each youth in the center is given the opportunity to earn course credits for completion of education and training experience. There were no youth securely detained in the center during the annual compliance review week; therefore, no youth interviews were conducted.

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

The center has a career education competency development program provided by the Monroe County School District for all youth in secure detention. The center utilizes Type 1 instruction to include career and life skills programming. Florida Shines is an assessment tool utilized by the school district to assess a youth's abilities and interests based upon their age, assessed educational abilities, goals of the youth, length of stay, and custody characteristics at the center. Career Source services are also utilized to assist youth with internships, training, and job placement.

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

The center has a written policy and procedures which addresses the provision of rewards and consequences to encourage youth to fulfill program expectations. The center utilizes an approved statewide behavioral management system (BMS) which ranges from levels one, two, and three and includes rewards for positive behavior and consequences for negative behavior which is outlined in the policy. The rewards and privileges increase as youth progress through the system. It was observed the BMS posted throughout the center. There were no youth securely detained during the annual compliance review week to observe the implementation of the BMS. Three staff were interviewed and stated supervisors provide feedback on the implementation of the BMS weekly and as needed There were no youth securely detained in the center during the annual compliance review period; therefore, no youth interviews were conducted. Three staff were interviewed and stated the BMS is affective and staff speak with youth to discuss the consequences being imposed. Three staff were interviewed and stated youth are given the opportunity to explain their behavior, and staff speak to the youth about alternative acceptable behavior. Three staff were interviewed and stated only levels can be taken away as a consequence and they have never seen a co-worker take meals, snacks, clothing, education, or medical care away from a youth for acting out.

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

The center has a written policy and procedures, by way of the behavior management system (BMS), which restricts certain types of punishment in response to negative youth behavior including corporal punishment, group punishment, youth-on-youth punishment, and the use of drugs to control behavior. A review of the Department's Central Communications Center (CCC) incident reports for the past six months indicated there were no incidents reported against staff using unauthorized punishment. Three staff were interviewed and confirmed neither group or

corporal punishment is used at the center and they have not observed a staff encouraging a youth to beat up another youth.

2.18 Grievances	Satisfactory Compliance

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

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

The center has a policy and procedures to address youth grievances. The center had no grievances since the last annual compliance review. The center does have a grievance process in place. Youth are provided a pencil and grievance form, which are easily accessible in the intake office and each living module, should they want to submit a grievance. The youth submits a written complaint and it is entered in the Facility Management System (FMS). During the informal phase, the staff member will attempt to resolve the complaint with the youth. If the complaint is not resolved, the grievance is addressed with the on-duty supervisor, who documents any findings. If the grievance reaches the appeal phase, it is reviewed by the superintendent or supervisor. An interview with the superintendent indicated the grievance process has a formal and informal phase. If the issue is not resolved in the informal phase, it is to be reviewed by the supervisor within twenty-four hours. Three staff were interviewed and knew the grievance process. There were no youth securely detained in the center during the annual compliance review week; therefore, youth interviews were not conducted.

2.19 Trauma-Informed Care	Satisfactory Compliance

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

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

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

The center has a policy and procedures for trauma-informed care. A review of three staff training records verified each youth received trauma-informed care training. A tour confirmed the center has a soft room and other areas throughout the center with soothing colors and child-friendly schemes. Arts and crafts are provided to the youth to incorporate a time for self-

reflection and creativity. An interview with the superintendent indicated the center has art supplies, soft blankets, slippers, and pillows.

Standard 3: Mental Health and Substance Abuse Services

3.01 Designated Mental Health Clinician Authority (DMHCA) [Contract Provider]	Limited 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 maintains a written policy and procedures to ensure there is a single licensed mental health professional identified as the designated mental health clinician authority (DMHCA), who is responsible for the coordination and implementation of mental health and substance abuse services. The center maintains a contract with Maxim Healthcare Services, Inc. to provide mental health and substance abuse services. Maxim Healthcare Services, Inc. subcontracts with Camelot Community Care, Inc. who sub-contracts with Guidance Care Center, Inc., to provide comprehensive mental health and substance abuse services. Psychiatric services are provided through Camelot Community Care, Inc. The DMHCA is responsible for the coordination and implementation of mental health and substance abuse services in accordance with Florida Administrative Code. Reviewed documentation supported the center's DMHCA is a licensed mental health counselor. The DMHCA maintains a clear and active license in the State of Florida, with an expiration date of March 31, 2019. The DMHCA shall be on-site twenty hours a week, Monday through Friday, and as-needed on Saturday and Sunday. A review of the center's sign-in and sign-out logs for the past six months reflected the DMHCA was only on-site February 1, 2019, March 22, 2019, and June 7, 2019. During an informal interview with the shift commander, it was explained the DMHCA may have been on-site more than what was documented; however, she does not always utilize the sign-in and sign-out logs. The center was able to provide several precautionary observation logs which were signed by the DMHCA on additional various dates and times, indicating she was on-site; however, they were unable to provide any further documentation to validate the additional time the DMHCA may have been on-site. An interview with the DMHCA indicated she is available twenty-four hours a day and available for crisis intervention. In addition, the DMHCA shall provide weekly direct clinical supervision to two part-time master's and/or bachelor's-level clinical staff. The DMHCA also meets weekly with the psychiatrist to discuss each youth who is receiving services.

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

The center maintains a written policy and procedures to ensure mental health services and substance abuse services are provided by individuals with appropriate qualifications. The center's contract with Maxim Healthcare Services, Inc. provides for a regional mental health and substance abuse clinical director for the south region, one designated mental health clinician authority (DMHCA), and a psychiatrist. Maxim Heath Care Services, Inc. subcontracts with Camelot Community Care, Inc. who subcontracts with Guidance Care Center, Inc. for the provision of all mental health and substance abuse services. Camelot Community Care, Inc. subcontracts with a psychiatrist who is an osteopathic physician. Reviewed practice found the

center maintains a DMHCA and a licensed psychiatrist. The DMHCA is employed with Guidance Care Center, Inc., and the psychiatrist is subcontracted with Camelot Community Care, Inc. Reviewed licenses for each licensed professional found each maintained a clear and active license in the State of Florida.

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

The center maintains a written policy and procedures to ensure mental health services and substance abuse services are provided by individuals with appropriate qualifications. Clinical supervisors must assure clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience. Reviewed documentation validated there are two non-licensed mental health clinicians. One non-licensed staff is a master's-level and the other is a bachelor's-level. Reviewed documentation found the non-licensed clinicians are qualified to provide services based on their education, training, and experience. One of the non-licensed clinicians received 105 hours of training and the other received eighty-three hours of training. The training included five Assessments of Suicide Risk (ASR) conducted on-site in the presence of a licensed mental health professional. The designated mental health clinician authority shall provide weekly face-to-face clinical supervision, which includes a summary of directions, instructions, and recommendations. Weekly supervision will be documented on the Department's Licensed Mental Health Professionals and Licensed/Certified Substance Professionals Direct Supervision Log and may be conducted individually or in a group setting. The center was only able to provide group supervision logs for the master's-level clinician for four weeks and individual supervision for one week during the past six months, and group supervision for seven weeks for the bachelor's-level clinician with no individual supervision during the past six months. The group supervision logs only addressed Department youth for one session. The individual supervision log only addressed one Department youth for one session. The other youth addressed had no involvement with the Department and the names were redacted from the supervision logs.

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

The center maintains a written policy and procedures ensuring the mental health and substance abuse needs of the youth are identified through a comprehensive screening process and ensuring referrals are made when youth are identified with mental health and/or substance abuse needs or are identified with a possible risk of suicide. The procedures included a standardized screening process, which included a review of the Positive Achievement Change Tool (PACT) Mental Health and Substance Abuse Report and Referral Form, a review of the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2), and Suicide Risk

Screening Instrument (SRSI). A review of three youth mental health and substance abuse records validated upon a youth's intake, the juvenile probation officer (JPO) administered the MAYSI-2 for each youth. The SRSI was completed in each of the three reviewed records. The PACT Mental Health and Substance Abuse Report and Referral Form was required in two of the three records and each was completed. The form was not required in the third record because of the commencement of the Community Assessment Tool. Additionally, the procedures outlined a standardized process for the referral of youth identified as in-need of an Assessment of Suicide Risk (ASR) or further mental health and/or substance abuse evaluation to the Camelot Community Care, Inc. clinician. Each of the three reviewed records documented the SRSI detention section was completed by a juvenile justice detention officer in the Department's Juvenile Justice Information System (JJIS). The SRSI nursing and/or mental health section was completed by the mental health clinician in each reviewed record. Each of the three youth were identified with a need for further assessment based on the admission assessments and each youth was identified with an elevated suicide risk factor. Reviewed documentation validated each applicable youth was placed on precautionary observation and a mental health referral was complete. Documentation found each of the three youth had an Assessment of Suicide Risk completed by the licensed or non-licensed trained clinical staff.

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

The center maintains a written policy and procedures ensuring youth who are identified through preliminary screening or during intake and admission, as having mental health and/or substance abuse issues or needs are referred for a further in-depth mental health and/or substance abuse evaluation. In an interview, the regional clinical director stated youth are referred for a comprehensive evaluation based on the results of the Positive Achievement Change Tool (PACT), Massachusetts Youth Screening Inventory – Second Version (MAYSI-2), the PACT Mental Health and Substance Abuse Referral Form when applicable, and staff observations. The center utilizes the Global Appraisal of Individual Needs (GAIN-1), a comprehensive bio-psychosocial assessment designed to support clinical diagnosis, placement, treatment, planning, performance monitoring program planning, and economic analysis. Each GAIN-1 is completed by mental health staff. A review of three youth mental health and substance abuse records found each youth was referred for a mental health and substance abuse evaluation and each new evaluation was completed within fourteen days of admission. None of the three youth were applicable for a comprehensive assessment, as they were not detained for longer than thirty-days.

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

The center maintains a written policy and procedures ensuring mental health and substance abuse treatment planning focuses on providing mental health treatment and/or substance abuse treatment, which will reduce or alleviate the youth's symptoms of mental disorder or substance abuse impairment and enable the youth to function adequately. Each youth determined to need mental health treatment, including treatment with psychotropic medications or substance abuse treatment while in the center, must be assigned to a mini-treatment team. The mini-treatment team meets bi-weekly to discuss each youth receiving services. An interview with the designated mental health clinician authority (DMHCA) confirmed the center's practice. A review of three youth mental health and substance abuse records indicated each youth required treatment services. Reviewed mini-treatment team documentation supported each applicable youth was assigned to a mini-treatment team consisting of the DMHCA, the center's administration, mental health and substance abuse staff, nursing department staff, and juvenile justice detention officer staff. Mini-treatment team meetings are held in conjunction with the center's detention reviews. A treatment team was not able to be observed, as the center had no youth securely detained at the time of the annual compliance review. Three reviewed records found each youth had a copy of an Authorization for Evaluation and Treatment (AET) form. A signed youth consent for substance abuse treatment and youth consent for release of substance abuse treatment records was not applicable for any of the three youth records reviewed, as none of the youth were receiving substance abuse treatment. Each of the reviewed treatment plans outlined each youth would receive individual counseling one time, bi-weekly and two will meet with the psychiatrist for medication management. There were no recommendations for group treatment in any of the three reviewed treatment plans. All treatment notes were documented on the required form in two if the three youth records. One youth had a chronological note entered and did not include all required elements. The center maintains a Chapter 397 license which expires on July 11, 2019. There were no youth securely detained at the time of the annual compliance review to interview regarding mental health and substance abuse services.

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

The center maintains a written policy and procedures ensuring mental health and substance abuse treatment planning focuses on providing mental health treatment and/or substance abuse treatment which will reduce or alleviate the youth's symptoms of mental disorder or substance abuse impairment and enable the youth to function adequately. All youth receiving mental health and substance abuse treatment 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 the youth's release. A review of three youth mental health and substance abuse records found two were applicable for requiring an initial treatment plan completed within seven days of initiation of treatment. One youth had an individual treatment plan because he was already engaged in services with the provider in the community. Both applicable reviewed plans were completed within the required seven-day time frame and included the reason for referral for treatment, the initial Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) diagnosis, initial treatment methods, and goals. Each youth was applicable for psychiatric services and/or psychotropic medication and frequency of monitoring. The reviewed plans were signed by the youth and mini-treatment team members to include the licensed clinician, mental health staff, center administration, and other applicable treatment team members. Two of the three reviewed youth mental health and substance abuse records were applicable for an individual treatment plan. Each reviewed plan supported they were developed by the thirty-first day of the youth's admission and were signed by the licensed mental health clinician within the ten-day required time frame. Each was signed the same day the plan was developed. Each reviewed individual plan identified the youth's DSM-5 diagnosis, symptoms which are treatment focused, treatment goals, strengths, and abilities. All three reviewed treatment plans were applicable for psychiatric services and/or psychotropic medication monitoring. None of the reviewed individual treatment plans required a thirty-day treatment plan review. The mental health and substance abuse discharge summary was completed on the Department's required form for each youth. The discharge summary was signed by the clinical staff, licensed mental health clinician, and treatment team members. None of the discharge summaries were signed by the youth; one youth was released to the adult jail, and two youth were released prior to obtaining signatures. An interview with the regional clinical director explained parents/guardians are provided a copy of the discharge summary by mail, and the assigned juvenile probation officer is provided a copy of the discharge summary by e-mail.

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

The center maintains a written policy and procedures ensuring psychiatric services are provided to youth in need to include psychiatric evaluation, consultation, medication management, and medical supportive counseling. Psychiatric services are provided to youth in need of services, as indicated by symptoms of mental disorder or substance-related disorder, or to youth who are being treated with psychotropic medication subsequent to their admission to the center. Scheduling of the psychiatrist will be coordinated by Camelot Community Care, Inc. and the center's superintendent for services to meet contractual and Florida Administrative Code requirements for psychiatric services. The center's approved facility operating procedures (FOP) includes tele-psychiatry. The FOP indicates the psychiatric care delivered through tele-psychiatry is intended to remain the same as rendered face-to-face care. Psychiatric services are conducted through tele-psychiatry one hour a week. A review of three youth mental health and substance abuse records indicated two applicable youth who were admitted to the center on prescribed psychotropic medications. One additional youth who was not admitted with medication requested psychiatric services. Each youth was referred for an initial psychiatric diagnostic interview. The initial psychiatric interview was conducted within fourteen days of each youth's admission and included all required elements inclusive of the reason for the referral, history, mental status examination, Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) diagnosis, treatment recommendations, prescribed medication with the explanation for the need when applicable, and frequency of medication monitoring. There were no youth applicable for being prescribed medication subsequent to admission. Each of the two youth on psychotropic medications received an in-depth psychiatric evaluation within thirty days of intake or the referral utilizing the Department's Clinical Psychotropic Progress Note (CPPN). Reviewed practice reflected the psychiatrist provided on-going medication management and both CPPNs were completed in full. There were no applicable youth requiring Tardive Dyskinesia monthly monitoring. Reviewed documentation validated consent for psychotropic medication was not required because there were no new medications prescribed or any changes to existing medications. Each reviewed youth record contained a copy of the signed Authority for Evaluation and Treatment.

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

The center maintains a written policy and procedures ensuring a suicide prevention plan is in place to safely screen, refer, assess, monitor, and protect youth with elevated risk of suicide in the least restrictive means possible. The plan was revised and approved by the superintendent on June 10, 2019 and the designated mental health clinician authority (DMHCA) on May 15, 2019. The plan included the identification and assessment of at-risk youth for suicide, suicide risk alert, levels of supervision, suicide precautions, referrals, notification and communication, immediate staff response, use of extra precautions, review process, and emergency contact telephone numbers. The plan is maintained in the center's master control and accessible to all staff.

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

The center maintains a written policy and procedures ensuring a suicide prevention plan is in place to safely screen, refer, assess, monitor, and protect youth with elevated risks of suicide in the least restrictive means possible. A review of three applicable youth mental health and substance abuse records indicated each youth was placed on precautionary observation (PO) resulting from being identified with an elevated risk of suicide at the time of admission. Reviewed documentation found all three applicable youth records documented a suicide alert was placed in the Department's Juvenile Justice Information System (JJIS). Each of the thee completed mental health/substance abuse referral summaries contained documentation requesting an Assessment of Suicide Risk (ASR) be completed for each youth and each of the three records documented completion of the ASR. The ASR was completed within twenty-four hours for all applicable youth. Three ASRs were completed by the non-licensed mental health clinicians and reviewed by the licensed mental health counselor (LMHC) within twenty-four hours. Reviewed training records for the non-licensed mental health therapist supported they received the required suicide prevention training to complete the ASR. The non-licensed therapist completed twenty hours of training and supervised experience including five ASRs, and/or crisis assessments, conducted on-site in the physical presence of the LMHC. A review of the center's logbooks clearly documented the beginning and ending times youth were placed on PO. There was documentation to reflect administrative and/or supervisory staff provided instructions related to the suicide risk assessment findings and suicide precaution decisions during the shift briefings. Three interviewed staff were able to articulate the center's procedure when a youth is identified with an elevated suicide risk. Each staff stated they would notify the mental health authority, search the youth and his/her room for sharp objects, document supervision, and place the youth on constant sight and sound supervision. There were no youth securely detained at the time if the annual compliance review.

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

The center maintains a written policy and procedures ensuring the staff assigned to monitor each youth on suicide precautions must maintain one-to-one supervision or constant supervision and document their observations of the youth's behavior on the Department's Suicide Precautions Observation Log. A review of three applicable youth placed on precautionary observation (PO) documented Suicide Precautions Observation Logs were

maintained for each youth. Each completed log documented the safe housing areas, and each documented the observations in real time, at required intervals. Reviewed logs supported the mental health therapist and shift supervisor(s) reviewed and signed, as required for two of the three youth. One youth had two PO logs and only one was signed by the licensed mental health clinician and the superintendent. The center had no youth applicable for secure observation.

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

The center maintains a written policy and procedures ensuring all staff will receive at least six hours of suicide prevention and implementation of suicide precautions training annually. The mental health clinical staff will assist in training staff on suicide prevention, including verbal and behavioral cues which indicate a suicide risk, throughout the year. All staff who work with youth must be trained in suicide precautions and emergency response procedures and participate in mock suicide drills quarterly, on each of the three shifts. Three reviewed staff training records found each received the required four hours of instructor-led and two hours of computer-based training of suicide prevention and implementation of suicide precautions training, in the Department's Learning Management System (SkillPro). The center conducts mock suicide drills on each shift, at least quarterly. Reviewed mock suicide drills from July 2018 through May 2019, supported drills were conducted at least quarterly on all three shifts and each staff participated in at least one drill semi-annually. Each drill documented the demonstration of life-saving techniques including utilization of cardiopulmonary resuscitation (CPR) and the automated external defibrillator (AED). Staff who are not present during the during a quarterly mock drill have the opportunity to review each mock drill scenario and procedures to understand the process and receive the necessary training to respond to an incident of suicide attempt or incident of self-inflicted injury in the center during monthly all-staff meetings. This practice was validated by the center's shift commander and the south regional detention chief.

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

The center maintains a written policy and procedures ensuring the center responds to youth in crisis in the least restrictive means possible to protect the safety of the youth and others while maintaining control and safety of the center. The center maintains a crisis intervention plan which was revised and approved by the superintendent on June 10, 2019 and the designated mental health clinician authority (DMHCA) on May 15, 2019. The plan detailed crisis intervention procedures inclusive of verbal de-escalation and Protective Action Response, as set forth in Florida Administrative Code, notification and alert system, referrals including self-referral, crisis assessment and follow-up mental health status examination, communication, supervision, mental health supportive services, and documentation and review. The plan is maintained in the center's master control and accessible to all staff.

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

The center maintains a written emergency care plan outlining mental health and substance abuse emergency procedures and ensure youth who are believed to be an imminent danger to themselves or others, due to mental illness or substance abuse impairment, receive emergency mental health or substance abuse services. The plan was revised and approved by the superintendent on June 10, 2019 and designated mental health clinician authority (DMHCA) on May 15, 2019. The plan detailed emergency procedures inclusive of immediate staff response, notification and communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment under Chapter 394 Florida Statute (Baker Act), transportation for emergency mental health evaluation and treatment under Chapter 397 Florida Statute (Marchman Act), return from emergency mental health or substance abuse services, documentation, training and mock drills, and review. The center utilizes Lower Keys Medical Center for crisis stabilization. The plan is maintained in the center's master control and accessible to all staff.

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

The center maintains a written policy and procedures ensuring the center responds to youth in crisis in the least restrictive means possible to protect the safety of the youth and others while maintaining control and safety of the center. The center's mental health crisis intervention plan includes a notification and alert system, means of referral inclusive of self-referral, communication, supervision, documentation and review. An interview was conducted with the regional mental health and substance abuse clinical director for the south region who confirmed the center had no applicable youth requiring a crisis assessment since the last annual compliance review.

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

The center has not had any Baker and Marchman Act proceedings during the annual compliance review period; therefore, this indicator shall be rated as non-applicable.

Standard 4: Health Services

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

The center has a contractual agreement with Maxim Healthcare Services, Inc. to provide comprehensive medical, mental health, substance abuse and psychiatric services. An osteopathic physician (DO) serves as the designated health authority (DHA) and performs administrative duties. The DO holds an unrestricted license to practice in the State of Florida, with an expiration date of March 31, 2020. The DHA is contracted to be on-site one time a month, for a minimum of two hours, and is on-call twenty-four hours a day, seven days a week. A review of the center's logbook for the past six months found the DO was on-site for the months of December 2018, February, and April 2019 for a minimum of two hours. A review of the center's roster and logbooks found the DO was not on-site for a minimum of two hours for the month of May 2019 although there were youth in the center. In addition, a review of the center's logbooks also found the DO was not on-site for the months of January 2019 and March 2019 due to the center not having any youth on-site when the DO was to conduct a site visit. Reviewed documentation found the DO conducts site visits around the last week of each month. The program also has an advanced registered nurse practitioner (ARNP), who provides on-site clinical services each week, at a minimum, twenty hours a week. Through an interview with the DHA, it was determined the final decision making regarding the provision of healthcare, rests with the DHA. The center has a collaborative protocol last signed by the DO and the ARNP respectively on October 8, 2018. Interviews with the DHA and ARNP showed they clearly understood their roles at the center. Documentation related to healthcare services and the review of youth healthcare records showed the DHA provides oversite for all healthcare provided at the center. A review of licenses of all medical staff, which include the DHA and ARNP, found all licenses were clear and active.

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

The center has a written policy and procedures to address health-related procedures and protocols. A review of the center's facility operating procedures (FOP) for all health-related procedures and treatment protocols utilized at the center found they were signed by the designated health authority (DHA) and the superintendent. The last annual review of treatment protocols was completed in December 2018 and the last annual review of FOPs was completed on July 5, 2018. A review of the healthcare policies and procedures cover page found all newly employed healthcare staff received a comprehensive clinical orientation to the Department's healthcare policies and procedures. The nursing protocols acknowledgement form was signed by the registered nurse (RN), licensed practical nurses (LPN's), and superintendent in July 2018.

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

The center has a written policy and procedures addressing authorization of treatment for youth. A review of three closed youth individual healthcare records found each youth had an Authority for Evaluation and Treatment (AET) form filed in their record, with a parent/guardian signature, along with a witness signature. Each reviewed AET was a copy and contained a legible stamp with the word "COPY" on each AET. None of the youth healthcare records were applicable for a Limited Consent for Evaluation and Treatment.

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

The center has a written policy and procedures ensuring the parent/guardian is informed of significant changes in the youth's condition and obtains consent of new medications or treatment which is prescribed. A review of three closed youth individual healthcare records found they were not applicable for parental notification of over-the-counter (OTC) medications not covered by the Authority for Evaluation and Treatment (AET). A request was made for additional youth records; however, there have not been any additional youth who have required parental notification since the last annual compliance review.

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

The program has a written policy and procedures to ensure the parent/guardian is informed of and provides consent for the prescription of new psychotropic medications, discontinuances, or psychotropic medication adjustments. Parental/guardian consent shall be obtained prior to the initiation of new psychotropic medications and/or changes in a psychotropic medication regimen. Notification includes mailing page three of the Clinical Psychotropic Progress Note (CPPN). The center's contracted psychiatrist's practice is to maintain the youth's same medication regimen (dosage and type) for which the youth was admitted. Three youth individual healthcare records were reviewed and were not applicable for parental notification. A request was made for additional youth records; however, there have not been any additional youth who have required parental notification for any new psychotropic medication and/or changes in a psychotropic medication regimen within the last twelve months.

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

The center has a written policy and procedures to ensure each youth's immunization history and status is verified to meet state and Department requirements. A review of three closed individual healthcare records contained a Florida Certification of Immunization and/or a Department Immunization Tracking Record. The center's practice is to obtain consent from the parent/guardian within thirty days and then refer to the health department to administer the immunization. Each reviewed youth record contained a signed Authority for Evaluation and Treatment (AET) form providing consent for any necessary vaccinations. No youth records documented religious exemption.

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

The center has a written policy and procedures regarding the Healthcare Admission Screening form which indicates each youth, upon admission, will receive a facility entry screening by the intake officer. A review of three closed youth individual healthcare records found each contained a Medical and Mental Health Admission Screening form completed on the date of admission by the juvenile justice detention officer and reviewed by the licensed practical nurse (LPN) or advanced registered nurse practitioner (ARNP) within twenty-four hours. The information was entered into the Department's Juvenile Justice Information System (JJIS) Admission Wizard. An interview with the superintendent found the registered nurse (RN) and the LPN completes the healthcare admission screening for youth.

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

The center has a written policy and procedures to alert staff of medical issues which may affect the security and safety of youth at the center. Information pertaining to medical alerts are entered into the Department's Juvenile Justice Information System (JJIS). The center's practice is to place all youth identified with having a chronic medical conditions and/or medical grade two through five on the alert list in JJIS. A review of three closed youth individual healthcare records found two youth were applicable for medication side effects associated with medication use. Two youth had an alert entered for vision impairment and the other youth had an alert entered for suicide risk. A review of JJIS confirmed the alerts were updated and/or removed, as needed. A review of the center's Facility Management System confirmed each alert was visibly documented for each applicable youth. Three staff were interviewed to determine how they were informed of a youth's medical alerts. Each staff reported they are informed by reviewing the logbook and during shift meetings. Two staff reported they are informed by the alert form. Additionally, one staff reported being informed by e-mail. When asked to rate how effective the process for communicating alert information was at the center, each staff rated the process as very good.

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

The center's mental health staff complete the suicide risk screening; therefore, this indicator rates as non-applicable.

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

The center has a written policy and procedures to ensure all youth are oriented to the general process of healthcare delivery services at the center. The center's practice is to have the nurse or a non-licensed staff knowledgeable with the healthcare delivery system provide healthcare orientation upon each youth's admission. A review of three closed individual healthcare records found each youth received an orientation to healthcare services and health education within twenty-four hours of admission, which was documented on the Health Education Record. Orientation is inclusive of a review of sick call, access to medical care, what to do in an emergency, introduction to the medication process including medication side effect monitoring, right to refuse care, what to do in the event of sexual assault or attempted sexual assault, the non-disciplinary role of healthcare providers, and a review of healthcare contacts.

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

The center has written policy and procedures to ensure the designated health authority (DHA) is notified in accordance with the Department's requirements. The center's practice is to notify the DHA of the admission of any youth with a chronic medical condition, psychotropic medication, or medical concern. Notification is documented by licensed medical staff on the intake progress note maintained in the youth's individual healthcare record (IHCR) and an e-mail is filed in the IHCR. Three closed youth IHCRs were reviewed. Documentation found each youth was admitted with mental health medications and the DHA was notified by telephone, or e-mail within the required timeframe and documented in the youth's IHCR.

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

The center has a written policy and procedures to ensure a healthcare admission rescreening is completed each time the physical custody of the youth changes and if the youth is returned or re-admitted to the center. A review of three closed individual healthcare records found there were no applicable youth whose custody changed during their stay at the center. A request was made for additional youth records; however, there have not been any youth since the last annual compliance review whose custody status changed.

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

The center has a written policy and procedures regarding the Health-Related History (HRH) form, which indicates the HRH form shall be completed no later than seven days following the date of admission. A review of three closed youth individual healthcare records (IHCR) found a new HRH form was completed for three youth within seven days of admission. Each HRH form was reviewed by the advanced registered nurse practitioner and was maintained in the youth's IHCR. The HRH form was completed before or at the same time as the Comprehensive Physical Assessment for each youth.

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

The center has a written policy and procedures indicating the Comprehensive Physical Assessment (CPA) will be completed within seven calendar days of admission or maintain a current CPA. A review of three closed youth individual healthcare records (IHCRs) found one record, a new CPA was completed by the advanced registered nurse practitioner (ARNP) within seven days of admission. Two records contained a current Comprehensive Physical Assessment (CPA) completed within the past year and a review of the CPA was documented by the ARNP within seven days of admission. The medical grade was documented on each CPA and an alert was generated in the center's alert system for youth assigned a medical grade between two and five. One of the three youth refused a portion of the CPA, a signed and dated refusal form was documented within their IHCR. A review of the Department's Problem List within each youth's IHCR found it was updated by the nursing staff, as required.

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

The center has a written policy and procedures ensuring all female youth over twelve years of age who are sexually active or identifies their menstrual cycle as two weeks late shall receive a qualitative urine pregnancy screening. Youth can also request a pregnancy test be given while in the center. A review of three closed youth individual healthcare records (IHCRs) found one youth was applicable for review. One additional closed IHCR was selected and was applicable for review. A review of the two applicable records found one youth refused testing for qualitative urine pregnancy screening. One youth agreed to have the testing completed. Both youth refused a gynecological examination. Documentation of each youth's refusal was maintained in the youth's IHCR. Reviewed documentation confirmed the designated health authority (DHA) provided a written order requesting the qualitative urine screening test examination to be completed.

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

The center has a written policy and procedures regarding tuberculosis screening (TB) which indicates all youth are required to be screened for TB and accurate documentation of results will be maintained by the center. A review of three closed youth individual healthcare records (IHCRs) found each contained a completed Tier 1 tuberculosis screening (TST) questionnaire located within the Medical and Mental Health Screening form as part of healthcare admission screening. A TST was documented in each IHCR. All records documented when the TST was placed, when it was reviewed, and the results. None of the youth tested positive or displayed symptoms of tuberculosis. The results of the TST were documented on the Comprehensive Physical Assessment and Infectious and Communicable Disease form.

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

The center has a written policy and procedures to ensure completion of the sexually transmitted infection (STI) screening. A rescreening is required to be completed if any youth has been out of the Department's custody for more than thirty days. Three closed youth individual healthcare records (IHCRs) were reviewed and documentation confirmed each youth was screened for STIs. Each youth refused to be tested for STIs. One additional youth IHCR was reviewed. Reviewed documentation confirmed the youth was screened for STIs. The youth's results were documented on the Infectious and Communicable Diseases form.

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

The center has a written policy and procedures ensuring all youth at risk for human immunodeficiency virus (HIV) shall be offered counseling, testing, and referrals for medical treatment. Three closed youth individual healthcare records (IHCRs) found each youth was offered the opportunity to receive counseling, testing, treatment, and referral for HIV; however, one of the three youth consented to the test and signed a HIV Antibody Test Youth Consent Form. Two youth signed declining consent to have the test completed. A request for additional youth records was made. Two additional records were reviewed, and each documented the youth consented to HIV testing. The HIV test was completed, by the on-site licensed practical nurse (LPN) the same day each applicable youth consented to the testing. The LPN is a certified HIV counselor. Each of the three applicable youth records documented youth received pre-test and post-test counseling by a certified HIV counselor. The name of the staff completing the testing was documented. HIV results for the applicable youth were maintained confidentially within the youth's IHCR. No results were documented in the chronological progress notes or the internal alert system. There were no youth on-site during the week of the annual compliance review to conduct youth interviews.

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

The center has a policy and procedures regarding sick call process for request and complaints, which states the center will provide sick call seven days a week. The center has regularly scheduled sick call hours for youth to be evaluated by a licensed nurse. Sick call is conducted twice daily from 9 :00 a.m. to 10:00 a.m. and from 1:00 p.m. to 2:00 p.m. and is completed by the advanced registered nurse practitioner (ARNP) or the licensed practical nurse (LPN). Each youth can access the sick call process by notifying a juvenile justice detention officer (JJDO) of any medical complaint(s) and the JJDO enters the sick call request into the center's Facility Management System (FMS), which electronically generates a notification of the submitted sick call request to the nursing staff. The designated health authority (DHA) and/or ARNP provides routine sick call and follow-up care when youth are referred to them by nursing staff. The center has approved protocols in place for when nursing staff are not on-site to review sick call complaints. When nursing staff are not on-site, the JJDO supervisor reviews the sick call complaints and completes a non-healthcare report. The nursing staff or DHA reviews the non-healthcare report upon returning on-site. A review of three closed youth individual healthcare records (IHCRs) found one youth was applicable for placing a sick call request. One additional closed IHCR was selected and was applicable for placing a sick call request. Each applicable record found documentation of a sick call request form and a progress note in subjective objective, assessment, and plan (SOAP) format in the IHCR. One youth was seen by the licensed practical nurse (LPN) for the sick call within twenty-four hours. The ARNP reviewed the sick call request within twenty-four hours of the LPN seeing the youth. One youth was seen by the ARNP within twenty-four hours. Youth signatures were documented on the sick call log in both instances. None of the sick calls required treatment or referral off-site. There were no instances in which a youth presented a similar sick call compliant three or more times in a two-week period. There were no youth onsite during the week of the annual compliance review to conduct youth interviews.

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

The center has a policy and procedures regarding sick call process for visits. The center has regularly scheduled sick call hours for youth to be evaluated by a licensed nurse. Sick call is completed by the advanced registered nurse practitioner (ARNP) or the licensed practical nurse (LPN). Two applicable youth individual healthcare records (IHCRs) were reviewed, including each youth's sick call index, the corresponding Facility Management System generated sick call list, and the sick call referral log. One sick call was conducted by the ARNP. The other was conducted by the LPN and was reviewed by the ARNP within twenty-four hours. There were no sick call visits to observe during the annual compliance review. The ARNP reported, during an informal interview, youth who have presented a repeated similar sick call complaint are referred to the designated health authority. There were no youth on-site during the week of the annual compliance review to conduct youth interviews. Three staff were interviewed to determine who conducts sick call and each staff reported the nurse conducts sick call. Additionally, one reported the doctor conducts sick calls.

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

The center has a written policy and procedures to ensure all youth in restricted housing or confinement have timely access to medical care, as required by the Department. A review of three closed youth individual healthcare records found there were no youth applicable for medical confinement. A request was made for additional youth records; however, there have not been any youth applicable for medical confinement since the last annual compliance review.

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

The center has a comprehensive process for the provision of episodic care and first aid to include episodic care performed by non-healthcare staff. The center utilizes an episodic care log to document episodic care and first aid treatment. The log contains all required information to include the date, name of youth, the youth's Department's identification number, nature of illness or injury, treatment rendered, staff initials, nurse initials, verification of who provided episodic care, and whether the youth was recommended for off-site care. The center has seven first aid kits located in master control, intake, two modules, medical, and two located in the transporting vehicles. All first aid kits were sealed with a snap tab. The contents of the first aid kits were current and documentation confirmed monthly first aid kit inventory inspections were conducted by the nursing staff. A review of three youth individual healthcare records found one youth received episodic care. A request was made for additional youth records; however, there have not been any youth since the last annual compliance review who were applicable for episodic care. Reviewed documentation found the problem-oriented elements which were used to chart pertinent information pertaining to the nature of the youth's ailment including identification of the subject, objective, assessment, and plan (SOAP) to address the complaint. Episodic care was administered by nursing staff. The center has one suicide response kit maintained in master control. A random review of suicide response kit found the kit contained the required items including knife for life, wire cutters, and needle-nose pliers.

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

The center has a written policy and procedures to ensure emergency care and response to emergency situations. A review of emergency care procedures found the center has one automated external defibrillator (AED). All non-healthcare staff who have direct contact with youth maintain current certifications in first aid and cardiopulmonary resuscitation (CPR) with AED. A review of seven staff training records found all staff were trained in CPR, first aid, and the AED. The AED is maintained in the medical clinic and is checked weekly by the nursing staff. The AED batteries expire January 2023 and the pads will expire in December 2019. The nurse reported the batteries were changed a year ago and the pads were changed June 2019. An observation of the nurse powering the device on during the week of the annual compliance review confirmed the device was active. Reviewed documentation supported medical drills were conducted at least quarterly on each shift for the last six months and documented all the

required elements. The center maintains a list of emergency phone numbers in the medical clinic and in master control. Three interviewed staff stated they are able to call 9-1-1.

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

The center has a written policy and procedures regarding off-site care, which indicates the Summary of Off-Site Care form shall accompany the youth to the off-site provider, to be completed and returned to the facility and filed in each youth's individual healthcare record, along with any additional forms or discharge instructions routinely used by the off-site provider. Three closed youth healthcare records (IHCRs) were reviewed and were not applicable for off-site care. One additional youth record was reviewed and was applicable for off-site medical emergency care. The IHCR contained a Summary of Off-Site Care form, discharge documentation, and instructions. Reviewed documentation confirmed the designated health authority or advanced registered nurse practitioner reviewed and signed all off-site care findings, instructions, and information. None of the youth required referrals for follow-up testing or appointments.

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

The center has a written policy and procedures ensuring youth with chronic medical conditions receive regularly scheduled evaluations and treatment to include all necessary follow-up care as required. A review of three closed youth individual healthcare records found there were no youth applicable for the existence of chronic conditions. A request was made for additional youth records; however, there have not been any applicable youth who had a chronic condition and required periodic evaluations since the last annual compliance review. No applicable youth have been on-site more than ninety days, requiring the tracking of periodic evaluations, within the last year.

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

The center has a written policy and procedures ensuring when youth are admitted with prescribed medications, the prescribed medications can only be accepted if the medication is from a licensed pharmacy with a current, patient-specific label intact on the original medication container. The center's practice for the nursing staff is to verify medication with the parent/guardian delivering medication to the center. A review of three closed youth healthcare records found each were applicable for youth admitted to the center with current prescribed medications. Reviewed practice supported the center had a prescription verification process. Nursing staff verified the medications youth were prescribed upon admission through a review of each youth's accompanying information and telephone contact with each youth's parent/guardian. The designated health authority (DHA) was notified and consulted regarding the medication. Each youth was admitted with psychotropic medication and documentation

supported the psychiatrist reviewed the applicable youth on psychotropic medication and conducted an initial psychiatric interview. Reviewed documentation confirmed the nursing staff documented the verification on the Department's Medication Receipt, Transfer, and Disposition form.

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

The center has a written policy and procedures ensuring all youth prescribed medications shall have a current, valid order and are given pursuant to a current prescription or practitioner's order. Youth admitted to the center are continued on psychotropic medication until completion of the initial psychiatric evaluation. A review of three closed youth individual healthcare records found each youth was taking medication upon admission. Each youth record contained a current, valid order given pursuant to a current prescription. Each youth record documented a practitioner order indicating medication to be continued. There were no changes to or discontinuation of medication noted in the applicable youth records. The initial Medication Administration Record in each record matched the youth's medication list.

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

The center has a written policy and procedures to ensure all medications are stored in separate secure and locked areas inaccessible to youth. A review of the medical clinic found the clinic is secured under lock and key. Medical staff and trained supervisory non-healthcare staff have access to the clinic. Supervisory non-healthcare staff are trained by the nurse to assist youth with self-administration of medication. All prescribed medications, over-the-counter (OTC) medication, and controlled and non-controlled medication are identified and stored in separate and secure areas inaccessible to youth. The center has a locked medication cart located within the medical office, houses oral prescription and OTC medications prescribed for youth. Medication in the cart is separated by each module and each youth. A second locked medication box is in the medication cart and stores controlled medication. Bulk supplies of sharps and OTC medications were stored in locked cabinets in the medical clinic. The center also has a secured refrigerator used solely for medications. The center had tuberculosis skin test (TST) medications requiring refrigeration at the time of the annual compliance review. The center currently contracts with a pharmacy for procurement of medication. The center maintained a policy and procedures for the destruction of unused or expired medication. Nursing interviews indicated the center's practice is to return all unused non-controlled prescribed medications to the pharmacy for a credit. Medications not returned to the pharmacy are destroyed by the advanced registered nurse practitioner or the license practical nurse. Reviewed documentation found the center maintains an active modified Class II Type B Pharmacy Permit which will expire on August 31, 2019.

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

The center has a written policy and procedures to ensure all medications and sharps are inventoried, as outlined in Department Rule 63M. A review of the medical clinic found the clinic is secured under lock and key. Medical staff and trained supervisory non-healthcare staff have access to the clinic. Supervisory non-healthcare staff are trained by the nurse to assist youth with self-administration of medication. The center maintains an inventory for all medications and medical equipment classified as sharps. Reviewed documentation for the past six months found weekly inventories were conducted, as required. The center maintains perpetual inventories for over-the-counter (OTC) and prescription medications. A sample review of three bulk OTC medications and sharps validated the inventories were accurate with no discrepancies. There were no youth securely detained at the time of the annual compliance review; therefore, no current prescribed medications could be counted for accuracy. All medical equipment classified as sharps and OTC were securely stored in separate locked cabinets in the medical clinic.

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

The center has a written policy and procedures for controlled medication. There were no youth prescribed controlled substances at the time of the annual compliance review. The center's practice is to conduct shift-to-shift inventories of all controlled medications with two nurses present. The beginning and ending medication count before and after each administered dosage are inventoried, utilizing the Department's Controlled Medication Inventory Records form. Youth-specific prescribed medication is inventoried at receipt of the medication by the center and again upon discharge of the youth. A review of the controlled inventory logs for the past six months validated there was one youth taking a prescribed controlled medication. Documentation reflected the inventory was accurate and conducted pursuant to the center's policy.

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

The center has a written policy and procedures ensuring each youth receiving either prescription medications on a routine basis or over-the-counter (OTC) medication will be documented on the standard Department Medication Administration Record (MAR). The center utilizes the standard Department MAR, to document the administration of prescribed medication. A review of three closed individual youth healthcare records (IHCR) were reviewed. Each applicable MAR documented medication was administered as ordered and each contained clear start and stop dates. Staff initialed each administered medication. There were no indications of lapses or errors in medication administration. All three reviewed MARs indicated each was completed to include the youth's name, Department's identification number, date of birth, and assigned medical grade, youth allergies, medical precautions, and medical alerts. The center maintains an active MAR book located on the medication cart. Each youth

had a current photograph attached to the MAR and nursing staff documentation of side effect monitoring on the MAR.

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

The center has a written policy and procedures ensuring medication administration shall occur, as scheduled, in a comprehensive, accurate, and organized manner in the program, only by a licensed nurse. The center's practice is to have nursing staff administer medications when they are on-site. Most medication is administered during nursing hours; however, trained juvenile justice detention officer supervisory staff can administer medicine once approved by the registered nurse when nursing staff are not on-site. There have not been any youth at the center on parenteral medication during the annual compliance review period. Observation of a medication pass was not conducted during the week of the annual compliance review due to the center not having any youth on-site. However, the licensed practitioner nurse was able to explain the process as outlined by the Department's requirements. There were no youth onsite during the week of the annual compliance review to conduct youth interviews.

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

The center has a written policy and procedures to direct medication administration by non-licensed staff. Select supervisory staff are the only trained non-healthcare staff allowed to administer medication. The center has an updated roster list of all approved staff which have been trained on the facility training curriculum for assisting youth with self-administration of medication by the registered nurse. All approved, trained staff are only allowed to administer over-the-counter medications and oral prescription medications when licensed nursing staff are not on-site. There were no documented instances of non-licensed staff supervising self-administration of medication since the last annual compliance review. There were no youth onsite during the week of the annual compliance review to conduct youth interviews. Three staff were interviewed to determine whether they provide medication to youth. Two staff reported providing medication to youth and one staff reported not providing medication to youth.

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

The center has a written policy and procedures to address psychotropic medication monitoring. The center's practice is to notify the designated health authority (DHA), the facility's prescribing psychiatrist and the designated mental health clinical authority upon each applicable youth's admission. Three closed youth individual healthcare records were reviewed. Reviewed progress notes documented notification to the required parties when youth were admitted on psychotropic medication. Reviewed documentation validated each applicable record showed the designated

health authority (DHA) was notified upon admission and the psychotropic medications were continued until the psychiatrist conducted an initial diagnostic interview. An initial diagnostic psychiatric interview was conducted for all three-applicable youth within fourteen days of admission. The center did not maintain any standing orders for psychotropic medications, nor were there emergency treatment or pro re nata (PRN) orders for psychotropic medications.

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

The center has a written policy and procedures for ensuring there is an approved plan for infection control. The infection control plan outlines prevention, containment, treatment, and reporting requirements related to infectious diseases, as outlined in the Occupational Safety and Health Administration (OSHA) federal requirements and guidelines. The infection control plan was last approved by the designated health authority on March 24, 2019 and addresses infection control procedures including prevention, containment, treatment, and reporting requirements. There were no reportable incidents for which the local county health department, Centers for Disease Control and Prevention (CDC), and the Department's Central Communications Center (CCC) should have been notified of an infectious disease since the last annual compliance review.

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

The center has a written policy and procedures addressing infection control, which indicates the facility must administer a comprehensive program of education and prevention regarding blood borne pathogens. Staff shall receive infection control pre-service infection control training upon hire and in-service training annual thereafter. A review of one pre-service training record and three in-service annual training records confirmed each staff received training on the center's exposure control plan. Three closed youth individual healthcare records were reviewed and each documented completion of the required healthcare education. Reviewed documentation supported each youth received infection control training within seven days of admission to the center.

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

The center has a written policy and procedures ensuring the exposure control plan is written in accordance with the Occupational Safety and Health Administration (OSHA) standards to provide a safe environment for youth, staff, and visitors. The center maintains a written exposure control plan which was updated, reviewed, and signed by the designated health authority on March 24, 2019 and signed by the superintendent on June 12, 2019 during the

week of the annual compliance review. The exposure control plan also addresses procedures on handwashing, proper disposal of needles and other sharps, procedures for maintain a clean worksite, procedures for handling contaminated laundry, procedures post-exposure evaluation and follow up, and a system of medical record keeping for employees with occupational exposure. There were no incidents involving a contagious disease requiring the quarantine or hospitalization of at least ten percent of the total population of youth or staff since the last annual compliance review.

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

The center has a written policy and procedures for the care of pregnant youth to include procedures for medical issues, nutrition, education, and medication. The designated health authority or advanced registered nurse practitioner shall provide a routine, focused medical oversight evaluation of the youth's pregnancy every thirty days. The center reported not having any youth who were pregnant admitted into the center since the last annual compliance review.

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

The center has a written policy and procedures ensuring pregnant youth are provided nutritious foods in sufficient quantities meeting the standards of the minimum daily allowances for pregnant youth. Each pregnant youth receive prenatal, post-partum, and parenting education including topics directly related to healthcare issues and medical risk for pregnant adolescents. The center reported not having any youth who were pregnant admitted into the center since last annual compliance review.

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

The center has a written policy and procedures ensuring all non-healthcare staff involved in supervision or treatment of pregnant youth shall receive appropriate education and training on female healthcare by a licensed nurse. A review of one pre-service records and three annual in-service training records documented training in Detention Services Women's Health. The training included the topics of monitoring, observation, emergency care of the pregnant youth, and other prenatal healthcare educational topics. Documentation reviewed confirmed all training was conducted by the center's registered nurse.

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 facility for any reason, all staff assigned to supervise the youth are informed.

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

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

The center has a written policy and procedures regarding the active supervision of youth. During the annual compliance review week, there were no youth on-site. Video surveillance was used to observe movements in the areas of education, medical, dining room, hallways, and modules. There were one or more staff with each group. Observations verified staff maintained sight and sound supervision at all times and positioned themselves to ensure the safety of youth and staff. A random review of the logbook for the past the past six months indicated prior to youth movement, headcounts were conducted at the beginning and ending of each shift. Three staff were interviewed and all three stated they believe there is enough staff to provide safety and security of the youth and staff. Three interviewed staff also reported counts are conducted at the beginning and ending of each shift and before and after meals and school.

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

The center has a written policy and procedures which addresses ten-minute checks. The center has a total of fourteen operable cameras with a recording capacity of thirty days. The center uses visual observation forms to document the ten-minute checks. When conducting room checks, staff must pause at the door and look into the room to ensure there are no issues with the youth. A random review of video surveillance was conducted for B and C shifts. A review of six different days was conducted and validated ten-minute checks were consistently conducted and documented in real time on the visual observation forms. Three staff were interviewed and stated room checks are conducted every ten-minutes when youth are in their room sleeping or for non-punishment reasons.

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 for census, counts, and tracking. Staff must know the exact number and location of all youth under their supervision at all times. Census counts are taken, reported to master control, and documented in the center's master control and living module logbooks. No youth movement is authorized until master control confirms the count. A random review of the master control logbook and living module logbook indicated counts are documented at the beginning and ends of each shift and randomly throughout the

shift. Census counts are also documented upon any change in population. At the time of the annual compliance review week, there were no youth in the center. Three staff were interviewed and confirmed emergency counts are conducted when a youth is believed to be missing, there is an electrical outage, after a major disturbance, and after any emergency drill.

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

The center has a written policy and procedures which addresses logbook maintenance. The center maintains separate logbooks for master control and for each of the two living modules. A review of each logbook found they were bound with numbered pages. A review of the logbooks for the past six months indicated entries were documented in ink, legible, included the date and time of the entry, a brief description and the initials of the staff completing the entry. Further review of the logbook included safety and security issues, medical issues, special needs, alerts, fire and escape drills. All errors were struck though with a single line and initialed by staff making the correction.

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 which addresses logbook reviews. The center maintains a master control logbook and two living module logbooks for each of the two modules. All entries include the date and time of the entry, a brief description and the initials of the staff. The juvenile justice detention officer supervisor (JJDOS) reviews the logbooks when the shift is accepted. The JJDOS reviews the logbook maintained in the assigned living area when responsibilities are accepted at shift change. A review of the logbooks for the past six months verified the JJDOS from each shift reviewed the master control logbook as required. A review of

the living module logbook for the past six months verified the JJDO coming on-duty reviews the logbook. Further review of the logbooks verified the superintendent or designee reviewed the logbook on a weekly basis.

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

The center has a written policy and procedures for key control. All keys are on a tamper resistant key ring and are secured in a lock box located in master control. Emergency keys are kept in the superintendent's office in a lock box. The center maintains a master key inventory which identifies the number of keys, as well as the key functions for each key ring. A review of the key inventory was conducted and reflected the actual keys on each ring. The issuance of keys is documented in the Department's Juvenile Justice Information System (JJIS) shift report. A review of shift reports for the past six months found the appropriate documentation which included the date, time, who was issued, and who received the keys. All staff received training in key control and were observed carrying keys on their person at all times. Policy states if a key is lost or becomes missing, a supervisor is notified, if the lost keys are not found. There were no lost or missing keys noted since the last annual compliance review. All personal keys are secured in assigned lockers prior to entering the secure side of the building. Three staff were interviewed regarding restricted key. Each interviewed staff reported only restricted keys can access medical records, youth property, mental health records and case management records. Three staff were interviewed and knew the center's daily process for tracking keys.

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

The center has a written policy and procedures for vehicles and maintenance. The center has two vehicles, one caged sedan and one fifteen passenger caged van. The center does not have a maintenance mechanic and the weekly and monthly vehicle inspections are conducted by the supervisors or transportation officers. Prior to and after use, vehicles are visually inspected for contraband. Observations of both vehicles found each contained the appropriate number of

operational seat belts, a window punch, seat belt cutter, fire extinguisher, and first aid kits. Each vehicle also contained a copy of the transportation policy. A review of documentation confirmed an annual inspection was conducted on the caged sedan; however, an annual inspection was not conducted on the fifteen-passenger van. This was brought to the center's attention and an inspection was completed during the annual compliance review week. There were no youth on-site to interview or observe the transportation process. Further observation of both vehicles found they were secured when not in use.

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

The center has a written policy and procedures for tools and sensitive items. The policy forbids youth to use or access any tools. The center does not store tools. Youth may use cleaning items such as brooms, mops, buckets, and other common household items under direct supervision of staff. Three staff were interviewed and were and all three were knowledgeable and stated the youth are only permitted to use mops and brooms. There were no youth in the center during the annual compliance review week; therefore, youth were not observed cleaning.

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

The center has a written policy and procedures for kitchen tools. Food service is provided by the Monroe County Sheriff's Office and meals are prepared in the kitchen at the county jail and delivered to the center. There are no kitchen tools stored at the center. Three staff were interviewed and verified this practice.

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

The center has a written policy and procedures for the access and use of tools. The center's policy forbids youth to use or have access to tools. Youth may use mops, brooms, and buckets under the direct supervision of staff. Three staff were interviewed, and each staff stated youth are only permitted to use mops, brooms and buckets. At the time of the annual review, there were no youth on-site; therefore, no youth observations were able to be conducted.

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

The center has a written policy and procedures for the inventory of all flammable, toxic, caustic, and poisonous items which addresses the proper use, storage and disposal of toxic, flammable, caustic and poisonous items. There are steps outlined should a chemical spill occur. Observations indicated safety data sheets (SDS) were located in the secured closet where chemicals are stored. A random review of the inventory and SDS verified the corresponding chemical was stored. Chemicals were observed to be behind a locked door, inaccessible to youth. Any chemical in need of disposal is performed by the Monroe County Facilities Maintenance Department.

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

The center has a written policy and procedures for access to all flammable, toxic, caustic, and poisonous items which addresses the proper use, storage, and disposal of toxic items. There are steps what should be done if there is a chemical spill. Safety Data Sheets were located in the secured closet where the chemicals were stored with staff access only. Three staff were interviewed, and each confirmed youth are not allowed access to chemicals and other toxic items. Each stated they either add the chemicals to the water or spray the cleaning chemicals onto the area being cleaned and the youth would then wipe off the area. There were no youth in the center during the annual compliance review week; therefore, youth interviews were not conceded

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

The center has a written policy and procedure for the disposal of toxic, flammable, caustic, and poisonous items with clear instructions for chemical spills and the steps to be taken should a spill occur which include shutting down the air handlers and ventilation system, closing all doors and requesting assistance from outside the center. The Monroe County Facilities Maintenance Department handles all disposals of these items. The shift supervisor was interviewed and verified this practice. All liquid waste, such a mop water, is disposed of down the drain in a utility closet. The center does not have kitchen services on-site; therefore, there is no grease trap or other liquids to dispose of in the center.

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

The center has a written policy and procedures for confinements under twenty-four hours. The center had one confinement under twenty-four-hours during this annual compliance review period. A supervisor review was conducted within the two-hour time frame. When the confinement was ended, the superintendent or designee documented their review within the forty-eight-hour required time. Room searches prior to the youth entering the confinement cell were conducted. Cameras and windows were free from obstruction. . A review of the confinement report found the youth was searched prior to entering the confinement cell and the youth behaviors were documented in the visual observation report as required. Three staff were interviewed, and each knew what to do when a youth is placed in confinement.

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

The center has a written policy and procedures for confinement over twenty-four hours which requires confinement reports to be submitted within one hour of the incident and reviewed within two hours by the superintendent or designee. The supervisor must conduct reviews within three-hours, document the youth's behavior, and the reason for continued confinement. All confinements beyond the twenty-four-hour time span must be approved by the regional director or designee. The center had no confinements beyond twenty-four hours since the last annual compliance review.

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

The center has a written policy and procedures to effectively manage emergency and disaster events. The center has a Continuity of Operations Plan (COOP) which was approved by the Department. The plan addresses protocols for various emergency situations and relocation procedures in the event the center must be evacuated. Two COOP drills were conducted, one in January 2019 and one in May 2019, which both were conducted prior to the 2019 hurricane season. The January drill indicated no youth were on-site and May's drill indicated one youth was on-site and was evacuated to the Miami-Dade Regional Juvenile Detention Center. Observations made of the drill forms indicated each contained a scenario, emergency checklist, and e-mails to document the drills. A review of the center's logbook verified the drills were documented, as required. Three staff were interviewed and three stated they participated in a weather drill, one stated a major disturbance, and one stated a bomb threat.

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

The center has a written policy and procedures to address escape drills. The policy requires drills to be conducted quarterly. Documentation provided indicated escape drills are conducted monthly on each shift each month. Further review of the documentation indicated scenarios, the dates and times of each drill, and the staff participating in the drill. Each drill was reviewed, critiqued, and provided recommendations for improvement by the supervisor. A review of the logbooks indicated the drills were noted, as required. Three staff were interviewed, and all three-staff indicated they participated in an escape drill.

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

The center has is a written policy and procedures for addressing fire prevention and safety. The center has a fire prevention and safety plan which has been approved by the state fire marshal. A review of the drills indicated they are conducted monthly and on each shift as required. Three staff were interviewed and indicated they participate in monthly ire drills. A review of the center's logbook verified dills are documented. Three staff were interviewed and stated they have been instructed on what to do in case of a fire. Each interviewed staff also stated they have participated in fire drills.

Program Name: Monroe Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: Monroe County / Circuit 16
Review Date(s): July 11-14, 2019

MQI Program Code: 1076
Contract Number: N/A
Number of Beds: 10
Lead Reviewer Code: 154

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.01 * Initial Background Screening	3.03 Non-Licensed MH/SA Clinical Staff
2.12 Daily Activity Schedule	
3.01 Designated Mental Health Clinician Authority (DMHCA)	