STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Manatee Regional Juvenile Detention Center

(State-Operated)
1803 5th Street West
Bradenton, Florida [34205]

Review Date(s): [February 25-28, 2020]

Promoting Continuous Improvement and Accountability
in Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Brenda Comadore, Office of Program Accountability, Lead Reviewer (Standard1)
Marvin Bliss, Office of Program Accountability, Regional Monitor, Standard 2
Melissa Johnson, Office of Program Accountability, Central Regional Supervisor, Youth and Staff Interviews
Pete Keelan, DJJ South Region Education Coordinator, Standard 2
Greg Mahoum-Nassar, Office of Program Accountability, Regional Monitor, Standard 4
Gus Mazorra, Office of Program Accountability, Regional Monitor, Standard 3
Ariel Veguilla, DJJ Detention Behavioral Specialist**,** Standard 5

Program Name: Manatee Regional Juvenile Detention Center
Provider Name: State - Operated
Location: Manatee County / Circuit 12
Review Date(s): February 25-28, 2020

MQI Program Code: 298
Contract Number: N/A
Number of Beds: 60
Lead Reviewer Code: 172

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
5.13 Confinement Under Twenty-Four Hours	
5.14 Confinement Over Twenty-Four Hours	

Standard 1: Management Accountability
Detention Rating Profile

Indicator Ratings

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

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

Standard 2: Youth Management
Detention Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Detention Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Detention Rating Profile

Indicator Ratings

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

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Program Overview

The Manatee Regional Juvenile Detention Center (MRJDC) is a state-owned detention facility, operated by the Department, located in Bradenton, Florida. The center serves youth in Manatee, Sarasota, Desoto counties, and, on occasions, the counties of Highlands, Hardee, and Polk in Circuit Twelve. Male and female youth who are detained pending adjudication, disposition, or placement in a residential commitment program are housed in the sixty-bed center. Youth are provided services which include youth orientation, behavior management, safety and emergency procedures, transportation, mental health, and healthcare services.

The center's educational services are provided by the Manatee School Board. The center's management team includes the superintendent, two assistant superintendents, one administrative assistant, seven juvenile justice detention officer (JJDO) supervisors, and forty-six JJDOs. Mental health and healthcare services are provided through the contracted provider, Camelot Community Care. Mental health services are provided by two licensed clinical staff; one of which is the licensed designated mental health clinician authority (DMHCA), and four non-licensed clinical staff. 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 Maxim Healthcare Services, Inc. There are six medical positions; one designated health authority (DHA), one advanced practitioner registered nurse (APRN), one registered nurse (RN), and two licensed practical nurses (LPNs). The medical clinic maintains nursing coverage seven days a week, twenty-four hours a day. Food services are provided by Department staff and include menus, meal planning, meal schedules, special diets, nutritional analysis, daily allowance, food preparation, health certifications, food product standards, sanitation, and cleaning. Staff are responsible for the custody and control of youth in their care, providing youth supervision twenty-four hours a day, seven days a week. The center has four living modules which are divided by male and female. There are fifty-eight security cameras at the center, of which all fifty-eight were operational. The center was clean and had various hand-painted murals painted throughout the common areas and youth dormitories. The center was free of graffiti and pests. At the time of the annual compliance review, the center had seven vacancies, which included five JDO Is and two JDO IIs.

Standard 1: Management Accountability

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

The center has a policy and procedures to address background screening of all new staff. The center hired thirty-six new staff since the last annual compliance review. A completed and eligible background screening was found in the Background Screening Unit (BSU) system for each of the thirty-six newly hired detention staff. Each staff's background screening was rated as "Eligible" prior to the staff start date. No exemptions were needed for newly hired staff. The center did not utilize any new volunteers during the annual compliance review period. However, four volunteers were screened and approved prior to any access to youth. The center teachers are employed by the Manatee County School Board, which is responsible for the teacher background screenings. The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to the Department's BSU for each on January 24, 2020.

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

The center has a policy and procedures to address the rescreening of all staff every five years of employment. The center had three staff eligible for a five-year background rescreening. All three staff were detention center staff, and each had a completed and eligible background rescreening completed within the required timeframe and submitted to the Department's Background Screening Unit.

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

The center has a policy and procedures to address the provision for an abuse-free environment, as well as an established code of conduct which all juvenile justice detention officers are required to acknowledge and comply with. A signed code of conduct was found for seven selected records for review of center staff. An interview with the superintendent confirmed the code of conduct is in place to ensure staff act appropriately in their supervision of youth and the steps taken if a staff member is suspected of improper conduct. Seven staff records were reviewed for violations of the code of conduct and commendations. None of the seven staff records were applicable for violations of code of conduct. None of the seven staff were applicable for commendations.

A review of the center's Central Communications Center (CCC) reports, incident reports, and youth records found no additional improper conduct or documented violations of the code of conduct in employee records. Seven staff were interviewed and each described the process for youth who wish to call the CCC or the Florida Abuse Hotline. The staff reported they call the supervisor, allow the youth to make the call, step away to allow privacy, and talk to the operator after the call to obtain the incident number and operator information. Five of seven staff reported never hearing a co-worker use profanity, two staff stated they had heard profanity once in a while but as a slip, not in a threatening manner. All seven staff reported never hearing a co-worker threaten, intimidate, or humiliate the youth. Five staff reported the working conditions were good and improving and two reported the conditions were very good and further explained the culture at the center was positive and they felt supported by center administration. Seven youth were interviewed and each reported they felt safe at the program and never been hindered from contacting the Florida Abuse Hotline or CCC. All seven youth reported the staff are respectful towards youth. Five youth stated the staff never use profanity., Two youth stated they hear profanity from staff occasionally. All seven youth reported never hearing staff threaten or intimidate youth.

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

The center has a policy and procedures in place to address contacting the Central Communications Center (CCC) to report any reportable incidents which occur at the center. The center had thirty-three reportable CCC incidents in the last six months. The superintendent was interviewed and verified the reporting process of staff reporting to the CCC within two hours of the incident occurring. Five CCC reports were reviewed, two were medical incidents, two were complaints against staff, and one was an escape. All five incidents were called into the CCC within the required two-hour time frame. The center has not experienced an increase in reportable CCCs. The center's reportable CCC incidents are comparable to the previous reporting year.

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

The center has a policy and procedures to address the use of physical intervention techniques in accordance with the Florida Administrative Code. The center abides by the statewide detention Protective Action Response (PAR) plan. The center's PAR rate during the fourth quarter was 14.43, which is higher than the statewide Detention PAR rate of 12.00. The center's PAR rate remains consistent with the previous annual compliance review. The center had one hundred and fifty-two PAR incidents during the annual compliance review period, of which, fifteen were reviewed. All fifteen PAR reports had all narratives completed by the end of the employee's work day. All PAR reports included narratives from each identified party involved. None of the PAR reports was applicable for mechanical restraints. Each of the PAR reports had reviews completed by the supervisor, PAR instructor, and superintendent or designee. All of the PAR incidents reports for the center were documented, and reviews were completed within the required seventy-two-hour time frame. Seven staff were interviewed and each reported staff encourage communication and attempt to talk to youth prior to engaging in PAR, which staff reported using as a last resort. An interview with the superintendent confirmed routine checks are completed by the administration in the Facility Management System to follow-up on any PAR incidents, as well as, daily review of logbooks and videos to ensure all incidents are appropriately handled and reported.

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

The center has a policy and procedures to address pre-service requirements and ensure staff are trained in accordance with Florida Administrative Code. The center trains all staff in

accordance with the Florida Administrative Code and follows the statewide pre-service/certification plan for new detention employees. Seven staff records were reviewed for pre-service training/certification. Each staff completed all phase one and phase two trainings, including Protective Action Response (PAR), cardio pulmonary resuscitation (CPR)/first aid/automated external defibrillator (AED) certification training, mental health and substance abuse, suicide prevention, Prison Rape Elimination Act (PREA), human trafficking, active shooter, and the Department's Detention Center Operations training, which were all completed prior to contact with youth. Additionally, each staff completed the detention officer academy and was certified within 180-days of hire. All training was entered in the Department's Learning Management System (SkillPro).

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

The center has a policy and procedures to address in-service required twenty-four hours and supervisory eight hours of training. The center follows the statewide detention training plan for in-service staff and maintains a training calendar which is updated as changes occur. The superintendent was interviewed and verified the staff complete both face-to-face and online trainings as outlined on the center's training calendar. Seven staff records were reviewed for in-service training and each had more than the required twenty-four hours of training in the 2019 calendar year. Each staff had documentation of completing a Protective Action Response (PAR) update, cardio pulmonary resuscitation (CPR)/first aid/automated external defibrillator training and certification, suicide prevention training, and professionalism and ethics training. Two of the reviewed staff are supervisory staff. One staff completed one hundred and twenty-eight hours of in-service training including the required eight hours of supervisory training in the areas of management, leadership, employee relations, communication skills, and fiscal. The remaining staff completed seventy-six hours of in-service training, including the required eight hours of supervisory training in management, leadership, communication skills, and fiscal. All training was entered in the Department's Learning Management System (SkillPro).

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

The center has a policy and procedures in place to address the sharing of alert information. Seven staff were interviewed and each verified the process for sharing alert information, which occurs during shift briefing and reported it as an effective way to communicate alerts. A review of the center's logbooks for shift reports confirmed alerts were appropriately placed in the logbook. Seven youth alerts were reviewed and each had alerts entered and downgraded by the appropriate person in the required time frame. The center's alerts are entered, updated, and downgraded by the corresponding administrative staff on an ongoing basis. All medical alerts are entered by medical staff, all mental health alerts are entered by the center's licensed clinicians, and all safety and security and gang alerts are entered by program administration. A review of the Department's Juvenile Justice Information System confirmed client management, medical, safety and security, and gang alerts were all entered and appropriately documented.

Standard 2: Assessment and Performance Plan

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

The center has a policy and procedures to ensure youth are admitted to the center in accordance with Florida Administrative Code. Seven youth records were reviewed for admission. All seven records contained an arrest affidavit/custody order or courtesy hold order. Six contained a Detention Risk Assessment Instrument (DRAI) and one was not applicable due to not being admitted through the juvenile assessment center. All seven records contained a Suicide Risk Screening Instrument (SRSI). All seven records had the Admission Wizard printed and placed in the record. Each Admission Wizard documented youth were frisked, electronically searched, stripped searched, medical, mental health, and substance abuse screenings. Six of the seven Admission Wizards documented the youth were able to make a telephone call, one youth refused. All seven Admission Wizards documented youth were offered a snack or meal. An admission was unable to observed during this review period.

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

Seven youth records were reviewed for orientation. Documentation revealed orientation was completed within twenty-four hours of admission for each youth, with each youth acknowledging

the orientation by signature. The orientation process included identification of key personnel, the daily activity schedule, the center's rules and regulations, visitation, telephone calls, grievance procedures, access to medical, mental health, and substance abuse services, access to the Florida Abuse Hotline and the Central Communications Center, behavior expectations and related consequences, and possible new law violations for destruction of property. One of the seven youth rights form was missing the staff signature. One of the seven youth records was missing the staff signature on the orientation acknowledgement form. Seven youth were interviewed. All seven youth reported they were provided with information about the center's rules and regulations, daily schedule, education services, visitation, abuse reporting, and the behavior management system.

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

The center has a policy and procedures to address the classification of all youth. The center has classification procedures to ensure all youth admitted to the center are classified to provide the highest level of safety and security and placed in the proper room. Seven youth records were reviewed. Admission Wizards were completed in each record, which included a review of the youth's history, sex, height, weight, age, level of aggressiveness, identified special needs, history of sexual offenses, the Victimization and Sexually Aggressive Behavior (VSAB) form, medical, suicide risk identified or suspected, escape, gang affiliation, and security. Youth were assigned to rooms based on classification procedures. Alerts were entered into the Department's Juvenile Justice Information System (JJIS), as applicable. At the time of the annual compliance review, no youth were classified as being a suspected gang member or as a gang member. There were no youth classified as being sexually aggressive in the seven records reviewed.

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

The center has a policy and procedures to address notification of juvenile probation officer (JPO) designated as the gang representative. A review of seven youth records indicated all youth were screened for gang affiliation during intake. Information from the intake screening is provided to the shift supervisor regarding alleged gang information and subsequently forwarded to the center's gang representative. During the annual compliance review while reviewing the Department's Juvenile Justice Information System (JJIS), two of the seven youth were identified with gang association, as a result, an email was sent to all parties, as required. The superintendent reported the center shares gang information with each youth's assigned JPO and local law enforcement, in addition to the gang representative.

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

The center has a policy and procedures to address the possession of youth property during intake. Seven youth records were reviewed and found applicable for having personal property. Each record documented youth property was inventoried by the admitting juvenile justice detention officer (JJDO) and entered into the Department's Juvenile Justice Information System (JJIS). A Property Receipt Form was printed and signed by each youth and JJDO in all seven records. Youth property is placed in a bag with a copy of the Property Receipt Form and youth information, and the bag is placed in a secured room. Money and other valuable items are placed in a clear tamper-proof bag and placed in a drop safe, which is under camera surveillance. An admission process could not be observed during the annual compliance review. The tamper-proof bags are labeled with the youth's name, Department's identification number, a listing of the items in the bag, youth and staff signatures. The personal property logbook was reviewed and documentation supported the youth's personal property items were placed in the drop safe. All seven records contained a signed Letter of Acknowledgement regarding unclaimed property. Seven youth were interviewed and each reported staff checked their personal property and each youth signed a property receipt upon admission to the center. An interview with the superintendent confirmed the process for the receipt of youth property. There were no incidents regarding lost or stolen property since the last annual compliance review.

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

The center has a policy and procedures to address the safeguard of youth property. Upon entering the center, youth personal property is stored within two separate areas in the center. Youth clothing is stored in a property room with access restricted to supervisors and intake personnel. Property items of value are secured in a tamper-proof bag and secured in the drop safe, which is under surveillance. Currently, only administration and supervisors have access to the drop safe. Valuable property is removed daily and stored into the main safe area, which is also under surveillance. Property bags are listed in a binder by date order. Property is purged by the staff assistant after a youth departs the center and notice of thirty-day disposal is sent to the parent/guardian. A review of Central Communications Center (CCC) reports for the past six months indicated there were no incidents related to youth property reported. The superintendent was interviewed and clearly explained all procedures related to storage of youth personal property.

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

The center has a policy and procedures to address youth release. Three closed youth records were reviewed for release documentation. All three records confirmed the center was consistent in photocopying the identification (ID) cards of the individuals to whom the youth were released to. For youth released to HUB transporters, IDs were photocopied and the center identified the transporter by name. Each of the three records documented court orders and other paperwork related to the release were reviewed by the supervisor. There was no missing required documentation. Each record documented each youth's identity was confirmed prior to release. There were no releases to observe during the week of the annual compliance review. There were no Central Communications Center (CCC) report for unauthorized release during the reviewed time frames.

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

The center has a policy and procedures to address release of youth personal property. Three closed records were reviewed for release of each youth's personal property. All three records contained a copy of the property receipt on file and were signed by each youth and parent/guardian. The center's property logbook documented property was released to each youth upon release from the center. There is a process in place to purge property and send a letter to the parent/guardian informing them of the intent to dispose of the property if the property is not picked up after thirty days. The superintendent interview indicated property not picked up is either donated to a non-profit organization or discarded.

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

The center has a policy and procedures to address medication and aftercare instructions for released youth. Three records of youth released from the center with medication were reviewed and two were found applicable for release of medications with aftercare instructions prior to the youth exiting the facility. A medication receipt form was completed in each of the three records reviewed. All forms were signed and dated by all required parties. A review of documentation in all three records found the supervisor checked to confirm if each youth had any medication upon their release. The process followed by the center for release of medication is medical staff bring the medication to the lobby area, and a review and count of the medication is completed with the parent/guardian. The parent/guardian, medical staff, and witness signed the medication receipt and a copy is placed in the closed record.

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

The center has a policy and procedures to address the review of youth in secure detention. The superintendent reported the center has the detention review specialist designated to coordinate detention reviews weekly. The meetings address youth alerts, confinements/behavior issues, current court status, any issues relative to youth's placement (if committed), education, medical and mental health concerns. Documentation of detention reviews indicated they occurred during the past six months. A detention review meeting was observed during the week of the annual compliance review. All youth on detention status were reviewed which included any follow-up information needed from previous reviews, pending court dates, commitment status, release dates, and other pertinent information. The weekly reviews include representatives from mental health, medical, education services, probation, and residential staff. The reviews were attended either in person or by telephone by circuit probation staff and all departments within the center.

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

The center has a policy and procedures to address the daily activity schedule of youth in the center. The daily activity schedule is posted in each living area and outlines the days and times for each youth activity. A review of the center's logbooks indicated the daily activity schedule is being followed as required. Seven youth, seven staff interviews, and observations during the annual compliance review indicated the center follows the daily activity schedule. The schedule includes times for personal hygiene, meals, visitation at a minimum of twice a week, education, indoor and outdoor recreation for one hour which includes daily large muscle exercise, shift change, faith-based services, groups, shower time, bed time, and down time for youth.

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

The center has a policy and procedures to address the adherence to daily youth schedule. Observations during the annual compliance review confirmed youth moved to and from class, meals, and other activities as scheduled. Logbooks documented the schedule was followed unless an emergency event or disturbance occurred which was documented in the logbooks when they occurred. Any changes to the schedule must be approved by the shift supervisor or administration. Seven staff were interviewed and each reported the activity schedule is being followed. Six of the seven youth interviews indicated the schedule was being followed, with one youth reporting the schedule is not being followed.

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

The center has a policy and procedures to address educational access for youth at the center. The facility's educational program managed by the Manatee County School District operates on a year-round basis, providing the youth within the facility 250 days of instruction distributed over twelve months with a minimum of twenty-five hours weekly. Upon review of the school's schedule and according to the school's on-site lead educator, the teachers have ten dedicated days for professional development. This was supported by an interview with the on-site lead educator, by observing the yearly academic calendar as well as a daily academic bell schedule.

A review of seven random selected samples from the facility's Central Command logbooks, identified school is occurring with minimal interference. This was verified by witnessing past video recording of youth movements of the seven provided samples through the interviewing of

the facility's lead educator, review of the youth responses, and an interview with the central regional detention director during the review period.

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

The center has a policy and procedures to address career education for youth at the center. The facility provides appropriate career education to the youth based upon the youth's age as well as assessed cognitive and educational abilities. The career education component which is offered is categorized as a type one career/vocational curriculum. This classification which stresses "soft skills" includes but not limited to communication, decision making, and interpersonal skills. During an interview with the facility's lead educator, it was confirmed the career education component also provides the youth with employment and life skills guidance through various exercises which deal directly to exploring career choices, creating career inventories, and introductions to résumé creation.

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

The center has a policy and procedures addressing the behavior management system (BMS) to ensure the safety and security of youth and staff. The center provides a system of rewards, privileges, and consequences to encourage youth to fulfill the BMS expectations. The BMS system includes rewards for positive behavior and consequences for inappropriate behavior. The behavioral norms and expectations for youth are posted throughout the modules for youth. Youth are informed of the BMS during the admission process.

The BMS is a three-level system. Each youth enter at level two when admitted and their levels can move up or down, depending on their behavior in the center. The center's level two provides each youth with all basic rights and some additional activities and incentives. The center incentives and activities include playing games, a later bed time, and access to television. The youth can progress to level three with positive behavior. The center's level three system provides youth with all basic rights and will receive additional privileges such as a 9:30 p.m. bed time, receive haircuts, participation on honor module, and participate in choirs. Youth levels are updated daily on their level sheets. Youth can view their status and may ask questions, if needed. Inappropriate behavior is documented in the center's logbook.

A review of the level sheets and logbooks confirmed this practice. During the annual compliance review, observations of the youths' behavior in the center were made and staff were giving youth positive reinforcement for appropriate behavior. Documentation revealed administration staff rewarded the level three youth for positive behavior which included incentives. Seven youth

were interviewed on how they would rank the BMS. Five stated it was fair, one stated it was very good, and one stated it was poor. When questioned on the consequences they received were fair or unfair; two youth stated consequences were fair and five stated they have never received consequences. Each youth stated youth are not allowed to punish other youth. Each youth stated they were never sent to their room for punishment. Seven staff were interviewed and each reported staff speak with youth to discuss the consequences being imposed and give the youth the opportunity to explain their behavior. Each staff stated youth will drop a level and/or lose points as a consequence to negative behaviors. Each staff stated they receive feedback from their supervisor regarding the implementation of the BMS system, as needed. According to the superintendent, the center utilizes the BMS level system rolled out by the Adapt and Transform Team and also identified staff who recently attended the BMS level system training.

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

The center has a policy and procedures to address unauthorized use of punishment. The center's behavior management system prohibits the use of group punishment, corporal punishment, or use of drugs to control youth behavior. Seven staff were interviewed and each staff advised consequences for inappropriate behavior never include loss of meals, snacks, sleep, school, or other rights and have never witnessed a co-worker utilize such a consequence. All seven staff stated never witnessing a co-worker to encourage a youth to beat up another youth. Seven youth were interviewed and three reported never having rights taken away as punishment. Three interviewed youth stated they received consequences for their actions and stated the consequences are loss of points or reduction of their level. Four of the seven interviewed youth stated they have never received consequences. Each of the seven youth stated they are not allowed to punish other youth.

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

The center has a policy and procedures to address each youth's right to grieve the actions of the center's staff as it relates to the violation or denial of basic rights and each youth is to be treated fairly, respectfully, without discrimination, and their constitutional rights protected. The process includes an informal phase, a formal phase, and an appeal phase meeting the required time frames set by the Department. Youth have access to grievance forms within their module by requesting staff to enter the grievance into the Facility Management System (FMS). Completed FMS forms are reviewed by staff and forwarded to the shift supervisor, who reviews the grievance. The supervisor reviewing the grievance will either resolve the issue/concern or forward the grievance to the superintendent. Since the last annual compliance review, there were no grievances filed. Seven staff were interviewed and each were able to state the grievance process. All seven youth stated they have never filed a grievance. The superintendent's interview clearly outlined the three phases of the grievance process and indicated grievances are entered and maintained in the FMS.

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

The center maintains a policy and procedures ensuring trauma-informed care is incorporated into the services provided for youth in custody. Center staff receive training in trauma-informed care as part of their pre-service and in-service requirements. A review of seven in-service and seven pre-service training records indicated all staff are trained in trauma-informed care in the Department's Learning Management System (SkillPro). All youth are being treated as if they were affected by trauma and can be re-traumatized at the center if careful precautions are not taken. Observations found the soft room is decorated with comfortable furniture, carpet, and

painted in soothing colors. There are positive murals on the walls throughout the center. The soft room is utilized by staff to calm youth down and/or for youth to have meetings with the therapists. An interview with the center's superintendent reported when a youth disclose they have experienced trauma, a mental health referral is placed in Facility Maintenance System (FMS).

Standard 3: Mental Health and Substance Abuse Services

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

The center has a policy and procedures to address the designated mental health clinician authority (DMHCA). The center has identified a designated DMHCA as the licensed mental health counselor (LMHC) who works a full-time schedule to ensure appropriate coordination and implementation of mental health and substance abuse services are available and administered according to established schedules. The DMHCA is also available by telephone when not on-site. A review of all practitioner licenses revealed the DMHCA holds an active and valid LMHC license in the State of Florida, with an expiration date of March 31, 2021.

The DMHCA also reviews all services administered by mental health providers; any changes in levels of supervision as a result of Assessments for Suicide Risk (ASR) administered by unlicensed therapists prior to youth's change of level. The DMHCA duties include the attendance and participation in administrative meetings to stay abreast of changes to policy.

The DMHCA interview described their role as being responsible for working with the administration at the center to ensure the timely provision of appropriate services.

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

The center has a policy and procedures to address licensed mental health and substance abuse clinical staff. Mental health and substance abuse services are contracted with Camelot Community Care. There is a total of six clinical staff. Two licensed mental health counselors (LMHCs) oversee the clinical staff. One of the LMHC is the designated mental health clinician authority (DMHCA) and ensures clinical staff are qualified based on education, experience, and training for services performed. All licenses were reviewed and found to be valid and clear, in accordance with Florida Statute, with expiration date(s) of March 31, 2021 for three clinicians, and March 17, 2024, October 10, 2024, and February 3, 2025 for the remaining clinicians.

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

The center has a policy and procedures to address non-licensed mental health and substance abuse clinical staff. The center is currently licensed for substance abuse services under Chapter 397. The center's current license expires on April 1, 2020. There are four non-licensed clinicians providing services at the center in which two of the four non-licensed clinicians are employed full-time, while the remaining two work at the center part-time. A review of the non-licensed clinician's personnel records revealed each hold the appropriate degree from an accredited college or university in the required field of study. Each of the non-licensed clinician's training records revealed each had the required twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services.

A review of the program's clinical supervision logs for the past six months indicated the completion of required weekly supervisory hours of all non-licensed clinicians by the required licensed mental health staff and documented on the required Department form. One of the non-licensed clinicians started working at the center on January 23, 2020; therefore, there were weekly supervision logs for one month of the annual compliance period. All supervision was provided to the non-licensed clinicians by the designated mental health clinician authority (DMHCA) or the licensed mental health counselor (LMHC) every week services were provided to each youth at the center.

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

The center has a written policy and procedures in place outlining the process for completing mental health and substance abuse screening on all youth upon their admission to the center. A review of seven youth mental health and substance abuse records revealed each youth were presented to the center with a suicide risk screening instrument (SRSI), the screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB), and six of the seven had the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2). The remaining youth without the MAYSI-2 in their record was a transfer from Polk County and Polk County does not utilize the MASY-2. A review of all seven youth records and required documentation was completed by the designated mental health clinician authority (DMHCA) upon each youth's admission to the center verifying the appropriate forms were included and notating any exceptions. Each assessment was completed in its entirety and each section was completed by required staff. All seven reviewed youth records indicated a risk of suicide. Based on this information, a Suicide Assessment Risk (SAR) was made and each youth was placed on suicide precautions until appropriate screenings could be conducted. All screenings were completed by a trained 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 has a policy and procedures in place outlining the process for ensuring youth identified through preliminary screening having mental health or substance abuse issues receive in-depth assessments shortly after intake to the system. A review of seven youth mental health and substance abuse records revealed five of the seven youth were identified as needing a mental health and substance abuse evaluation. All evaluations were completed within thirty-one days of the youths' arrival by the center's provider.

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

The center has a policy and procedures outlining the process to address mental health and substance abuse treatment services. A review of seven youth mental health and substance abuse records indicated five of the seven youth were applicable for receiving mental health and substance abuse services. Four of the seven youth were assigned to a mini-treatment team, with one of the seven youth refusing treatment. The mini-treatment team consisted of mental health clinical staff, one staff from a different service area, each youth, and each youth's parent/guardian, if possible. The four applicable youth received group or individualized treatment in accordance with the frequency required by the treatment plan. All seven of the reviewed records had a properly executed Authorization for Evaluation and Treatment (AET). All treatment notes were documented on the proper Department's form and each youth received necessary and appropriate mental health and substance abuse treatment and services reflecting diagnosis and treatment needs. Mental health staff had adequate access to each youth to provide the treatment services. Group therapy had no more than six youth in attendance. This was verified by reviewing the group therapy sign-in sheets for the review period.

The designated mental health clinician authority (DMHCA) indicated the center provides mental health and substance abuse groups. Treatment plans are developed and based on the results of the initial assessment. Completion of the treatment plan is a multi-disciplinary team effort, which includes members from medical, mental health, administrative, each youth, and their parent/guardian if available. Documentation of the meeting is filed in each youth's chart.

Two of the seven interviewed youth indicated they had not received any mental health or substance abuse services while at the center. Two of the seven youth rated mental health

services received as very good and two rated the services good. One of the seven youth rated the services as fair.

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

The center has a policy and procedures addressing development and review of an initial and/or individualized treatment plan for youth, as applicable. Of the seven youth records reviewed, three youth required a treatment plan. The treatment plans were in place within seven days of initiation of treatment and developed on the appropriate form. The form included the reason for referral, initial diagnosis/symptoms, initial treatment methods and goals, and psychiatric services which included psychotropic medications. The documents were signed by the provider and each youth. Members of the mini-treatment team were involved in the development of each plan.

One of the seven youth had been at the center long enough to necessitate an individual treatment plan. This plan was developed prior to the youth's thirty-first day at the center and was signed the day of development. The treatment plan included the necessary elements, such as diagnosis, treatment focused symptoms, goals, psychiatric services, pharmacological intervention, and any progress notes. The plan was not signed by the youth, team members, or parent/guardian as required. Three of the seven reviewed youth records required treatment and services provided by a licensed psychiatrist. During the annual compliance review period, there were no individual treatment plans requiring review.

The seven youth records reviewed did not have discharge summaries prepared at the time of the review period. Three additional youth records were requested which had mental health/substance abuse treatment discharge summaries for review. Each of the three youth records were all properly completed upon each youth's discharge. The summary was provided to each youth, parent/guardian, and juvenile probation officer (JPO).

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

The center has a policy and procedures in place outlining the process for providing psychiatric services for youth in need of such services. Seven youth records were reviewed and four required a treatment plan. The initial treatment plan was completed within seven days of treatment initiation and completed on the appropriate Department form in each applicable record. The initial psychiatric interview form contained the reason for referral for treatment,

history (to include medical, mental health and substance abuse history), mental status examination, applicable prescribed medication, and explanation of the need and frequency of medication. Four of the reviewed seven youth records confirmed four youth were admitted with psychotropic medication. All four eligible youth were referred for a psychiatric interview and each received an initial diagnostic interview, within fourteen days of admission. In depth, psychiatric evaluations were conducted within thirty days of admission on four of the seven youth. The evaluations included the reasons and factors leading to the referral, historical information, mental status examination, identification of individual, family and environmental factors, Diagnostic and Statistical Manual of Mental Disorders Fifth edition (DSM-5), treatment recommendations and interventions for youth to assist in stabilizing psychiatric disorder, prescribed medication and frequency of medication monitoring/management, explanation for the need for psychotropic medications related to each youth's diagnosis, target symptoms, potential side effects, risks, and benefits of taking the medication. All evaluations indicated each youth's adherence to medication, height, weight, and blood pressure documented on the last page of the evaluation. All evaluations were signed and dated by the psychiatrist and all seven youth records confirmed verbal parental consent was pursued.

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

The center has a policy and procedures governing suicide prevention plans. The plan was approved on July 29, 2019 by the superintendent and the designated mental health clinician authority (DMHCA). The plan includes the identification and assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and review process in accordance with Florida Administrative Code.

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

The center has a policy and procedures detailing the suicide prevention services which includes the identifying, monitoring, observing, housing, and supervising any youth identifying potential suicide risk. All seven reviewed youth records identified each youth was determined to be at-risk and each youth was placed on precautionary observation status. A referral was completed for each youth to receive an Assessment of Suicide Risk (ASR). Each of seven youth records contained the Suicide Precaution Observation logs; however, one of the seven youth's observation logs were missing an entry on January 15, 2020. The missing entry was also noted

by the licensed mental health clinician (LMHC), during the clinician's review of the observation logs. In each of the seven youth records reviewed, the superintendent or designee was immediately notified of the suicide risk, and the appropriate referrals made to include risk alerts being entered into the Department's Juvenile Justice Information System (JJIS).

In all seven youth records reviewed, an Assessment of Suicide Risk (ASR) was completed within twenty-four hours with appropriate follow-up prior to removing each youth from precautionary observation. In each youth record, documentation confirmed a conference was held by the superintendent and licensed mental health professional before reducing the level of supervision. Four of the seven youth ASRs reviewed were completed by a licensed professional and three of the seven youth records were completed by a non-licensed clinical staff under the supervision of a licensed professional. All non-licensed staff received twenty hours of ASR training. There were no youth who had been placed in secure observation status (one on one), during the annual compliance review period. Two of the seven interviewed youth stated being on suicide observation and for every occasion, each youth was observed by staff at all times.

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

The center has a policy and procedures to address the use of suicide precaution observation logs contained in the center's facility operating procedures (FOPs) – Suicide Prevention Plan and Suicide Prevention Services. All seven reviewed youth records contained the suicide precaution observation log as each youth was deemed at risk upon admission. A review of the precaution observation logs verified the logs were maintained for the duration of the youth on this status and signed by each shift supervisor and a mental health clinician. Six of the seven logs had the required observation entries. One of the seven precaution observation logs reviewed was missing a required observation entry. This caused the observation interval to exceed the thirty-minute requirement on this instance and the discrepancy was noted by the licensed mental health counselor (LMHC). All seven youth interviews indicated staff were always with them while they were on suicide precautions.

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

The center has a policy and procedures to address staff training in suicide prevention. According to Florida Administrative Code, all staff who work with youth must receive six hours of annual training on suicide prevention and implementation of suicide precautions. A review of seven staff in-service training records and thirty-two staff pre-service training records revealed all staff received the required six hours of suicide training and all training was documented in the Department's Learning Management System (SkillPro). A review of the center's mock suicide drill documentation verified the center conducts drills monthly on each shift, well exceeding the quarterly requirement. A review of the mock suicide drills sign-in participation sheets during the annual compliance review period, confirmed all staff who have direct contact with youth participated in at least one quarterly drill on a semi-annual basis. Staff who are not present

during a mock drill can review the drill scenario and procedures, as a copy is maintained in the shift logbook. A review of seven staff interviews indicated they were aware of the location of the suicide response kits indicating they are located in master control, medical, and the officer area in each wing.

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

The center has a policy and procedures to address the crisis intervention process. The crisis intervention plan outlines how staff are to respond to youth in crisis incidents and covers the notification and alert system, means of referral to include self-referral, communication, supervision, documentation, and review. This plan reinforces the importance of responding to youth in crisis in the least restrictive means possible, insuring the protection and safety of youth and others, while maintaining control of the center. This plan was approved on July 29, 2019 by the superintendent and the designated mental health clinician authority.

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

The center has a policy and procedures to address the emergency care plan. This plan includes the immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment under Florida Statute 394 (Baker Act), transport for emergency substance abuse assessment and treatment under Florida Statute 397 (Marchman Act), documentation, training, and review process. A copy of the emergency care plan is available in the superintendent’s office, medical clinic, mental health office, and the briefing room. The emergency care plan was approved by the designated mental health clinician authority (DMHCA) and the center’s superintendent on July 29, 2019.

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

The center has a policy and procedures to address the process for responding to, de-escalation, and intervention services for youth in crisis. The center's designated mental health clinician authority (DMHCA) advised there were not any incidents during the annual compliance review period requiring the completion of a crisis assessment. A review of all Central Communications Center (CCC) reports verified there were no crisis assessments reported during the review period. The DMHCA advised if there were an incident requiring a crisis assessment, it would be entered in the Department's Juvenile Justice Information System (JJIS) and staff would follow the facility operating procedures (FOPs), the mental health crisis intervention plan, and mental health crisis intervention services. The mental health crisis intervention plan and mental health crisis intervention services outlines the responsibilities of the juvenile justice detention officer, mental health, and administration which the plan contains the emergency contact numbers in the event of an incident requiring crisis assessment.

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

The center has a policy and procedures, as well as an emergency care plan, addressing the process for handling youth who are believed to be a danger to themselves or others, due to mental illness or substance abuse. During the annual compliance review period, the center had three instances where the Baker Act was utilized. Each of these three youth were inactive; however, the center provided copies of the documentation for each case. All three records indicated each youth was placed on suicide precautions prior to being transported to the Baker Act facility and when re-admitted to the center. All three applicable records each contained a referral for a mental status examination, which was completed when each youth returned to the center. Each of the three youth mental status examinations were completed by a licensed or a non-licensed clinician acting under the direct supervision of a licensed professional.

Each of the three youth were placed on precautionary observation upon their return to the center from the Baker Act facility. The documentation provided for each of the three youth contained precautionary observation logs which all related to the Baker Act process. A review of the Department's Juvenile Justice Information System (JJIS) alert database revealed each youth had an alert for suicide risk. There was also information regarding each youth's Baker Act and other pertinent information in the alert system.

During the annual compliance review period, there were no instances where the Marchman Act was utilized.

Standard 4: Health Services

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

The center has a policy and procedures to address the designated health authority contract. Documentation revealed the center has a contractual agreement with Maxim Healthcare Services, Inc. to provide comprehensive medical, mental health, substance abuse, and psychiatric services at the center. A licensed physician serves as the designated health authority (DHA) and performs administrative duties. The DHA holds an unrestricted clear and active license which meets all requirements for independent and unsupervised practice in the State of Florida. The DHA's license expires on January 31, 2021 and has specialty training in internal medicine. The DHA is contracted to be on-site once a week for a minimum of five 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 in comparison with the center's timesheets found the DHA was on-site in accordance to contractual requirements with one exception. The DHA did not provide services between 09/07/2019 to 09/20/2019 due to a reported illness. The DHA did have a back-up, who if needed, would have responded to any medical emergencies and provide coverage. When the DHA is on vacation or has a scheduled absence, Maxim Healthcare Services provides for back-up coverage. Maxim provides a medical doctor (MD) who is electronically available for acute medical concerns, emergency care, and coordination of off-site care, twenty-four hours a day, seven days a week. The DHA is responsible for communication with center's staff regarding medical needs of the youth. The DHA was not available to interview.

An extensive interview was conducted with the registered nurse (RN) manager and the advanced practitioner registered nurse (APRN) who confirmed the role of the DHA. The APRN holds an unrestricted clear and active license which meets all requirements for independent and unsupervised practice in the State of Florida and expires on July 31, 2021. The APRN has a collaborative practice protocol in place filed with the Department of Health and approved by the DHA. The APRN specialty certification is from the American Academy of Nurse Practitioners as a Pediatric and Family Nurse Practitioner and is on-site twice a week, Mondays and Wednesdays. APRN hours are posted on the wall outside of medical and lists the schedule as Monday and Thursday. An interview with the APRN reflected a collaborative practice protocol is maintained and the APRN is on-site weekly. The APRN reported assisting with sick calls and episodic events including referrals and coordination of off-site care, training, periodic evaluations, and comprehensive physical assessments. The licenses of all medical professionals at the center were reviewed and found to be valid and current.

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 policy and procedures to address all health-related procedures and protocols utilized at the facility. Documentation revealed the designated health authority (DHA) has signed and updated all the written treatment protocols and Facility Operating Procedures (FOPs) on

07/21/2019. The DHA updated all nursing protocols and signed on 08/31/2019. All the current nursing staff reviewed, signed, and dated a cover page on all FOPs, treatment protocols, and other procedures as listed signifying they have read the FOPs and any new health-related Department policies.

An annual compliance review of all FOPs was also completed by the superintendent on various dates in July and August 2019. This is demonstrated by a signature and date of the DHA and the center's superintendent on each FOP. The treatment protocols for the trained non-healthcare providers was updated by the DHA in August 2019. There is documentation the non-healthcare staff reviewed and had annual training in accordance with these 2019 protocols. All newly employed healthcare personnel received a comprehensive clinical orientation to Department's healthcare policies and procedures, given by a registered nurse (RN). The reviewed FOPs for psychiatric services and psychotropic medication management documented a review by the psychiatrist on July 31, 2019.

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

The center has a policy and procedures to address the completion of the Authority for Evaluation and Treatment (AET) or limited Consent for Evaluation and Treatment for youth in the custody of the Department. A review of seven youth individual healthcare records (IHCRs) reflected four of the seven records contained a completed AET signed by the parent/guardian. One youth's AET was signed by a Department of Children and Families (DCF) representative. One youth's AET was signed by a parent/guardian whose youth was in DCF custody. One youth's AET was ordered by the court. Each of the youth's AETs were completed prior to each youth receiving care for this admission and witnessed by a Department of Juvenile Justice (DJJ) representative. No parent/guardian refused to sign an AET.

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

The center has a policy and procedures to address parental notification and consent. A review of seven youth individual healthcare records (IHCRs) found documentation in all records for parental notification. None of the reviewed IHCRs were applicable for over-the-counter (OTC) medications or vaccinations not covered by the Authorization of Evaluation and Treatment (AET). No Religious Exemption from Immunization forms were submitted since the last annual compliance review. Two youth received off-site care. The first youth received off-site care for emergency care. The second youth received off-site care for prenatal care. In each record, the supported nursing staff notified each parent/guardian by telephone and in writing. Five youth were applicable for parent/guardian notification to obtain consent for the prescription of new psychotropic medications and/or adjustments or discontinuations to existing medications. Supporting documentation in each applicable IHCR confirmed telephone consent was obtained prior to initiating or making changes to psychotropic medications and written notification in the form of the acknowledgement of Receipt of Clinical Psychotropic Progress Note (CPPN) was forwarded to the parent/guardian by way of certified mail and included the third page of the CPPN.

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

The center has a policy and procedures to address the screening of youth for healthcare concerns, upon admission. Seven youth individual healthcare records were reviewed and each of the youth were screened upon admission for healthcare concerns. This was completed utilizing the standard Medical and Mental Health Admission Screening form on the date of admission. All seven were completed by a juvenile justice detention officer (JJDO) and signed by a supervisor. All the forms were reviewed by a licensed nurse within twenty-four hours. In addition, each had a Medical/Mental Health Screening form completed on the day of admission entered into the Department's Juvenile Justice Information System (JJIS) electronic medical record (EMR). During an interview, the superintendent confirmed a licensed nurse completes the healthcare admission process.

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

The center has a policy and procedures to address orientation of all youth to the general process of healthcare delivery of services. Seven youth individual healthcare records (IHCRs) were reviewed for youth orientation to healthcare services. Each reviewed IHCR included documentation to support each youth received a general healthcare orientation within twenty-four hours of their admission to the center. The healthcare topics included access to medical care, sick call process, emergency situations, medication process, right to refuse care, what to do in case of sexual assault or attempted sexual assault, non-disciplinary role of healthcare staff, a review of healthcare contacts, and the role of the healthcare providers. The facility operating procedures (FOP) contract on Health Education Topics were reviewed.

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

The center has a policy and procedures to address notification of the designated health authority (DHA) or designee when youth admitted requires emergency care or routine notification. Documentation revealed four of the seven reviewed youth individual healthcare reports (IHCRs) supported the DHA was notified within twelve hours of admission for youth with a chronic medical condition, psychotropic medication, or medical concern. One youth was not applicable. None of the reviewed youth IHCRs were applicable for emergency care upon their admission to the center. Four youth was admitted on prescribed psychotropic medications and the DHA was notified, as required. Each applicable youth was referred to the advanced practitioner registered nurse (APRN) or the DHA. During an informal interview, the superintendent reported the nursing staff and APRN complete the healthcare admission screening.

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

The center has a policy and procedures to address the completion of the Department Health-Related History (HRH) form. Documentation revealed seven youth individual healthcare records were reviewed for containing a current standardized Department (HRH) form which were completed for all youth admitted into the physical custody of the center. All seven HRH forms were completed by a licensed nurse within seven days of admission and were completed prior to or at the same time as the completion of the Comprehensive Physical Assessment (CPA).

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

The center has a policy and procedures to address the completion of the Comprehensive Physical Assessment (CPA) form for all youth admitted to center. Seven youth individual healthcare records were reviewed for containing a completed CPA form, either new or reviewed, for each youth admitted into the physical custody of the detention center. All seven CPAs were completed or reviewed within seven calendar days of admission. There was a current CPA, at the time of admission for all seven youth. Four youth had existing CPAs reviewed and the remaining three youth had a new CPA completed. Each of the CPAs was completed or reviewed by the advanced practitioner registered nurse (APRN). Each of the youth received tuberculosis (TB) screening within seventy-two hours of admission. Three of the seven IHCRs documented a focused evaluation at readmission. All seven CPAs included the medical grade and required marks for each field of the examination. Any areas not completed were indicated as deferred by clinician. There were no applicable youth with any symptoms of active TB in the center at the time of the annual compliance review. The Department's Problem List was updated for each, as required.

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

The center has a policy and procedures ensuring each youth is provided the opportunity to receive counseling, testing, and treatment for human immunodeficiency virus (HIV). Seven youth individual healthcare records (IHCRs) were reviewed and each of the seven youth were clinically screened for sexually transmitted infections (STIs) on the day of admission. Three of the seven youth were referred to the designated health authority (DHA) or advanced practitioner registered nurse (APRN) for further evaluation. The results of tests are noted on the Infectious and Communicable Disease (ICD) form located in the IHCR. Rescreening is conducted, if the sexually active youth has been out of physical custody for over thirty days. Referrals are documented on the STI form and/or the progress notes. All three youth had testing documented in the progress notes and results filed in the lab section of the record.

The center also maintains an agreement with and utilizes the Manatee County Health Department for HIV counseling and testing. All seven reviewed youth IHCRs supported each

youth was offered HIV screening/testing. Three of the seven youth consented while four did not consent, as documented on the Department's Human Immunodeficiency Virus Antibody Test Youth Consent form. HIV results are directly accessed by the youth during the day of testing. The youth are given a card to call for their results. The center has discontinued the process of securely sealing the results in an envelope marked "confidential" and filed in the applicable youth's IHCR. The center also maintains a HIV and STI testing log. Reviewed documentation in each applicable youth's IHCR confirmed pre-test counseling and post-test counseling was provided by the University of Miami's Hospital. Seven interviewed youth each reported they can request a HIV test.

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

The center has a policy and procedures to address the sick call process and response time for all youth in the center. Documentation revealed all youth at the center can make sick call requests and have their complaints treated appropriately through the sick call system. The system is computer generated starting with the youth requesting from a staff member to be seen at sick call. Direct care staff enter sick call requests, generated by the youth into the Facility Management System (FMS). This entry then generates a notice to the nurse for a timely review. The center has a back-up procedure for notification to the nurse in situations when FMS is unavailable. There are regularly scheduled hours for the youth to be evaluated by a licensed nurse, daily from 9:00 a.m. to 11:00 a.m. and throughout the day as needed. Only a licensed nurse conducts sick call. None of the seven reviewed youth individual healthcare records (IHCRs) presented similar sick call complaints three or more times within a two-week period which would have required a referral to the medical doctor (MD) or advanced practitioner registered nurse (APRN). No youth complained of any severe pain which staff was unfamiliar. Seven staff were interviewed regarding who conducts the sick call process. Seven staff reported sick call was conducted by the nurse. Sick call forms were observed on the living module during the center tour and sick calls at the center are entered into FMS by direct care staff. Two additional youth records were provided for confinements. Both youth were questioned daily for sick call/health complaints and documented in each of the IHCRs. An observation of the sick call process was observed during the week of the annual compliance review. The youth was escorted by the juvenile justice detention officer supervisor (JJDOS) to the medical clinic. Verbal consent was obtained from the youth prior to the observation. The youth signed the sick call request log prior to being examined. The youth was screened by the registered nurse (RN). The RN followed all elements outlined in accordance to the Department's policy. The youth was examined in a private area and the JJDOS was seated near the examination cubicle. Seven youth were interviewed regarding the sick call process. Two youth stated they can be seen within one day. Five youth stated they never requested a sick call. Seven interviewed staff indicated sick call is conducted by nursing staff and the doctor.

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

The center has a policy and procedures to address episodic care and first aid care. Documentation revealed the center has a comprehensive process in place for the provision of episodic care and first aid. Medical and dental emergency care is available including emergency medical services (EMS), twenty-four hours per day. Episodic care is documented by healthcare staff using a standard narrative. Trained non-healthcare staff can provide treatment when a nurse is not present, utilizing the required Department's form for on-site healthcare by non-healthcare staff. There is an on-site tracking log for all episodic care. The individual healthcare records (IHCRs) of seven youth for Episodic Care Log for the past six months was reviewed and compared with all on/off-site events from the IHCR sampled. Five of the seven youth were applicable. Each youth's records were applicable for and contained healthcare staff documentation of episodic care. Each youth's episodic events were applicable and documented education and/or instruction to each youth. Four youth were applicable for plans for follow-up care and were placed on the alert list. Three received parental notification. Each youth record of episodic care, first aid or emergency care conformed to professional standards, contained subjective, objective, assessment, and plan (SOAP) elements and was entered on the episodic care log. There was one exception on 12/12/20, one youth episodic care was not recorded on the episodic log.

First aid kits are in each living area, classrooms, master control, kitchen, and one is assigned to each vehicle but is stored in master control until the vehicle is used. The first aid kits are checked monthly by administrative staff to ensure all required contents are present and have not reached their expiration date. Supplies are inventoried and restocked when the seal is broken, items are used, or when items expire. The designated health authority (DHA) has identified and approved the required contents for all the first aid kits. An observation of all first aid kits contained at minimum the DHA required contents and none of the contents were expired. First aid kits were randomly selected and inspected for expired items and none were found. The center maintains two automated external defibrillators (AED) located in the medical clinic and master control with procedures located in the AED box as well as audio instructions. The nursing staff checks the AEDs weekly to ensure the battery and pads are operable. A review of the AEDs check log for the past six months verified this practice. During the annual compliance review, observations were conducted while the nurse confirmed a green operating light and checked the expiration dates of the battery and pads for the AEDs. The expiration date for the batteries on both AEDs are checked by an outside contractor. The pads expire on March 28, 2021. The center conducts emergency drills and emergency drills including CPR/AED at least quarterly on each shift. Emergency and cellular telephone numbers are in master control and the medical clinic and is accessible to all staff. A review of emergency drills for the past six months verified the center conducted drills, as required. A review of seven staff's training records supported each staff received the required training on emergency care and the supervisory staff received all required training including training on epinephrine auto-injector. Only healthcare and trained supervisory non-healthcare staff can administer the epinephrine auto-injector for youth requiring administration, when applicable. Seven interviewed staff each reported they can call 9-1-1, if necessary.

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

The center has a policy and procedures to address timely referrals and the coordination of off-site medical services. Seven youth individual healthcare records (IHCRs) were reviewed, of which, three youth were applicable. Two youth required off-site care and one youth required off-site care from a hospital emergency room. The designated health authority (DHA) was notified for each event. The center provided timely referrals and coordination of medical services to off-site healthcare providers and documented such services, as required by the Department. A Summary of Off-Site Care form was used for all three instances. Discharge documents were filed in each record and reviewed by the DHA. The DHA signed/initialed all off-site care findings, instructions, and information. All follow-up testing, referrals, and appointments requiring documentation were tracked and each youth received appropriate, timely follow-up care, as needed.

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

The center has a policy and procedures to address regularly scheduled evaluations and necessary follow-up for youth with chronic conditions. Seven youth individual healthcare records (IHCRs) were reviewed and seven youth were applicable for having a chronic medical condition and/or taking prescribed medications. Two youth were classified with a body mass index (BMI) greater than thirty. None of the youth were applicable for taking anti-tuberculosis medication. One youth was pregnant. Seven youth were placed on the chronic condition and alert lists. The center's youth who have chronic conditions receive regularly scheduled evaluations and necessary follow-up but youth are not normally at the center for more than ninety days. None of the reviewed seven youth were at the center more than ninety days. Periodic evaluations are conducted prior to renewal of any prescription medication. None of the youth reviewed have a communicable disease.

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

The center has a policy and procedures to address all medication and pharmaceutical products are stored safely, accurately, and in accordance with state, federal, and industry standards. Youth who take medication while in the custody of the center are administered medications by healthcare professionals. Supervisors are trained in medication administration and administer medication in the absence of healthcare professionals. The center maintains a list of staff permitted to have access to the clinic and medications.

A review of seven youth individual healthcare records (IHCRs) reflected six youth were prescribed psychotropic medication prior to admission to the center. Each IHCR had the required designated health authority (DHA) notification and verification with parent/guardian,

when applicable. Three of the six youth medications were either modified or additional psychotropic medication was prescribed. The remaining one of the seven youth had medication brought into the center by their parent/guardian and the IHCR properly documented the medication. All medication was stored in a container intact with the original label and were approved medication. When applicable, the physician or psychiatrist was contacted to obtain consent and an order to resume the medication until a diagnostic psychiatric interview was conducted. There were no applicable over-the-counter (OTC) medications not listed on the Authority for Evaluation and Treatment (AET) form administered. There were no undocumented explanations for lapses or errors in administered medication in any of the reviewed records. One of the seven youth required parenteral medication while in the center and the medication was administered by a trained and licensed healthcare staff. The center utilizes the Department's standard Medication Administration Record (MAR) for each youth receiving either prescription medications or OTC medications. A review of seven youth IHCRs verified medication administration was documented on the Department's MAR which includes the youth's name, Department identification (DJJID) number, date of birth, allergies, precautions, medical grade, medical alerts, youth's current picture, start and stop dates, and monitored side effects. Further review of the MARs indicated all seven youth received their medication as prescribed and staff and youth initialed the MAR after the administration of the medication.

During an interview with the registered nurse (RN), it was reported the center utilizes the RX Destroyer for the disposal of medications. Seven youth interviews confirmed documented procedures of medication administration. The center maintains an agreement with a consultant pharmacist to provide a registered consultant pharmacist on-site once a month. The registered consultant pharmacist is jointly responsible for the disposal of controlled medications and narcotics. All other unused blister-pack medications are sent back to the pharmacy for a credit.

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

The center has a policy and procedures to address the management of medication and sharps inventory. The policy states a perpetual inventory and at least weekly inventory is completed for all sharps, bulk stock medications, and working stock medications. All medical equipment classified as sharps are securely stored inaccessible to youth. The policy states stock to be inventoried by using a routine perpetual inventory. A random inventory of three sharps was performed. The inventory matched the count for the items.

A perpetual inventory is utilized for all bulk stock prescription medication, bulk stock over-the-counter (OTC) medications, and working stock OTC medications. There is a weekly inventory count of all prescription and OTC medications. There is a procedure in place for inventory discrepancies. There was a randomly selected sample of three stock prescriptions, three bulk stock OTC medications, three controlled substances, and three working stock OTC medications. The count for each matched the inventory without any discrepancies.

Documentation revealed all prescription, OTC, bulk stock, working stock, oral, vaginal, and topical medications are stored in separate, secure areas which are inaccessible to youth. All medication is stored separately. Refrigerated medications are located separate from food storage. There is secure storage for all items considered sharps such as needles, syringes, scissors, suture removal kits, and intravenous catheters. This storage area is inaccessible to

youth. Narcotics and other controlled substances are stored behind two locks with two separate key access; the locked door to the clinic and in the locked medication cart. The detention center has a process for the destruction and disposal of expired or discontinued medications and detecting and responding to inventory discrepancies. Disposal of medication is done using a commercial product, approved by the Drug Enforcement Administration (DEA), Drug Bister disposal system and is used in accordance with state board of pharmacy and the DEA disposal plan.

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

The center has a policy and procedures to ensure proper procedures are followed to prevent the spread of infectious diseases or illnesses in the center. This policy addresses prevention, containment, treatment, and reporting requirements related to infectious diseases. The plan covers hand washing, childhood diseases, contagious illnesses, viral and bacterial diseases, tuberculosis (TB), hepatitis, blood borne pathogens, pediculosis, scabies, methicillin-resistant staphylococcus aureus (MRSA), food borne illnesses, bio-terror, and chemical exposures. Hepatitis B immunizations are available to all staff and staff are informed of the availability of the immunization upon hire. Staff have access to protective equipment and many were observed with medical gloves. The center did not have any incidents related to infection control during the annual compliance review period. The center also maintains an Exposure Control Plan/Infection Control Plan and was approved by the designated health authority (DHA) on July 30, 2019. Seven youth individual healthcare records (IHCRs) were reviewed for infection control education. All seven youth IHCRs documented the youth received infection control training within seven days of their admission to the center. 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. A review of seven staff's training records indicated each staff received pre-service and in-service training on the center's Exposure Control Plan/Infection Control Plan. There were no reportable incidents for which the local county health department, Centers for Disease Control and Prevention (CDC), and/or the Department's Central Communications Center (CCC) should have been notified since the last annual compliance review.

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

The center had one discharged youth's individual healthcare record available to review for pregnancy care. The youth was already diagnosed as pregnant. Prenatal care began immediately upon admission for the youth. The center commenced providing prenatal care at recommended intervals. Prenatal care is provided to the youth or the youth is referred to outside providers at recommended intervals. The designated health authority (DHA) was notified upon admission. The DHA and or advanced practitioner registered nurse (APRN) will provide a routine, focused medical oversight evaluation of the youth's pregnancy every thirty days, if the

youth is at the center for thirty days. The youth was discharged after a couple of days. The licensed professional healthcare staff and trained non-licensed healthcare staff will provide routine daily monitoring and observation for indications of pregnancy complications. There is a documented plan for post-birth psychological and physical care. The center's facility operating procedures (FOPs) are in place for care and treatment of pregnant youth. The center provides nutritious foods in enough quantities to meet the standards of the minimum daily allowances for pregnant youth. Each pregnant adolescent receives a training packet covering prenatal, post-partum, and parenting education including topics directly related to healthcare issues and medical risk for pregnant adolescents. Each pregnant youth's packet contains education on alcohol and drug usage, smoking, nutrition, sexually transmitted diseases, contraception, prenatal care, birthing process, postpartum care, basic baby care (feeding, diapering, bathing), child/infant development, and parenting skills. The licensed healthcare professional staff provides routine monitoring of the pregnant youth's nutritional and weight status during her pregnancy.

All non-healthcare staff involved in the supervision or treatment of pregnant youth receive appropriate education annually. Four of the seven in-service staff training records were for non-healthcare staff involved in the supervision or treatment of pregnant youth. All four had received the require annual training. The in-service training includes training on monitoring, observation, and, emergency care of the pregnant youth. A licensed nurse provided in-service education on female healthcare.

Standard 5: Safety and Security

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

The center has a policy and procedures to address active supervision of youth. During the annual compliance review, youth supervision was observed each day of the review. Youth and staff observations were conducted on the modules, in the classrooms, in the cafeteria, in the transportation area while preparing for transport, and upon returning from a transport. Line movements were observed throughout the facility throughout the week. There were always two or more staff with each group of youth. Detention staff maintained continuous sight supervision of all youth in their assigned area. The interactions between staff and youth demonstrated active supervision. Staff were positioned in the areas and line movements supported active supervision. The juvenile justice detention officers and master control operators communicated to receive authorization for all movement within the center. The master control logbooks for the past six months were reviewed and reflected there was documentation to support head counts were being conducted on a consistent basis during the beginning and ending of each shift and prior to youth movement. Seven staff were interviewed and each responded they think there are enough staff at the center to provide for the safety and security of the youth and staff.

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 each check in real-time, manually or electronically. Documentation must include the actual time of each visual observation and initials of the staff conducting the check; pre-printed times are not acceptable.

There shall be no obstructions (e.g., clothing, memos, pictures) over windows and areas where direct line of sight is needed.

If an officer, in the course of completing visual observation, is unable to see the youth or any part of the youth's body, the officer shall, with the assistance of another officer, open the door to verify the youth's presence.

The center has a policy and procedures to address ten-minute checks. The facility has fifty-eight cameras in which all are operational. All recordings are stored for thirty days using a digital video recording system. All ten-minute checks are completed using a wand system. Staff tap a metal pin located on the door of each sleeping room with the wand. The checks are recorded with the date, time, and staff identification. Video tapes were observed for the completion of ten-minute checks by staff. The review of the tapes found staff from the first, second, and third shifts conducted ten-minute checks, as stipulated in the center's policy and procedures. The checks were documented in real time. Seven interviewed staff stated ten-minute checks are conducted on youth when they are placed in their rooms for sleeping or 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 policy and procedures to address census, counts, and tracking. Daily observations determined census counts of the youth were taken. The juvenile justice detention officers (JJDOs) in collaboration with master control, document the head counts at the beginning and end of each shift, emergencies, routine group movement, population change, and random head counts. This is accomplished by the JJDOs utilizing two-way radios. A review of the center's logbooks determined head counts, youth movements, and daily census were

documented, as required. A random sample of seven staff were interviewed and each reported emergency counts are conducted when a youth is missing, not visible, or after a major disturbance. Documentation did not include youth not physically present. A random sample of seven staff were interviewed and each reported counts are conducted at the beginning and end of each shift. If the count is not correct, master control will request a recount.

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

The center has a policy and procedures to address logbooks. The center maintains separate logbooks in master control and for each living module as well as a logbook for visitors and a logbook for contracted staff. A review of logbooks for the previous six months revealed each logbook was bound with numbered pages, entries were made with blue or black ink and included the date, time of the event, or incident with the name of the staff and youth involved as well as a brief description of the event, and the initials of the staff making the entry. Reviewed documentation for the past six months revealed the safety and security of the facility including medical, special needs, and mental health alerts were highlighted. Reviewed logbooks reflected all errors are struck through with a single line and are dated and initialed by the person correcting the error. Reviewed master control logbooks included emergency situations, incidents, fire and escape drills, population counts at the beginning and end of each shift, group movements, admissions, and releases. When a youth is placed in confinement; the time they are released from confinement and any time a youth is placed on precautionary or secure observation and the time the precaution ended was also documented in the logbook.

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

The center has a policy and procedures to address logbook reviews. Logbook entries were reviewed for each living area for the past six months. The center utilizes three living areas. Documentation determines the superintendent and the captains review the logbooks weekly. Those entries were documented in blue ink. The juvenile justice detention officer supervisors reviewed the facility logbook maintained at master control for each shift daily along with the logbooks maintained in the living area, these reviews were also recorded in blue ink. The juvenile justice detention officers in charge of the living area record their reviews using black ink.

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

The center has a policy and procedures to address key control. An observation of the center's key control procedures was conducted. Each key was placed on a tamper-resistant key ring. The center's emergency keys were maintained within master control. Only the superintendent, captains, supervisors, and the maintenance staff have access to the center's emergency keys as the superintendent reported and observations confirmed. The observations conducted determined the emergency keys provide the action of going out and leaving out through the exterior doors, providing access to evacuation areas. The supervisors for each of the three shifts maintain the inventory for all keys. The center documents the shift, the ring number, the number of keys on each ring, capability of each key, and who the key is issued to. The center also documents the date and time the key was issued and returned. Seven staff records were reviewed and each staff had key control training. An observation of staff during daily activities was conducted. Observations confirmed juvenile justice detention officers (JJDOs) were

responsible for the security of their issued keys and accounted for their issued keys during their work schedule. The key identified also matched the key they signed out. The issued keys were always on the staff. Youth were not observed to have control of the keys at any time during the annual compliance review. There were no accounts of the center's keys leaving the grounds during the scope of the annual compliance review period. Each day of the review, the annual compliance review team personal keys were observed to be secured in master control prior to entering the facility. The center's policy delineates the proper key control requirements and training for staff. The policy requires staff to report all missing or lost keys immediately upon gaining knowledge. Seven interviewed staff reported the center's daily process for tracking keys include using the key log, a chit, and utilizing master control to properly secure and store personal and visitors' keys. Staff also reported the center's practice is to keep inventory of keys, prohibit youth from accessing keys, replacing damage keys, and searching the facility and youth for any reported missing keys. Three random samplings of keys assigned to JJDOs working the floor during the review confirmed they were knowledgeable of what the tags represented on each key ring and the number of keys assigned matched the number of keys on the ring.

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

The center has a policy and procedures in place for transportation and operation of Department vehicles. The center has a total of eight vans used to transport youth. Two of the eight vans were surplus in January 2020 and are no longer used. All vehicles were observed to have the appropriate number of seat belts, a seat belt cutter, a window punch, a fire extinguisher, and a first aid kit with approved items. An observation of post-transport activities was completed during the week of the annual compliance review. Observations reflected the vehicle was searched for contraband by staff after the transport. Staff searched the youth after removing the youth from the van. Youth and staff were interviewed and stated they used their seatbelts. The transport staff were in possession of the vehicle's logbook and a binder containing the Vehicle Log, gas credit card, and vehicle registration. These items are stored in master control when not in use. A security check was conducted of all vehicles and confirmed the center's vehicles were locked when not in use. Reviewed documentation found each vehicle is inspected prior to transport. Reviewed documentation supported the maintenance mechanic completed weekly and monthly vehicle checks on each vehicle. A review of the vehicle maintenance invoices confirmed all vehicles received an annual inspection within the previous year, as required.

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

The center has a policy and procedures in place to ensure all tools and equipment related to maintenance and the kitchen are properly stored, inventoried, and maintained. A visual observation of the tool shed for maintenance was conducted. Tools were stored in a locked shed, inside full-length cabinets which is inside a locked and fenced-in area on the back of the

detention center. The area is locked when not in use and no youth have access to any tool, nor the area. This area is off-limits to detention staff as well, with only the maintenance mechanic and center administrators having authorized access to the area. The tools were found to be properly identified as Department of Juvenile Justice property and in a designated place using a shadow board. The center maintains a perpetual inventory of all tools. The superintendent reviews the inventory and signs off on the inventory monthly. Interviews with administrative staff indicated any broken or defective tools would be removed for repair or replacement. This would be immediately reported to the superintendent with an incident report also being completed.

The kitchen also maintains sharp tools in a locked cabinet attached to the wall in the kitchen. Food service personnel are responsible for the inventory and security of knives and other kitchen items. There was one instance of a tool missing from the kitchen during the last six months. The tool, a four-inch green handled paring knife, is routinely stored in the locked cabinet of the secure area and restricted from any youth access. The missing tool was reported and according to the report a diligent search was conducted for the knife, closed circuit video recordings of the area were reviewed as well but the knife was never recovered but replaced. The incident was reported to the Central Communications Center within the time frames allotted by the Department. Staff maintains a perpetual inventory of kitchen tools and counts are documented at the beginning of each day, midday, and at the end of the day. Reviewed inventory sheets reflected all tools were accounted for except for the one discrepancy. Two of the seven interviewed staff stated they were not knowledgeable of the practice for loss or damaged tools, but stated they do not utilize any tools.

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

The center has a policy and procedures addressing youth access to tools and other cleaning items. Youth are not permitted to use tools, kitchen, or medical equipment. All such items are secured and inaccessible to youth. Seven interviewed youth stated they may only use mops and brooms for cleaning purposes. This practice was confirmed in a review of seven staff interviewed. Staff stated when youth use mops and brooms, they are under staff supervision.

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

The center has a policy and procedures to address the inventory of flammable, toxic, caustic, and poisonous items. Flammable, toxic, caustic, and poisonous items are maintained in secured areas with access limited to maintenance and administrative staff only. Safety Data Sheet (SDS) logbooks are maintained in the same location the chemicals are stored. Inventories of flammable, toxic, caustic, and poisonous items are maintained by the center's maintenance mechanic. The SDS and inventories were compared for the items on-site and were found to be accurate and complete.

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

The center has a policy and procedures to address toxic materials which prohibits youth access to flammable, toxic, caustic, or poisonous items. Youth are not permitted to access any materials which are flammable, toxic, caustic, and/or poisonous. There were no toxic materials were observed to be stored in the center in any place accessible to youth during the week of the annual compliance review. Six of the seven interviewed youth each responded they do not use cleaning agents such as bleach, toilet, or window cleaner; however, one youth stated they have used bleach but one of the staff handled the item. Seven interviewed staff each responded youth are not allowed to clean with toxic, flammable, or poisonous substances.

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

The center has a policy and procedures to address proper use, storage, and disposal of flammable, toxic, caustic, and poisonous items. The plan addresses the procedures to follow in the event of a chemical leak or spill. An interview with the center's maintenance mechanic confirmed materials are disposed of by the policy in place. The kitchen has a grease trap to dispose of grease which is disposed through a contracted vendor. Medical biohazardous waste is disposed of with a contracted vendor. The interview with the maintenance mechanic further confirmed there were no chemical spills or leaks at the center within the annual compliance review period.

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

The center has a policy and procedures to address confinement under twenty-four hours. Forty-five confinement reports were reviewed from the past six months. In all forty-five reports and with observation confirmed confinement room windows were free of obstruction and did not contain any non-fixed items. All youth in the reports were afforded living conditions approximating those available to the general population and had no contact with the general population while engaged in any activities. A review of confinement reports found six of the thirty-six reviewed reports, the juvenile justice detention officer supervisor (JJDOS) did not complete the confinement review within the required two-hour time frame. A review of forty-five youth's visual observation reports indicated three were missing and staff failed to write their initials in nine instances when documenting the youth's behavior while in confinement. Five ten-minute checks were late by several minutes of each check.

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

The center has a policy and procedures to address confinement over twenty–four hours. Three eligible confinement reports for confinements over twenty-four hours were reviewed. The confinements over twenty-four hours were approved by the center's superintendent or designee. Confinement beyond twenty-four hours after placement was approved by the regional director or designee by email for the three confinements. The juvenile justice detention officer supervisor (JJDOS) completed reviews evaluating the confinement every three hours in two of the three confinements. One confinement had a four-and-a-half hour gap between supervisor reviews. One of the three confinements did not include a review by a mental health professional every twenty-four hours, as required. Two of the three confinement visual observation reports could not be located by the program staff. All three confinements were approved by the regional director, as required. None of the confinements extended beyond three days; therefore, no confinement hearings were required. Based on the small sample size used to determine this rating, the Office of Detention Services is not in agreement with the rating. Additionally, this rating is not a reflection of the facility as a whole.

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

The center has a policy and procedures to address Continuity of Operations Planning (COOP). Annexes were attached to the COOP plan. The COOP plan was reviewed and approved within the required time frame. The center had documentation of conducting at least two drills each year. Staff completed a drill form which documented dates and times of drills, type of drill, shift, and staff participants. The written scenarios were attached to the drill forms and all the documentation was maintained in a COOP drill binder. Drills were also documented in the logbooks.

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

The center has developed, implemented, and maintained an escape prevention plan incorporating the Department's established policies and procedures regarding escapes. The center conducted escape drills, documented quarterly, and all staff were trained annually on escape prevention. Drills were maintained in a binder with the scenarios and required documentation including logbook entries when they were conducted. Four of the seven interviewed staff stated they have participated in an escape drill. The remaining three staff stated they did not participate in an escape drill.

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

The center has a policy and procedures to address fire drills. The policy implemented a disaster preparedness plan and fire prevention plan. Monthly fire drills are documented and maintained in a binder. The drills are conducted under varied conditions and on each shift. The procedures have been approved by the local fire official. Documentation was present in the logbook for the fire drills and all fire extinguishers were up-to-date and inspected annually. Six of the seven interviewed staff stated they have participated in a fire drill. The remaining one staff stated they did not participate in a fire drill. All seven staff stated fire drills occur monthly. Six of the seven interviewed youth stated they have been instructed on what to do in case of a fire and have participated in fire drills. The remaining one youth could not remember.