STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT
PROGRAM REPORT FOR

Okaloosa Regional Juvenile Detention Center
Department of Juvenile Justice
(State-Operated)
4448 Straightline Road
Crestview, Florida 32539

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

PROMOTING CONTINUOUS IMPROVEMENT AND ACCOUNTABILITY
IN JUVENILE JUSTICE PROGRAMS AND SERVICES

Rating Definitions

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

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

Review Team

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

Tara Frazier, Office of Program Accountability, Lead Reviewer (Standard 1)
Regina Berry, Escambia Regional Juvenile Detention Center, Captain (Standard 5)
Reba Chavis, DJJ Probation, Circuit 1, Juvenile Probation Officer Supervisor (Standard 2)
Jill Foy, Office of Program Accountability, Regional Monitor (Standard 4)
Patrick McKinstry, Office of Program Accountability, Regional Monitor (Standard 3)

Program Name: Okaloosa Regional Juvenile Detention Center
Provider Name: State Operated
Location: Okaloosa County / Circuit 1
Review Date(s): September 25-28, 2018

MQI Program Code: 828
Contract Number: N/A
Number of Beds: 30
Lead Reviewer Code: 166

Methodology

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

Persons Interviewed

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

Documents Reviewed

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

Surveys

- 5 # Youth
- 3 # Direct Care Staff
- 3 # Other: JPOS, FTC, Superintendent

Observations During Review

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

Comments

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

Standard 1: Management Accountability
Detention Rating Profile

Indicator Ratings

Standard 1 - Management Accountability		
1.01	* Initial Background Screening	Satisfactory
1.02	Five-Year Rescreening	Satisfactory
1.03	Staff Code of Conduct	Satisfactory
1.04	* Incident Reporting	Satisfactory
1.05	Protective Action Response (PAR)	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	Classification of Gang Members	Satisfactory
2.05	Notification of JPO Circuit Gang Rep	Satisfactory
2.06	Admission of Youth Personal Property	Satisfactory
2.07	Storage of Youth Personal Property	Satisfactory
2.08	Release	Satisfactory
2.09	Release of Youth Personal Property	Satisfactory
2.10	Release of Meds, Aftercare Instructions	Satisfactory
2.11	Review of Youth in Secure Detention and Home Detention	Satisfactory
2.12	Daily Activity Schedule	Satisfactory
2.13	Adherence to Daily Schedule	Satisfactory
2.14	Educational Access	Satisfactory
2.15	Career Education	Satisfactory
2.16	Behavior Management System	Satisfactory
2.17	* Unauthorized Use of Punishment	Satisfactory
2.18	Grievances	Satisfactory
2.19	Trauma-Informed Care	Satisfactory

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

Indicator Ratings

Standard 3 - Mental Health and Substance Abuse Services		
3.01	Designated Mental Health Clinician Authority (DMHCA)	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	Non-Applicable

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Standard 4: Health Services
Detention Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Detention Rating Profile

Indicator Ratings

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

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Strengths and Innovative Approaches

- Okaloosa Regional Juvenile Detention Center (ORJDC) has partnered with Eglin Air Force Base to provide mentorship for the youth in their care. Mentors come out to the center to mentor the youth in a variety of topics such as leadership and personal development. Due to the mentorship programs, the number of incidents has reduced when mentors are working with the youth.

- The center utilizes the Boys and Girls Club in Crestview as a safe place for the youth and mentors to continue working together after the youth is released from the center.

- Special events have been hosted at the center by the mentors from Eglin Air Force Base such as Flag Burning/Retirement ceremonies, K-9 demonstrations, and Prisoner of War/Missing is Action (POW/MIA) ceremonies. The center has also partnered with Healing Hoof Steps, an Equine Assisted Growth and Learning Association (EAGALA) certified program, in providing equine assisted psychotherapy/learning. It is a Tri-Team Approach using a licensed mental health counselor, an equine specialist, and horses. The first session was in January 2018, with a group of six youth participating. The equine therapy animals were brought to the center by the equine specialist.

Standard 1: Management Accountability

Overview

The center is a thirty-bed juvenile detention center located in Crestview, Florida. The center currently has one module (mod) housing females and one mod housing males. The center does have a third mod; however, no youth are currently being housed there. The center's master control room is centrally located with respect to the mods, allowing visibility of all youth. The center's administration staff consists of a superintendent, staff assistant, assistant superintendent, and training coordinator. During the annual compliance review, the center had nine vacancies, two other personal services (OPS) juvenile justice detention officers (JJDO) I positions, five JJDO I positions, one juvenile justice detention officer supervisor (JJDOS), and one JJDO II position.

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

Personnel records from sixteen staff, forty-one mentors, one volunteer, and six contracted staff were reviewed for initial background screenings. All background screenings were rated with an eligible status. All staff, excluding one mentor and two contracted employees, had an initial background screening completed prior to the hire/start date. According to the Facility Operating Procedures (FOP), mentors who assist or interact with youth on an intermittent basis for less than ten hours a month do not need to be background screened, which the one mentor would qualify. One contracted employee's hire date was August 29, 20118, background screening was completed on September 7, 2018, but did not actually start working at the center until September 18, 2018. The other contracted employee's hire date was July 20, 2018, background screening was completed on July 24, 2018, but did not actually start at the center until August 13, 2018. The Annual Affidavit of Compliance with Level Two Screening Standards was completed and submitted to the Department's Background Screening Unit (BSU) on January 3, 2018, meeting the annual requirement.

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

There were five employees eligible for a five-year re-screening. All five employees were re-screened prior to the anniversary date and rated with an eligible status. All screenings were completed no more than twelve months prior to the anniversary date.

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

The center has a code of conduct in place to ensure all communication and interactions between youth and staff are professional and respectful in nature. Since the center's last annual compliance review, three employees received disciplinary action. All three employees signed the code of conduct form prior to the disciplinary action taking place and those forms were located in each employee's records. All three employees received verbal reprimands for their attendance. Five youth were interviewed during the annual compliance review. All five youth said staff were respectful when talking to them or other youth. All five youth also responded they have never heard staff use curse words when speaking with them or other youth, as well as no threats toward them, or other youth, by staff. Overall, all five youth felt safe in this center. Five staff were interviewed during the annual compliance review. Four of the five staff reported they have never heard a co-worker use profanity when speaking with a youth, while the other staff stated they have heard it occasionally. All five staff reported they have never observed a co-worker use threats, intimidation, or humiliation when interacting with the youth. Finally, all five staff believe the working conditions in the center have been good over the past year. One of the staff reviewed received commendations and was Employee of the Month in May 2018.

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

The center had a total of twenty-nine incidents reported to the Central Communications Center (CCC) in the past six months. When the CCC is contacted by the center, it is by the supervisor or administrator when incidents meet the reporting guidelines. Five CCC reports, including one program disruption, three medical, and one youth behavior, were reviewed during the annual compliance review. One of the five of the CCC reports was not reported within the two-hour timeframe. The incident was called in two hours and twenty-six minutes late. Four of the five of the incidents were logged into the master control's logbook. After reviewing the internal incidents/grievances, there were no other incidents reportable to the CCC. The superintendent stated the center has received more medical complaints from the youth requiring them to take the youth off-site to seek medical care, resulting in a CCC report. The superintendent also reported, an increase in the number of staff injury as a result of the use of Protective Action Response (PAR). The superintendent is currently working with staff to equip them with better verbal de-escalation skills and perfecting staff's physical tactics, with the hope of increasing staff's confidence with working with the youth. If there is a situation with a youth the superintendent has added that a code be initiated, with the goal of preventing any physical intervention so staff can work as a team to de-escalate the situation.

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

The center had fifty-three Protective Action Response (PAR) incidents in the past six months. Five PAR incidents were reviewed during this annual compliance review. All five of the PAR reports were completed by the end of the staff member's workday and by all staff involved. None of the incidents resulted in a Level 3 response, therefore, a mechanical restraint supervision log was not required. None of the reviewed incidents resulted in serious injury to staff or the youth, so the Central Communications Center (CCC) was not notified. None of the youth involved in the incidents alleged abuse. All five of the reports were reviewed by all required parties within seventy-two hours, including a PAR instructor or PAR certified supervisor to determine if use of force was consistent with policy. A post-PAR interview was conducted with the youth within thirty minutes in all five incidents. None of the youth in these incidents needed a PAR medical review. The superintendent reviewed all five reports within seventy-two hours and made comments, the incidents were all conducted according to policy and curriculum. All PAR reports and post-PAR interviews are placed into the Department's Juvenile Justice Information System. After reviewing the internal incidents and grievances there were no other incidents classified as PAR. The center's PAR rate for the last quarter was 13.93, which is above the statewide PAR rate of 9.29. The superintendent stated there has been an influx of courtesy holds from other centers, as well as a change in the Florida Statue. Now when a youth is committed, the youth is placed in secure detention pending placement, where the youth tend to act out more because they seem to not care about the consequences of their actions. Finally, it was reported there has been an increase in the gang activity in the area, which causes some

rivalries inside the center between youth. All five interviewed staff stated they try to talk to the youth prior to using PAR or mechanical restraints.

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

Five staff records were reviewed for pre-service training and found all five staff were certified within 180 days of hire. All training was documented in the Department's Learning Management System (SkillPro). All of the staff received training/certification in Protective Action Response (PAR), cardiopulmonary resuscitation (CPR), Automated External Defibrillator (AED), first aid, mental health Services, substance abuse services, suicide recognition, prevention, and intervention, safety, security, and supervision (including emergency plans/procedures), Prison Rape Elimination Act (PREA), human trafficking, and the Department's facility operations (unit log, admissions, releases, and transfers) prior to having any contact with the youth. All five staff received training in essential skills, orientation, information security awareness, legal, Department of Juvenile Justice: The Organization, gang awareness, interpersonal/communication skills, and detainee behavior and consequences during phase one of training. Phase two training was completed at the academy and documented in SkillPro.

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

The center currently follows the in-service training plan which was signed and approved by the assistant secretary of detention services. According to the superintendent and the in-service training plan, staff are required to complete thirty-three hours of instructor-led courses and fourteen hours of SkillPro courses annually. Supervisors and administrators are required to take eight hours of supervisory electives within SkillPro. Five staff records were reviewed, which included two supervisory staff, for in-service training. All five staff received training/certification in cardiopulmonary resuscitation (CPR), Automated External Defibrillator (AED), first aid, suicide prevention (two hours of web-based instruction in the Department's Learning Management System (SkillPro) and four hours of instructor-led), and professionalism and ethics. Four of the five staff received the Protective Action Response (PAR) update. The fifth staff, the superintendent of the center, is the PAR instructor and her last certification was in 2016; therefore, was not required to have a PAR update at this time. All five staff completed well over the twenty-four hours of required annual training. Each of the two the supervisory staff completed eight hours of supervisory training in management, leadership, personal accountability, employee relations, communication skills, and fiscal. All of the training was documented in SkillPro. According to the superintendent, along with annual SkillPro and instructor-led courses, additional training is provided during superintendent meetings.

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

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

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

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

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

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

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

A review of five youth records was conducted, which included five medical, two allergy, five diet, two medication, one no strenuous activities, three suicide, and one gang activity alerts. All three suicide alerts were addressed by the center's licensed mental health care staff and downgraded and closed in Department's Juvenile Justice Information System (JJIS). All critical and special alerts were entered into JJIS. All alerts were verified prior to being placed into JJIS, if not automatically generated by the system. Any medical related alert was entered by and managed by the center's medical staff. A review of the JJIS alert system and logbooks was conducted and no issues were found. All five staff interviewed stated management informs them about issues within the center during staff debriefing. Four of the five staff reported it is documented in the logbook. Three of the five staff stated they are informed through the alert sheets passed out every shift debriefing, as observed during the review. One of the five staff stated during a meeting. Three of the five staff reported through e-mails and, when they relieve staff on the module, they are debriefed of any issues.

Standard 2: Assessment and Performance Plan

Overview

Okaloosa Regional Juvenile Detention Center houses youth who meet admission criteria for several reasons including, but not limited to, pending placement into a residential program, absconder, contempt of court, new law charges, violations of probation, and out-of-state runaways. Once a youth is screened and accepted into the center, they participate in an orientation process, which is outlined in the center's facility operation procedures. During this process, the youth are given the rules and regulations of the center, the Youth's Rights pamphlet, visitation and telephone schedules, grievance process information, the youth view a Prison Rape Elimination Act (PREA) video, and the expectation for behaviors is explained to them, including related consequences for unacceptable behaviors. The center has a daily schedule the youth follow, which includes hygiene, meals, education, groups, large muscle activities, and recreational activities. The youth are given daily access to medical and mental health services, if needed. The center also has a behavior management system designed to treat all the youth fairly and consistently.

2.01 Admission	Satisfactory Compliance

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

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

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

Each of the five reviewed records contained documentation completed by screening staff to include a review of all required paperwork, the Detention Risk Assessment Instrument, court order, arrest affidavit, Suicide Risk Screening Instrument, and substance abuse and mental health assessments. Each of the reviewed records contained the Department's Juvenile Justice Information System (JJIS) Admission Wizard, which documented the admission process including frisk, search, youth telephone call, youth meal, and medical mental health screening. All records contained documentation indicating the youth were frisked, stripped, and/or electronically searched by a juvenile justice detention officer (JJDO) of the same gender as the youth. These searches were conducted in areas under video surveillance. Documentation in all of the reviewed records indicated screening staff provided youth with an opportunity to make a telephone call to a parent/guardian or documented their refusal. Each youth was provided or offered a meal if admission was completed two or more hours prior to the next scheduled meal.

Documentation showing each youth was screened for medical, mental health, and substance abuse needs was present in all the records. At-risk youth for suicide ideations were placed on precautionary observation pending a mental health assessment from a licensed provider. There was not an opportunity to observe an admission process during the annual compliance review.

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

All five of the reviewed youth records contained all of the elements as outlined in the orientation process. Each youth record documented the orientation process was completed within twenty-four hours of admission to the center. All reviewed youth records contained documentation the youth were advised both verbally and in writing the following information: the center's rules and regulations, grievance procedures, visitation, telephone calls, medical, mental health, and substance abuse services, how to access the Florida Abuse Hotline and Central Communications Center (CCC), expectations for behavior and related consequences, possible new law violations for destruction of property, and youth rights. The orientation brochure provided to each youth has the information in writing covered during the orientation process. The youth are also provided a copy of the Youth Bill of Rights. Each record had a copy of the orientation brochure which was signed by the youth. The youth and staff initialed each section of the orientation brochure, documenting the contents were provided to the youth and discussed verbally with them. The orientation process includes a video regarding the Prison Rape Elimination Act (PREA). Posted in each module are items discussed during the orientation process. An orientation was not observed during the annual compliance review, as there were no new youth admissions. All five interviewed youth stated they were provided information about the center's rules and regulations, daily schedule, education services, visitation, abuse reporting, and behavior management system.

2.03 Classification	Satisfactory Compliance

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

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

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

All five of the reviewed youth records contained documentation supporting detention staff classified each youth for safety and security upon admission to the center. Screening staff documented their review of information concerning the youth's history and status in each of the youth records and the youth were assigned to a room according to risk level for safety and security. The classification process included physical characteristics, age and level of aggressiveness, special needs, history of violent behavior, gang affiliation, criminal behavior, history of sexual offenses, vulnerability to victimization, and suicide risk. Staff used the Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) form to screen youth to screen youth. All five of the youth were screened by detention staff for special needs. Two of the five youth were identified with physical disabilities, and one was identified with medial needs. Four of the five youth were identified with suicide risk. Alerts were placed into the Department's Juvenile Justice Information System by staff to identify each youth who had any mental health, suicide, medical, medication, or dietary needs. All five of the youth records were classified and assigned rooms based upon the classification process. Three of the five youth records were reclassified for changes in behavior (positive and negative) using the Level Adjustment Request Form. Two of the youth dropped down a level due to rule violations, and one youth's level was increased for model behavior.

2.04 Classification of Gang Members	Satisfactory Compliance

All newly admitted youth are screened to determine if he or she is a criminal street gang member or is affiliated with any criminal street gang.

Each facility shall identify a staff person to serve as a gang representative who shall review identified youth for suspected gang involvement or gang activity.

Staff screened all five youth when they were admitted to the center for gang membership or affiliation. Staff reviewed law enforcement questionnaires, alerts in the Department's Juvenile Justice Information System (JJS), Intake Wizard form, and questioned youth to identify youth

involvement with gangs. None of the five reviewed youth records were classified as gang members.

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

The center's policy indicates after a youth is identified with gang affiliation, the juvenile justice detention officer (JJDO) will enter an alert into the Department's Juvenile Justice Information System (JJIS) and notify the designated juvenile probation officer (JPO) by e-mail with a description of the suspected gang activity. The designated circuit gang representative notifies law enforcement and follows-up with documentation. None of the five reviewed youth records were for youth who were identified or suspected for gang involvement. Six additional records were reviewed; however, none contained any gang activity. A youth was suspected of gang-related activities post-admission during the annual compliance review, and the juvenile justice detention officer (JJDO) reviewed all the drawings, pictures, and notes. After identifying the youth as a suspected gang member, the JJDO put an alert in JJIS, and notified the JPO by e-mail with a description and copy of drawings, pictures, and notes relating to gang activity. Both the superintendent and designated JJDO were interviewed and were knowledgeable about the procedures regarding notification of the JPO gang representative indicating suspicions of gang activities.

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

Property receipt forms and valuable property receipt forms, if applicable, are included in all youth records when they are admitted into the center. All five of the reviewed youth records had a copy of the property receipt with youth and staff signatures, and all youth signed a letter of acknowledgement regarding any unclaimed property after thirty days of release. One of the five youth records were applicable for entering the center with money and personal items of value, which were verified and secured in a clear tamper proof property bag. The bag was labeled with the date, youth's name, Department identification number (DJJID), and a list of items in the bag, and placed into the drop safe. A juvenile justice detention officer supervisor (JJDOS) and another staff member are required to open the safe. The transaction was documented in the drop safe logbook and included the date, time, youth's name, DJJID, printed name of the officer who secured the property, and initials. Procedures are in place for youth who refuse to sign the property receipt form. The supervisor is notified by the booking officer and the supervisor will document the youth's refusal on the form. All five of the youth had an assigned bag located in secure area. All clothing items and other property is placed in the bag and documented on the

property receipt. A copy of the property receipt form, with the list of personal property, was in each bag, and a copy was placed in the youth's record. The valuable property receipt form was placed in the applicable youth's record. There was not an opportunity to observe a new admission to the center during the annual compliance review. Four of the five interviewed youth stated staff checked youths' personal property and had them sign a form stating the personal property was correct. During an interview, the superintendent stated all youth's personal property is secured, inventoried, and signed by the youth. It is placed into a secured property room where only administrators and supervisors have access to the area. A camera monitors the entrance and exit of the property room door. Valuable property is dropped in safe with a lock by a supervisor/designee and is also under surveillance. All property is logged in the safe logbook for added security and record retention. Letters are sent out giving youth thirty days to pick up property pending disposal. If there is currency, it is forwarded to the bureau of unclaimed property.

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

The center has a policy and procedures in place outlining the safeguards of each youth's personal property until it is returned to the youth or parent/guardian. Observations of the center and storage of valuable and personal property was conducted. All five reviewed youth's property bags contained a detailed list describing the youth's personal items. The personal property was stored in a locked area, which is limited to designated staff and the entrance and exit is monitored with cameras. The drop-safe is also under video surveillance. The drop-safe procedures were demonstrated by two designated staff, and the safe functioned properly during the demonstration. The safe contents were removed, and each of the clear tamper-proof property bags were labeled with the date, youth name, Department identification number (DJJID), and a list of items in the bag. The bags were cross referenced with the logbook. There was not an opportunity to observe a new admission to the center while the annual compliance review team was on-site. Central Communications Center reports were reviewed from the past six months, and there were no reported incidents regarding youth property. The superintendent stated in her interview, to ensure a youth's personal property is secured, all personal property is inventoried and signed by the youth, and placed into a secured property room where only administrators and supervisors have access. A camera monitors the entrance and exit of the property room door. Valuable property is dropped in safe with a lock by a supervisor/designee and is also under video surveillance. All property is logged in the safe logbook for added security and record retention.

2.08 Release	Satisfactory Compliance

When releasing youth from detention, the releasing officer shall verify the court's authorization to release the youth. Care must be taken to ensure all case file information is reviewed to prevent the negligent release of a youth.

All releases from the program are court-ordered, with the exception of deaths, escapes, and expirations of detention time period. In the absence of a written order, documentation of a verbal order in open court may be used for release.

The on-duty JJDO Supervisor reviews all paperwork prior to release. The JJDO Supervisor is responsible for ensuring there are no holds, court orders, or other legal reasons not to release the youth.

Questions concerning release are presented and addressed by the Superintendent, or designee, prior to release.

The releasing officer shall verify the identification of the youth.

One youth release was observed during the annual compliance review, and three closed records were reviewed for release procedures. During the observed release, the on-duty supervisor reviewed all paperwork related to the youth's release, including documentation from the court, prior to youth's release. Identification of the responsible adult was not applicable, as the youth was transferring to the residential program located across the street. Staff walked the youth to the program. All required parties signed all applicable release forms. The youth was released on September 25, 2018, and the date of admission and date of termination documented in the case record correlated with the Department's Juvenile Justice Information System (JJIS).

All three closed records had documentation indicating the on-duty supervisor reviewed all paperwork related to release prior to youth's release, including the release paperwork provided by the court. All three youth records contained a photo copy of the identification of the youth's parent/guardian, and all required parties signed the applicable release forms. Two detention staff were interviewed, and both staff had a clear understanding of the release policy and procedures. Central Communications Center reports for the past six months were reviewed, and there were no reports of any unauthorized releases during this time.

2.09 Release of Youth Personal Property	Satisfactory Compliance

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

The center has a written policy and procedures regarding a youth's release from the center and retrieval of the youth's personal property. The releasing officer, youth, and parent/guardian review and sign the receipt of property form and compare the contents of the property with the property receipt. If a youth is eighteen-years of age or older, a signature is not required by the parent/guardian.

One release was observed during the annual compliance review, and procedures were followed except for a parent/guardian signing the property receipt form, due to the youth going to a

residential program. The youth compared the contents of the bag to the property receipt, and the youth and releasing officer signed the property receipt form. A supervisor reviewed the youth's record for all required paperwork and signed release paperwork. The releasing officer placed all of the signed paperwork, including the property receipt form, back into the youth's record. During an interview, the superintendent reported letters are sent out giving youth and/or the parent/guardian thirty days to pick up property pending disposal. If there is currency, it is forwarded to the bureau of unclaimed property. Two applicable youth records for unclaimed property held for more than thirty days were reviewed. Both records contained a copy of the youth signed property receipt and a thirty-day notice of impending disposal of property was sent to the youth and parent/guardian. During the safe-drop observation, two staff, a supervisor, and another detention officer were present. The supervisor opened the safe, removed the contents, and compared it to the bound log book. Each plastic bag was labeled with secure strip with the youth signature on it. The dates were checked for unclaimed property over thirty-days by the supervisor, and witness by detention officer. Each property bag was placed back in the safe after it was checked. After all the property was placed back into the safe-drop, it was locked by the supervisor and witnessed by the other detention officer.

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

Three closed records were reviewed for youth release of medication and all three youth records contained a signed acknowledgement of receipt of medications. The medication forms listed the names of medications, strengths, and amount released back to the youth. Medical staff obtain parent/guardian photo identification card and made a copy for the youth's record. The release and transfer of the medication was documented in the youth record and copies of the signed Medication Receipt, Transfer, & Disposition form, and parent/guardian identification card were all placed in each youth's Individual Healthcare Record.

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

On September 25, 2018, a detention review meeting was observed. The detention review specialist chaired the meeting and distributed a copy of the Department's Juvenile Justice Information System (JJIS) list of youth on detention status, an agenda detailing the number of youth status, and topics. A sign-in sheet was distributed for signatures, and individuals participating by telephone were written in by the detention review specialist. The juvenile probation officers (JPO) participated by telephone, and other attendees included the superintendent, medical staff, mental health staff, and education staff. The detention review specialist reviewed the list of youth and all attendees provided input and updates. Detention staff updated the JJIS daily statistical information report, and the assigned JPO was asked to update the youth notes with new information and provide necessary documents. Weekly detention reviews are conducted at the center with consistent documentation of attendance, participation, task assignment, and follow-up. Detention staff provided documentation from past detention reviews including JJIS documents, lists of youth currently on detention status, alert reports, circuit commitment waiting lists, detention review reports, sign-in sheets, and detention review agendas. Each youth on home detention and secure detention status were monitored for

changes in placement, behavior, alerts, medical, and other information. The superintendent designated a staff member to coordinate and conduct the detention reviews. Signatures by all the required staff participants were on the weekly sign-in sheets. An interview with the superintendent was conducted. The superintendent described the process, including who chairs the meeting, who attends, where, when, and what information is discussed at the reviews.

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

While the annual compliance review team was on-site, multiple youth activities were observed, and a copy of the daily activity schedule was obtained from staff. The schedule was posted on each module and in other areas of the center. The schedule had specific time blocks for each scheduled activity which included hygiene, meals, phone calls, snacks, free time, groups, medication pass, recreation, and large muscle activities. Education classes are scheduled during the week days, and visitation is scheduled twice a week. Three staff were informally interviewed about gender-specific programming, restorative justice activities, and life and social skills. Two of the three staff reported activities and groups were conducted on gender-specific and restorative justice. They reported the center uses lessons from The Truth About Drugs, Eight to Great, and Give Us Wings. The books provided specific topics addressing gender-specific information, restorative justice lessons, and life skills. The remaining staff reported topics for groups were provided by the supervisor and did not know the name of any of the books, but listed topics on life skills, problem solving, and gender-related topics. All three of the staff interviewed reported mentors from Eglin Airforce Base meet with the youth and use the book, The KID & The CEO. The daily schedule includes groups such as responding to anger, paying attention to our thinking, active listening, our thinking controls how we act, understanding and responding to other's feelings, problem solving, volunteer mentoring, Teens Assisting Puppies to Overcome Obstacles (TAPs TOO), and additional topics as assigned. There were no rescue animals, TAPs TOO, at the center while the annual compliance review team was on-site. Two of the five interviewed staff reported the center offer gender-specific programming as part of the daily schedule. They explained the center has Give Us Wings books for the girls, as well as discussing birthing babies, raising babies, and sexually transmitted diseases. For the boys, they have workout plans to help them develop large muscles. Each of the five interviewed youth reported the center has a daily activity schedule.

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

Observations of youth movement to meals, education classes, medication management, and indoor and outdoor muscle group activities, in accordance with the daily schedule, were made during the annual compliance review. A review of the notations in the logbooks recorded the time and movement of youth to meals, classes, groups, medication, hygiene, and the

multipurpose room. Five staff were interviewed and all staff reported the daily schedule was followed, and only administrative staff or supervisors are authorized to change the daily activities schedule. If the daily schedule is changed, documentation in the logbook and the reason for the change must be documented. All five youth interviewed reported the center's daily schedule is followed.

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

Interviews with school personnel, the Department's northwest region education coordinator, and other instructional staff at the center determined the school met the required 300 minutes/five hours a day for twenty-five-hours of instruction weekly. The Okaloosa County School District has a contract with the Radar Group who provides the education services to the youth at the center. School is offered year around from 8:30 a.m. until 3:30 p.m. Monday through Friday. School was canceled only one day in September because of a mandatory school closures in Okaloosa County. Documentation in the school logbook noted tornado warnings in Okaloosa and the surrounding areas were the cause of the school closures. Teacher's training and planning days are scheduled on the first Thursday of each month for the last half of the school day. Youth enrolled in educational programs will have the opportunity to earn course credit for completion of the education and training experience. If the youth are enrolled five or more days while at the center, credits are transferred to the Okaloosa County School Board and are then sent to youth's school. All five interviewed youth stated the center offers educational classes and they attend Monday through Friday. Four of the five youth said they attend math and science classes. Three of the five said they attend history, language arts, and physical education classes. One youth said they attend social studies, while another said English, and lastly, one said biology.

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

Interviews were conducted with school personnel, the Department's northwest region education coordinator, and the lead teacher at the center. The center logbooks were reviewed, and the requirements were met for Type 1 educational and career programming at the center. The Type 1 programming includes life skills, activities teaching personal accountability skills, and behavior and work habits for youth with varying lengths of stay, educational needs, age groups, and different levels of ability. Type 1 career education programming at the center includes communication, interpersonal, and decision-making skills. The center also offers employability skills, pre-vocational skills, and resume writing. My Florida Shines, a comprehensive education and career planning system, is utilized at the center. A computerized career inventory choices test is provided to youth who have been at the center for at least twenty-two days, and it is used as a guide in determining which career path they should consider. The Florida Skills Assessment (FSA) test is also conducted at the center.

2.16 Behavior Management System	Satisfactory Compliance

The program provides a system of rewards, privileges, and consequences to encourage youth to fulfill the program's expectations.

Each facility shall implement and maintain a behavior management system to meet the needs of the youth and the facility. The system shall be approved by the regional director and shall include rewards for positive behavior and consequences for inappropriate behavior.

The behavioral norms and expectations for youth shall be posted in all living areas and shall clearly specify appropriate and inappropriate behaviors.

Observations at the center found rules and expectations for the youth are posted in all living areas. A copy of the of the center's policy and procedures regarding the behavior management system (BMS), which was approved by the regional director was reviewed. The BMS provides a system, including positive and negative rewards, to address youth behavior while they are at the center and encourages them to meet the center's expectations. Youth are provided a copy of the center's handbook during the orientation and sign acknowledging the BMS rules were explained, and both the center staff, and the youth initial each rule as it is explained during the process. The center's BMS offers youth predictable rewards and consequences, and fair and consistent treatment in the implementation of the BMS. The BMS uses a three level system for rewarding positive behavior and, when they reach level three, the youth earn extra privileges. Based upon the youth's behavior, and responsiveness to staff interventions, they can move up and down the level system. Youth start on level two when they enter the center and have access to books and art projects. Level three is the highest level and has more privileges than level two to include access to video games, puzzles, and board games. Level one is the lowest level and youth are placed on this for serious rule violations to include, but not limited to, combative or aggravated resistance, felony property damage, and continued disruption of the center's programming. The superintendent or designee must approve placement on this level after three days. Basic rights are provided to youth on all three levels. The center has a Level Adjustment Request Form which is used to denote the reason for adjustment, positive or negative, and has areas for the supervisor to check for no action, freeze, and level increase or drop. At the bottom of the form, an information box lists what the consequences are for minor and major rule violations. Both the youth and staff sign the form, and above the signatures in bold print the statement, "Detainee advised that he/she has the right to file a formal grievance." If a youth receives a major rule violation or receives new law violations, the youth shall be adjusted to level one and can include restrictions or confinement. Youth can progress by going up to level three after three consecutive days of good behavior and can drop a level for inappropriate behavior and poor choices. Youth who consistently present good behavior and follow the rules and guidelines at the center and stay on level three status are rewarded with a level three party. The level three party is scheduled by the center every other Friday. Observations of staff and youth interactions and documentation found in the logbooks and five youth records were reviewed and found staff are following the guidelines outlined in the BMS. Level adjustments for both positive and negative behaviors were documented in the dorm room logbooks. Each of the five youth records reviewed had copies of the Level Adjustment Form with level changes for positive and negative rewards. One youth was observed in the school setting kicking the chair and raising his voice and staff were able to de-escalate him through verbal interventions. Later, the same youth apologized to everyone present and took responsibility for his actions and excepted the consequences outlined in the BMS. All five staff interviewed believe the center's BMS is effective and they speak with the youth to discuss consequences being imposed. All five staff also stated the youth are given the opportunity to

explain their behavior and they speak with the youth about alternative acceptable behaviors. All of the staff agreed the only thing allowed to be taken away from a youth as a consequence is their level. All staff reported supervisors provide feedback to staff regarding the implementation of the BMS on an as-needed basis. Three of the five interviewed youth rated the center's BMS as good. One said it was fair, while the last one rated it as poor. One youth reported consequences were fair, two said no, and the remaining two never had any consequences while at the center.

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

Policy and procedures for the administration of the behavior management system (BMS) at the center were reviewed and are in place. The center's policy and procedures guidelines prohibit the use of corporal punishment, group punishment, and the use of pharmaceuticals to control youth behavior. When a youth alleges a staff member used corporal punishment, staff are directed to contact the Florida Abuse Hotline and the Central Communications Center(CCC). Both numbers are posted in the modules for youth to view. All five staff interviewed stated no youth will lose their meals, snacks, sleep, or school as a consequence for inappropriate behavior. All five staff have never observed any staff encouraging youth to beat up another youth. Two of the five interviewed youth responded they have never received any consequences while at the center. When consequences were given, two out of the five youth reported their levels were taken away and one youth said he went to confinement for fighting so they took away his mat during the day while in confinement. Four of the five youth said they have never been sent to their room for punishment. The one youth who replied yes, said the door was shut and locked. Three of the five youth stated handcuffs or leg irons are not used on out of control youth to prevent them from hurting themselves or others. The other two youth stated they have never witnessed this.

2.18 Grievances	Satisfactory Compliance

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

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

The center has developed grievance policy and procedures ensuring the youth's right to grieve, and all youth are to be treated fairly, equally, and respectfully. The youth has a right to grieve the actions of the center's staff or circumstances of denial of basic rights. The grievance process has three phases outlining the steps for the youth and staff to follow; informal, formal, and appeal phases. A written response is not required at the informal stage of the process. At the informal stage, the juvenile justice detention officer (JJDO) attempts to resolve the issue, but if they are unable to resolve the issue, the grievance moves to the formal phase. During the formal phase, the youth submits a written grievance to the supervisor within two hours, and it requires a response of a juvenile justice detention officer supervisor (JJDOS) by the end of the shift, or no later than twenty-four hours. The appeal phase process is the final stage and the youth may appeal the outcome of the formal phase to the superintendent or designee, who have seventy-two hours to respond. All grievances are sent to the superintendent/designee and logged into the facility management system (FMS). A sample of five grievances from the past six months were reviewed and all five forms included the name of the youth, date, time, Department identification number, nature of grievance, each phase of the grievance, action taken, youth signature, and staff signature for each stage of the phase. All five of the grievances reviewed found staff dealt with each grievance appropriately and swiftly. Two were resolved at the informal stage, and only three of the five were sent to the supervisor within two-hours. One of the five grievances reviewed appealed the grievance, and it was sent to the superintendent the same day. The superintendent responded to the appeal with-in twenty-four hours. All five of the complaints were against staff at the center; however, none were alleging abuse. One of the five youth reported they were not allowed to file a grievance, however, their issue was resolved at the informal stage. Grievance forms are made available at the youth request, and staff try to resolve the grievance at the informal stage.

Four of five staff interviewed and reported they have never seen a co-worker take meals, snacks, clothing, education, or medical care from a youth because they were acting out. A follow up to the fifth staff replied that she misunderstood the question and that her answer would have originally been no as well. All five staff were able to communicate the grievance process in accordance to the center's procedures. Four of the five interviewed youth have never filed a grievance while at the center. The remaining youth rated the grievance process as poor.

2.19 Trauma-Informed Care	Satisfactory Compliance

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

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

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

The center is incorporating trauma-informed practices into the operating guidelines for delivery of services. Staff complete trauma-informed training in the Department's Learning Management System (SkillPro), as well as instructor-led training. The training includes techniques for recognizing youth with trauma and appropriate responses to use when interacting with youth. The center has a soft room, which may be utilized by the youth and staff, which it is decorated with positive art and contains soft furnishings. The center has positive quotes throughout and the walls are painted with bright colors. When staff identify youth with trauma-based needs, the youth is referred to mental health for treatment.

Standard 3: Mental Health and Substance Abuse Services

Overview

The Department has a contract with Maxim Healthcare Services, Inc., who subcontracts with Camelot Community Care, Inc., to provide mental health and substance abuse services at the center. The mental health and substance abuse department is staffed with one psychiatrist, one licensed mental health counselor (LMHC), and a registered mental health counselor intern. The LMHC is identified as the center's designated mental health clinician authority (DMHCA). Staffing for mental health and substance abuse services at the center are available on-site seven days a week, twenty-four hours a day.

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 identified a single licensed mental health professional, as the designated mental health clinician authority (DMHCA). The DMHCA is a full-time employee and is on-site five days a week, for forty hours a week. The DMHCA is a licensed mental health counselor (LMHC), licensed under Chapter 491; which was verified through the Florida Department of Health and expires March 31, 2019. A review of the sign-in logbook, which is maintained near the center's timeclock, demonstrated, at a minimum, the DMHCA is on-site weekly for a sufficient time to ensure appropriate coordination and implementation of mental health and substance abuse services are taking place. The Department has a contract with Maxim Healthcare Services, Inc., who subcontracts with Camelot Community Care, Inc., to provide mental health and substance abuse services, at the center. A copy of the DMHCA's license and subcontract, was available on-site for review. The DMHCA is certified as a qualified supervisor, pursuant to contract. An interview with the DMHCA found the DMHCA's role is to plan, organize, direct, and control all activities of mental health. The DMHCA reported he is on-site, forty hours a week. The DMHCA reported he personally provides all of the services offered along with one registered intern. In addition, the DMHCA meets with the psychiatrist once a week.

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

There are two licensed mental health professionals providing mental health and substance services at the center, each of the mental health professionals are licensed under the appropriate Florida Statutes and have clear and active licensures. The psychiatrist, an Osteopathic Physician, who is licensed pursuant to Chapter 459, F.S., and is board certified in psychiatry, and has completed a fellowship in child and adolescent psychiatry; verified through the Florida Department of Health and expires March 31, 2020. The licensed mental health

counselors (LMHC), who serves as the center's designated mental health clinician authority (DMHCA), is licensed under Chapter 491; which was verified through the Florida Department of Health and expires March 31, 2019.

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

The center and service provider are not licensed under Chapter 397. The service provider employs licensed mental health professionals under Chapter 491; whereas, under Chapter 397.4012, exemptions from licensure: the following are exempt from the licensing provisions of this chapter, subparagraph (7), a social worker, marriage and family therapist, or mental health counselor licensed under Chapter 491. The center has one part-time non-licensed mental health clinical staff person. The part-time employee is a registered mental health counselor intern, who is under supervision of a licensed mental health professional qualified supervisor. The registered mental health counselor internship expires June 4, 2023, verified through the Florida Department of Health. The registered mental health counselor intern holds a master's degree in the field of counseling. In addition, has completed twenty hours of training to include administration of five assessments of suicide risk, which were conducted in the physical presence of a licensed mental health professional. Each of the five assessments completed were documented on Department form MHSA 022; training was completed on May 3, 2018. The part-time non-licensed mental health clinical staff started working at the center on April 12, 2018. She has been provided twenty-three separate face-to-face direct supervision meetings by the licensed clinical supervisor since her employment. Each of the twenty-three direct supervision meetings were, at a minimum, one hour in length and were conducted individually. The twenty-three direct supervision meetings provided were each documented on Department form MHSA 019. The licensed mental health professional responsible for providing direct supervision, also reviews and signs comprehensive mental health evaluations, updated comprehensive mental health evaluations, initial mental health treatment plans, and individualized mental health treatment plans prepared by the non-licensed mental health clinical staff within ten calendar days of administration of the instrument. The licensed mental health professional responsible for providing direct supervision also has reviewed and signed each Assessment of Suicide Risk (ASR), follow-up ASR, crisis assessment, and follow-up crisis assessment conducted by non-licensed mental health clinical staff person within twenty-four hours of the referral for assessment. The clinical supervisor assures the part-time non-licensed clinical staff working under his supervision are performing services they are qualified to provide, based on education, training, and experience. The non-licensed mental health clinical staffing at the center is in accordance with 63N-1 Florida Administrative Code and the current subcontract between Maxim Healthcare Services, Inc., and Camelot Community Care, Inc.

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

Five youth records were reviewed for mental health and substance abuse admission screenings. Each of the reviewed records included a Positive Achievement Change Tool Assessment (PACT), Suicide Risk Screening Instrument (SRSI), and a Massachusetts Youth Screening Instrument – Version 2 (MAYSI-2). There was documentation of review for each of these instruments completed by detention staff in each of the five youth records reviewed. All of the youth records contained a completed SRSI, which was completed at intake. All of the SRSIs and MAYSI-2s were completed within the Department's Juvenile Justice Information System (JJIS). The five youth records had appropriate nurse and/or mental health staff required sections of SRSI completed, as required. The records had complete entries, which included a summary and recommendations in "Screening Results" sections. In three of the five records reviewed, each youth had a yes response on the SRSI noted on the Department form MHSA 002. The three applicable youth who were placed on suicide precautions, had a mental health referral completed; which documented the youth's need for an Assessment of Suicide Risk (ASR). Each of the three applicable screenings reviewed were completed by trained staff. The results of the PACT, SRSI, MAYSI-2 for each of the three applicable records indicated a need for further assessment and a referral was made. In addition, when necessary, the superintendent was notified of the screening instrument findings for each of the three records reviewed. In three of the five youth records reviewed, where the PACT Mental Health and Substance Abuse Report and Referral Form indicated a need for further assessment in the suicide category, each youth was subsequently placed on suicide precautions. Only two of the five youth required a referral for a comprehensive assessment to be conducted; subsequently, both referrals were reported to the mental health clinical staff. Three of the five youth were applicable for placement on suicide precautions and referred for an ASR. None of the MAYSI-2 assessments indicated a need for a comprehensive assessment to be completed. The superintendent was interviewed and reported suicide risk screenings are started by the screener at the juvneile assessment center (JAC), which is then sent to the officer completing the admission, reviewed by the supervisor, and then completed by mental health 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.	

Two of the five reviewed records were applicable for mental health and substance abuse evaluation referrals. Each of the applicable youth were identified upon admission and referred for a comprehensive mental health and substance abuse evaluation. Referrals generated were each documented on the Department's form MHSA 014. One of the two referrals generated required a new mental health and substance abuse evaluation, which was completed by the detention provider. The second youth had previously been referred for a comprehensive

evaluation; therefore, the detention provider conducted an updated mental health and substance abuse evaluation. Each of the referrals were completed within thirty days of referral. Both of the identified comprehensive mental health and substance abuse evaluations were completed on a comparable Department approved instrument. The comprehensive evaluations were administered by a licensed mental health professional. The superintendent has a written facility operating procedure which addresses practices for a thorough review of referred comprehensive evaluations forwarded to the detention center.

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

None of the five reviewed records were applicable for mental health and substance abuse treatment; therefore, three additional records were reviewed. Each of the youth were assigned to a mini-treatment team, consisting of mental health clinical staff, one staff from a different service area, the youth, and, when possible, the youth's parent/guardian. Each youth received mental health treatment in the form of individual, group, or family counseling, which was provided according to the frequency required by the youth's initial treatment plan. Two youth were determined to be in need of substance abuse treatment and received individual, group, or family counseling which was provided according to the frequency required by the youth's initial treatment plan. For each of the identified youth requiring mental health treatment, an Authority for Evaluation and Treatment (AET) covering mental health was obtained. For each of the identified youth requiring substance abuse treatment, a consent and information release concerning substance abuse was obtained. Treatment notes for each of the three applicable youth were documented on the Department's form MHSA 018. Group therapy is limited to ten or fewer youth with mental health diagnoses for mental health treatment groups. Those youth with substance abuse diagnoses are provided with individual sessions with a licensed mental health professional. The designated mental health clinician authority (DMHCA) was asked to describe treatment services provided for at the detention center. One interviewed youth reported the mental health and substance abuse services at the center were fair and the remaining four youth were not receiving mental health and substance abuse services. No explanation was provided as to how the one youth responded as to why mental health and substance abuse services were rated 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 facility. *All youth who receive mental health and/or substance abuse treatment while in a detention facility shall have a discharge summary completed documenting the focus and course of the youth's treatment and recommendations for mental health and/or substance abuse services upon youth's release from the facility.*	

The center has a policy and procedures which addresses practices for completion of an initial treatment plan. The initial treatment plan will be developed within seven days of initiation of mental health and or substance abuse treatment. None of the five reviewed records were applicable for the initiation of treatment planning; therefore, three additional records were reviewed. Each of the three applicable youth had an initial treatment plan completed within seven days of initiation of treatment. The initial treatment plans for each youth were developed on the Department's form MHSA 015 and included a reason for referral for treatment. The treatment plans included an initial Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) or Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis and symptoms. In addition, included, initial treatment methods and initial treatment goals. All three records reviewed had psychiatric services included; as a result of being on or prescribed psychotropic medication (which included frequency of monitoring). Each of the initial treatment plans included the signature of the licensed mental health professional completing the plan. In addition, the signatures of each mini-treatment team member involved in development of initial treatment plan, along with the youth. The youth's initial treatment plans included treatment and services provided by a licensed psychiatrist. The plans included frequency of psychotropic medication monitoring and management, and treatment recommendations.

The center has a written facility operating procedure (FOP), which addresses practices for completion of an individualized treatment plan. An individualized treatment mental health and or substance abuse plan is required when a youth enters on-going mental health, substance abuse, or treatment with psychotropic medication. The individualized mental health treatment plan must be developed by the mini-treatment team for a youth in receipt of treatment, whose stay within a detention center exceeds thirty days. The individual treatment plan must be completed by the thirty-first day the youth is in the detention center. Each individual treatment plan must be recorded on the Department's form MHSA 016. Each individual treatment plan must be based on an in-depth comprehensive assessment, comprehensive mental health/substance abuse evaluation, or updated comprehensive mental health/substance abuse evaluation. The treatment plans must be signed and dated by the mental health clinical staff person, the treatment team members who participated in development of the plan, and the youth. None of the youth required an individualized treatment plan. Each of the youth had either been released prior to development or the youth had not yet been in the center thirty-one days. During the annual compliance review, a mini-treatment team meeting was observed. The treatment team was comprised of medical, mental health, and detention staff. The treatment team members discussed and went over those youth who had treatment plans.

Three youth records were reviewed for mental health and substance abuse treatment discharge summaries. Each of the three youth records contained a mental health and substance abuse

treatment discharge summary, recorded on the Department's form MHSA 011. The form was completed for each youth upon the youth's transition or discharge from the center. All three mental health and substance abuse treatment discharge summaries were provided to the juvenile probation officer (JPO), youth, and parent/guardian (as allowed).

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 provides psychiatric services to those youth identified in need. The psychiatrist is an osteopathic physician who is licensed pursuant to Chapter 459, F.S., and is board certified in psychiatry, with a completed fellowship in child and adolescent psychiatry; verified through the Florida Department of Health and expires March 31, 2020. Youth entering the center on psychotropic medication or are referred for a psychiatric interview receive an initial diagnostic interview within fourteen days of the youth's admission to the center. None of the five reviewed records were applicable for psychiatric services; therefore, three additional records were reviewed. Each of the youth were on psychotropic medication. All reviewed initial psychiatric interviews included reason for the referral, history (medical, mental health and substance abuse history), mental status examination, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) or Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis and symptoms, treatment recommendations, explanation of the need for psychotropic medication, and frequency of medication monitoring/management. An in-depth depth psychiatric evaluation was conducted for one youth referred within thirty days of admission. The in-depth psychiatric evaluation included all required elements such as the reasons and factors leading to the referral, and history (developmental history, medical and substance abuse history, school history, social history, emotional development, peer relations, and family relationships. The psychiatric evaluation was signed by the psychiatrist conducting the assessment. When necessary, the psychiatric evaluation included page three of the Clinical Psychotropic Progress Note (CPPN); form HS 006. The center does not employ a psychiatric advance registered nurse practitioner (ARNP). Each of the psychiatric evaluations conducted, which indicated psychotropic medications would be dispensed, documented all required elements. Each of the psychiatric evaluations included telephonic contact with the youth's parent/guardian to discuss psychotropic medication issuance. Each of the psychiatric evaluations also included the signatures and dates of the psychiatrist conducting the assessment. All three records reviewed for issuance of psychotropic medications, contained an Authority for Evaluation and Treatment (AET); Department form HS 002. Each of the reviewed records, regardless of psychotropic medication drug dosage change, the parental/guardian provided verbal consent. Documentation was found on page three of the CPPN.

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

The center has a written plan detailing suicide prevention procedures. The plan includes the following: identification and assessment of youth at risk of suicide, staff training, which included

at least six hours of training annually on suicide prevention, and implementation of suicide precautions. The plan also includes quarterly mock suicide drills for all staff who encounter youth on each shift. In addition, the center's suicide prevention procedures included: suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and a review process; as referenced in the Department Rule 63N-1(2)(e)3(l) Florida Administrative Code. The center's written suicide prevention procedures were approved by the superintendent on August 8, 2018 and approved by the designated mental health clinician authority (DMHCA) on August 9, 2018.

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.*	

Five youth records were reviewed for suicide prevention services. Three of the five youth were identified to be at risk of suicide during the admission screening to the center and were placed on precautionary observation; at a minimum of constant supervision upon notification of being identified as being at risk. Each of the three youth had a suicide risk referral. In addition, an alert was initiated and entered into the Department's Juvenile Justice Information System (JJJIS). The Assessment of Suicide Risk (ASR) documented the time and date of assessment was conducted in real time. Each completed ASR indicated appropriate level of supervision. A suicide precaution observation log was completed in its entirety; which also included "safe housing areas." Each of the three completed ASRs involved a licensed mental health professional. There were no youth released prior to receiving an ASR or released while on any suicide precautions. Each of the three ASRs documented the superintendent or designee was notified immediately of the youth's suicide risk. A referral was made to the licensed mental health professional for each of the youth and placement on precautionary observation was authorized. The three youth had an ASR completed within twenty-four hours. None of the youth reviewed were identified as being in crisis. Two of the three ASRs were conducted by a licensed mental health professional and completed on Department form MHSA 004. The remaining ASR was completed by a registered mental health counselor intern and was subsequently reviewed by the licensed mental health professional. The registered mental health counselor intern completed her twenty-hours of ASR training on May 3, 2018. Each of the three ASRs conducted were discontinued on precautionary observations and placed on standard supervision. There was evidence within the center's logbook and on the ASR where administrative or supervisory staff provided instructions related to the suicide risk assessment findings. Appropriate entries within JJIS were found for each of the -youth when the youth were removed from precautionary observation. There were no youth requiring secure observation. The superintendent has an established review process for every serious suicide attempt or serious self-inflicted injury (requiring hospitalization or medical attention) and a mortality review for a completed suicide. The multidisciplinary review included circumstances surrounding the event, written facility operating procedures relevant to the incident, relevant training received by involved staff,

pertinent medical and mental health services involving the victim, possible precipitating factors, and recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and/or operational procedures.

In an interview with the superintendent, it was revealed secure observation is used for youth who pose a risk of harm to self or others. A staff is posted outside the room and maintains constant supervision of the youth. A mental health referral is completed and mental health is notified. A secure observation log is maintained documenting the youth's behaviors in thirty minute intervals. Youth in secure observation remain on secure observation until they are stepped down by a mental health professional. None of the five interviewed youth had been placed on suicide precautions. When asked what to do when a youth expresses suicidal thoughts, all five interviewed staff reported notify the mental health authority, search youth and his/her room for sharp objects, document supervision, and provide constant sight and sound supervision. Two of the five staff also included document in logbook and notify supervisor.

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

Five youth records were reviewed for the use of suicide precaution observation (PO) logs, of which three were applicable. There was a total of four PO logs from the three records reviewed. Each of the four PO logs where documented on the Department’s form MHSA 006, and maintained for the duration the youth is was on suicide precautions. On the four PO logs, each documented the appropriate level of supervision and observations of the youth’s behavior and documented in real time and did not exceed thirty-minute intervals. There were no warning signs observed for any of the PO logs. All of the suicide PO logs were reviewed and signed by each shift supervisor and licensed mental health professional. All four PO logs contained appropriate supervisory reviews and documentation of safe housing requirements. Three interviewed youth reported staff stayed with them at all times 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.	

Five staff training records were reviewed for completion of suicide prevention training. All five staff received a minimum of six hours annual suicide prevention and implementation of suicide precautions training. Training consisted of two hours of web-based training in the Department’s Learning Management System (SkillPro) and four hours of instructor-led training. The center completed seventeen mock suicide drills. The center had been on three shifts up until February 2018, however, due to staffing went to two shifts. Thirty-seven out of the thirty-nine staff applicable for direct contact with youth, participated in a mock suicide drill in the past six months. The two remaining staff have been out; one staff has been out on family medical leave act (FMLA) and the other staff has been out for military requirements. Three of the seventeen mock suicide drills conducted were not applicable for the demonstration of life saving measures, cardiopulmonary resuscitation (CPR), or use of suicide response kit (knife for life). Each of the mock suicide drills included methods for contacting other staff by radio or requesting back-up

support medical personnel and emergency medical services (9-1-1). The center did not have a process in place for staff who were not present during a quarterly mock suicide drill, which would afford them to have an opportunity to review each drill completed. During the annual compliance review, the center incorporated a review process for staff who were not present during a mock suicide drill. The process incorporated by the superintendent during the annual compliance review required all supervisors to review the drill with their respective shift and an additional sign-in sheet for those staff who need to review the drill will be attached to the drill reviewed. All five interviewed staff reported the suicide response kits are kept in master control and four staff replied medical, which are both the appropriate locations.

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

The center has a written mental health crisis intervention plan which details crisis intervention procedures. The written mental health crisis intervention plan includes a notification and alert system, means of referral (which includes self-referral), communication, supervision, documentation, and review process. The center's written mental health crisis intervention plan was approved by the superintendent on August 8, 2018 and approved by the designated mental health clinician authority (DMHCA) on August 9, 2018.

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

The center has a written emergency care plan which includes immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment under Chapter 394, Florida Statute (Baker Act), transport for emergency substance abuse assessment and treatment under Chapter 397, Florida Statute (Marchman Act), documentation, training, and a review process. The center's written emergency care plan was last updated and approved by the superintendent on August 8, 2018 and approved by the designated mental health clinician authority (DMHCA) on August 9, 2018. The written emergency care plan is located in the center's training room, master control, each mod, and on the center's K: drive electronically. The written emergency care plan is accessible to all staff.

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

The center did not conduct any crisis assessments during the annual compliance review period. The center has a written mental health crisis intervention plan which details crisis intervention procedures. The center's written mental health crisis intervention plan was approved by the superintendent on August 8, 2018 and approved by the designated mental health clinician authority (DMHCA) on August 9, 2018. The crisis assessment is completed on the Department's form MHSA 023. The center utilizes Fort Walton Beach Medical Center (Crisis Stabilization Unit), located in Fort Walton Beach, to provide mental health/substance abuse stabilization.

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

The program did not have a Baker Act or Marchman Act during the annual compliance review period; therefore, this indicator rates as non-applicable.

Standard 4: Health Services

Overview

The Department has a contractual agreement with Correct Care Solutions (CCS) to provide medical services at the center. CCS employs a State of Florida licensed medical doctor (MD) who serves as the program's designated health authority (DHA). The center has one full-time registered nurse (RN) and a full-time licensed practical nurse (LPN) on-site. In addition, the center has another RN and LPN who both work part-time. The center has a Collaborative Practice Protocol in place for two advanced registered nurse practitioners (ARNP) who work as-needed. The program also has a part-time psychiatrist for the purpose of overseeing medication management. Both the DHA and psychiatrist are required to be on-site a minimum of once a week, and available by phone twenty-four hours a day, seven days a week. All medications are maintained secured and inaccessible to youth within the center's medical department.

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

The Department has a contractual agreement with Correct Care Solutions (CCS) to provide medical services for the center. The center has a board-certified physician who is a licensed and serves as the designated health authority (DHA). Documentation reviewed found the DHA holds a clear and active unrestrictive license. The DHA is on-site at least once each week. The DHA is responsible for communication with center staff regarding youth medical needs, and electronic availability for acute medical concerns, emergency care, and coordination of off-site care twenty-four hours and day, seven days a week. Other specified duties include performance of comprehensive physical assessments, review prescribed medications and ordering of new medications, excluding psychotropics, and assisting in the development of policies and procedures for medical and dental episodic and emergency care, including annual reviews of episodic and emergency policies and procedures. The center also has a Collaborative Practice Protocol in place for two advanced registered nurse practitioners (ARNP) who work as-needed. The DHA was interviewed and stated they perform medical related duties such as periodic evaluations and sick call for youth. The DHA reported they are on-site a minimum of once each week and are available each day by telephone, if needed. In the event the DHA is on vacation or absent, they arrange coverage with the ARNP. The DHA reported having no concerns or issues with health care deliverance at the center. A review of the contract, as well as logbook verification for the previous six-months, found evidence the DHA was on-site at least once a week, as outlined in contract.

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

The center has facility operating procedures (FOPs) for all health-related procedures and treatment protocols utilized at the center. An annual review of all FOPs and treatment protocols by the designated health authority (DHA) and superintendent was documented with a revision date of July 5, 2018. Documentation reflected all nursing staff reviewed, signed, and dated the cover page in which all FOPs, treatment protocols, and other procures were found. An annual

review of all FOPs relating to psychiatric services and psychotropic medication management was documented. All new healthcare employees receive a comprehensive clinical orientation to the healthcare policies. Any updates to the protocols are reviewed by medical staff.

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

The center has a written policy and procedures addressing consent with regard to the healthcare provided to youth at the center. Five individual health care records (IHCR) were reviewed for the completion of an Authority for Evaluation and Treatment (AET). All of the IHCRs contained an AET. Two of the five IHCRs contained an original AET while three contained a copy. All three of the copied AETs were stamped as a "COPY." In all five records, the parent/guardian gave consent for treatment, as well as immunizations. All AETs were obtained prior to providing medical services to the youth. None of the youth reviewed were in the custody of the Department of Children and Families (DCF).

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

The center has a written policy and procedures outlining the requirements for parental notification and written consent of the parent/guardian. According to the written policy and procedures, the center will inform the parent/guardian of any significant changes in the youth's condition and obtain consent when new medications or treatments are prescribed. All five youth individual health care records (IHCR) were applicable for parental consent. In all five records, documentation reflected parental notification in each of the record's chronological progress notes. Notifications were made by telephone and witnessed and written parental notifications were sent out regardless of verbal consent by telephone. In all five records, consent was obtained for over-the-counter (OTC) medications not covered by the Authority for Evaluation and Treatment (AET). In one record, a youth was sent off-site for a non-routine dental procedure, the other four youth did not require emergency care or off-site treatment. According to the interview with the registered nurse (RN), parents/guardians are called immediately and mailed notification letters. The RN further reported contacts are made with the parent/guardian when any youth receiving new medication is admitted, confirming medications, vaccination needs, and mental health status.

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

The center has a written policy and procedures outlining procedures regarding parental consent and notification for youth taking psychotropic medication. None of the five reviewed youth individual health care records (IHCR) were applicable for psychotropic medication; therefore, three additional applicable records were reviewed a. In all three records, youth were admitted

on psychotropic medication and parental consent was obtained prior to the continuation of psychotropic medication. Verbal consent was documented, and notifications were sent by mail using the Acknowledgement of Receipt of CPPN, along with page three of the Clinical Psychotropic Progress Note (CPPN), and with explanatory information for the continuation of psychotropic medications. All three IHCRs reflected documentation of verbal consent obtained by telephone by the psychiatrist on page three of the CPPN; however, there was no witness documentation in all three records. Witness documentation was present on the chronological notes associated with the admission completed by the registered nurse (RN) reflecting medications were verified with the parent/guardian.

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

The center has a written policy and procedures addressing the process for the administration of required and ordered vaccinations. Five youth individual health care records (IHCR) were reviewed for immunizations. Each of the records reflected documentation in which the youth's immunization history was verified. Immunizations were verified by medical staff using the Florida SHOTS website. Each of the five IHCRs reviewed contained a signed Authority for Evaluation and Treatment (AET) reflecting consent for immunizations was given by the parent/guardian. In all five records, the youth's immunization records were up to date. There were no instances in which religious exemption was claimed. According to an interview with the registered nurse (RN), immunizations are verified by using the Florida SHOTS website.

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

The center has a written policy and procedures outlining the process for healthcare admission screening. Five youth individual health care records (IHCR) were reviewed for healthcare admission screening forms. Five of five IHCRs contained a medical and mental health admission screening form. Screening dates for all five youth matched the dates of admission. In all five records, the screening form was completed by a juvenile justice detention officer (JJDO). Four of the five screening forms were reviewed by a registered nurse (RN) within twenty-four hours and one of the screening forms was reviewed by a licensed practical nurse (LPN) within twenty-four hours. According to an interview with the RN, admission screenings are always completed within twenty-four hours of admission and screenings are completed by a RN, LPN, advanced registered nurse practitioner (ARNP), or medical doctor (MD). The superintendent reported the medical and mental health admission screening form is completed by a JJDO assigned to admission and is reviewed within twenty-fours by a nurse.

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

The center has a written policy and procedures ensuring an alert system is in place to alert staff when mental health, medical, or security issues exist which may affect the security and safety of the youth in the center. Five youth individual health care records (IHCR) were reviewed for medical alerts. Two youth had medical alerts for allergies, three for a chronic condition, and two for medication side effects. All alerts were verified, entered, and/or updated by appropriate staff. Alerts entered into the Department's Juvenile Justice Information System (JJIS) matched alerts found in the center's internal system. Alerts were observed posted in the kitchen on a tour of the center during the annual compliance review. A shift briefing was observed during the annual compliance review. During the briefing, each staff member was provided with a hard copy print out of the JJIS alerts in which each youth alert was reviewed. According to an interview with the superintendent, if medical concerns are identified during admission, the juvenile justice detention officer (JJDO) completing the admission will enter an alert. This information is passed on to officers on the module and the next shift will have the alert information documented on the JJIS alert print out. The superintendent further reported the nurse will then review, follow-up, and verify any medical alerts. All five interviewed staff reported they receive alerts from the JJIS alert print outs and during shift meetings. Additionally, staff reported alert information is received by reviewing the logbooks and the alert board. Four staff reported they feel the process for receiving this information is good and one staff reported the process is very good.

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

The Suicide Risk Screening Instrument (SRSI) is reviewed by mental health staff; therefore, this indicator is not applicable.

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

The center has a written policy and procedures ensuring all youth receive an orientation and have access to all healthcare services from admission through discharge. Five of five reviewed youth individual health care records (IHCR) reflected youth received a health care orientation upon admission to the center. All five youth signed and dated a receipt of health care orientation. Further, each IHCR had an electronic print out with the date and topic of all health education instruction they received while at the center. The center's health care orientation includes the following topics: access to medical care, sick call process, what constitutes an emergency, medication process to include side effects monitoring, the right to refuse and how it is documented, what to do in the case of sexual assault or attempted sexual assault, and the non-disciplinary role of health care providers.

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

The center has a written policy and procedures to ensure the designated health authority (DHA) is notified of all youth entering the center with chronic health conditions or youth in need of emergency care. Four of five youth individual health care records (IHCR) reviewed were applicable for youth with medical concerns or chronic conditions. None of the four youth required emergency care upon their admission to the center. In each of the four records, documentation of notification of the DHA within twelve hours was found in the chronological progress notes. Each of the four youth identified with a medical concern or chronic condition was referred to the DHA or designee. In an interview, the register nursed (RN) reported when a youth is admitted with a serious or chronic condition the DHA is notified immediately and the notification is documented in the Office of Health Services electronic medical record.

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

Three additional applicable youth individual health care records (IHCR) were reviewed for health care admission rescreening. In all three records, the center conducted a rescreening for youth with a change in physical custody. The rescreening was conducted by a juvenile justice detention officer (JJDO) and subsequently reviewed by a register nurse (RN). One rescreening required a review of the comprehensive physical assessment (CPA) and Health Related History (HRH) form in which the review was completed by an advanced registered nurse practitioner (ARNP).

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

The center has a written policy and procedures outlining the process for conducting or reviewing admission history. All five reviewed individual health care records reflected a Health-Related History (HRH) form was completed within seven days of admission by a licensed nurse. Four of the five IHCRs reflected a new HRH was completed and one IHCR reflected a review was completed. In all five records, the designated health authority (DHA) or designee completed a review of the HRH, as indicated on the Comprehensive Physical Assessment (CPA) form.

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

Five youth individual health care records (IHCR) were reviewed for completed of a Comprehensive Physical Assessment (CPA). Five of five IHCRs reviewed reflected a CPA was completed within seven days of admission. All five CPAs reviewed were completed by the advanced registered nurse practitioner (ARNP). Five of five IHCRs reflected the genital or gynecological portion of the CPA was refused. This portion of the exam reflected “refused.”

Each of the five IHCRs contained corresponding refusal forms completed by the youth for those portions of the CPA. All five of the reviewed youth reflected a medical grade of "1." The CPA was completed in full in each of the five IHCRs. Four of the five IHCRs required an update to the Department's Problem List and each update was completed, as required.

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

Two of the five individual health care records (IHCR) reviewed were applicable for female specific screenings/exams. One additional applicable IHCR was reviewed. All three youth gave consent for qualitative urine pregnancy screening. In each record, the youth were offered the gynecological exam, but refused. Refusal forms were found in each of the three IHCRs reviewed. In the event a female youth admitted to the center consents to the exam, a referral is made, and the exam is completed off-site. Two applicable youth were interviewed regarding receipt of gynecological, prenatal, and obstetric services. One youth reported services were not needed and one youth reported she has not received services. Documentation reflected this youth refused services; therefore, a referral was not made.

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

The center has a written policy and procedures addressing routine screenings for all youth for latent and active Tuberculosis (TB), as well as environmental controls in the case of the youth with active TB. Five youth individual health care records (IHCR) were reviewed for TB screenings. All five IHCRs reflected documentation of the completion of at least one verified Tuberculosis Skin Test (TST) on the Infectious and Communicable Disease form and the Comprehensive Physical Assessment (CPA). Documentation also reflected each of the Tier I TB screenings were completed within seventy-two hours of admission. In the five IHCRs reviewed, all tests reflected a negative result and no further evaluation was needed. According an interview with the registered nurse (RN), if a TST has been completed within the year, a new test is not required. The RN reported if the TST results are over a year old, a new TST will be administered.

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

The center has a written policy and procedures to ensure all youth are evaluated and treated (if necessary) for sexually transmitted infections (STIs). Five youth individual health care records (IHCR) were reviewed for STI screening. Documentation in three of the five IHCRs reflected the youth refused a STI screening. Corresponding refusal forms were located in each of the three IHCRs. One youth consented to screening, no further evaluation was needed, and results were documented on the Infectious and Communicable Disease form and filed in the lab section of the IHCR. One youth did not have documentation of STI testing or refusal of STI screening. In this record, the youth was subsequently offered the testing and refused. A refusal form was

completed and placed in the IHCR. According to the registered nurse (RN) interview, youth are offered STI screening upon admission and can request screening anytime thereafter. Additionally, the RN reported in the event further evaluation is necessary, a referral is made to the designated health authority (DHA). The RN stated STI screenings, evaluations, referrals, and testing are documented on the Infectious and Communicable Disease form.

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

The center has a written policy and procedures outlining the process for Human Immunodeficiency Virus (HIV) counseling and testing. The center has an agreement with an outside agency, Okaloosa AIDS Support and Informational Services (OASIS), to provide HIV testing and counseling. OASIS has a current certificate of registration issued by the Department of Health to provide HIV prevention counseling and testing which expires August 31, 2019. OASIS staff visit the center every other week to provide test results and counseling. A review of five youth individual health care records (IHCR) reflected each youth was offered HIV counseling and testing. Two of the five youth refused counseling and testing, as reflected by refusal forms located in their IHCRs. Documentation reflected three of the five youth consented to testing and were given pre-test counseling. The youth have not yet received their results; therefore, have not yet had post-test counseling. According to an interview with the registered nurse (RN), youth are asked upon intake if they consent to be tested and an outside agency (OASIS) comes to the center every other Thursday to conduct screenings and counseling. The RN reported this process is documented on the HIV log and Office of Health Services electronic medical record. All five interviewed youth reported they can request HIV testing.

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

The center has a written policy and procedures to ensure all youth in the center will be able to make sick call requests and have their complaints treated through the center's sick call process. Sick call is conducted Monday through Friday from 6:30 a.m. to 8:00 p.m. and Saturday and Sunday from 7:30 a.m. to 2:00 p.m. Sick call is conducted by a licensed nurse or by the designated health authority (DHA), if on-site. When there is no licensed nurse on-site, there are procedures in place for the shift supervisor to review the sick calls no longer than four hours after the request is placed. Two of the five reviewed youth individual health care records (IHCR) reflected youth placed a sick call since arriving to the center. One additional applicable IHCR was reviewed for sick call. Sick call progress notes are documented to include all elements of subjective, objective, assessment, and plan (SOAP) format. One of the three youth IHCRs reflected documentation in which the youth presented a similar complaint three or more times in two weeks. In this instance, a referral was made to the designated health authority (DHA). Five youth were interviewed regarding sick call. Five of five youth reported they are seen within one day of making a sick call request. According to an interview with the registered nurse (RN), youth are seen immediately once placing a sick call. The RN further reported all sick calls are reviewed by the clinical manager (RN) and put on the DHA/designee list for review as needed.

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

The center has a written policy and procedures addressing the sick call process. Two of the five reviewed youth individual health care records (IHCR) reflected youth placed a sick call since arriving to the center. One additional applicable IHCR was reviewed for sick call. Documentation in the IHCRs reflected all three of the youth's sick calls were conducted by a registered nurse (RN) and documented on the Facility Management System (FMS) generated sick call log, which was signed by youth and staff, indicating the youth was seen. Sick call was observed during the annual compliance review. The youth was escorted to medical by a juvenile justice detention officer (JJDO). Consent was granted by the youth prior to the observation of sick call. The registered nurse (RN) identified himself and stated why they youth was brought to medical. The youth was examined in the medical clinic behind a curtain where privacy was maintained. The JJDO was present in the clinic, close enough to provide security, but far enough away for the youth's privacy to be maintained. Five youth were interviewed in regard to who conducts sick call. All of the youth, as well as five interviewed staff, reported the nurse conducted sick call.

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

Two of the five youth individual health care records (IHCR) reviewed were applicable for restricted housing. One additional applicable IHCR was reviewed. Three of three IHCRs reflected documentation of nursing staff visiting youth in confinement daily to ask about any health-related complaints. In one case, treatment was necessary, and a detailed narrative was found in the IHCR. Two of the three youth IHCRs reviewed were applicable for prescribed medication and both IHCRs reflected the youth received medication, as ordered and on time. There were no youth in confinement/restricted housing observed during the annual compliance review. According to an interview with the registered nurse (RN), youth observed in confinement are asked questions by medical staff to ascertain their condition. Further, the RN reported if a juvenile justice detention officer (JJDO) will notify medical if necessary.

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

The center has a written policy and procedures outlining the process as it relates to episodic care, first aid procedures, and interventions for youth. The center has an on-site tracking log for episodic care. Three of the five youth individual health care records (IHCR) were applicable for instances of episodic care. In one of three records, a determination was made for the youth to be sent off-site the same day for emergency services. The two remaining youth were treated on-site, with one of the two needing a referral for off-site care. In all three records, documentation reflected the date/time of episodic care, nature of the complaint, findings of the person rendering care, referral to off-site care (if needed), education and instruction to youth (if needed), plans for follow-up, placed on alert list (if needed), parental notification, and the name, signature, and credentials of the staff providing care. A review of the episodic care log was conducted for the previous six months and matched up with the events documented in the three applicable IHCRs. Episodic care provided by the center's medical staff conforms to professional standards

and contains documentation with all elements of subjective, objective, assessment, and plan (SOAP) format. The center has thirteen first aid kits on-site which are all inaccessible to youth. The kits are fully stocked, monitored monthly, and replenished as needed. According to an interview with the registered nurse (RN), first aid kits are located on the mods, in master control, medical, and the kitchen. The RN reported the first aid kits are monitored monthly.

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

The center has a written policy and procedures establishing a process for providing emergency care or responding to an emergency situation. The center has an Automated Eternal Defibrillator (AED) located in the main hallway just outside of master control. AED instructions/procedures are located inside the secure box the AED is housed in. A licensed practical nurse (LPN) conducts monthly check on the AED to ensure it is operational. A test was conducted in front of the regional monitor during the annual compliance review. The batteries in the AED expire in February of 2023. The batteries were last changed in October of 2017. The pads in the AED expire in June of 2019. The pads were last changed in November of 2017. According to the written policy and procedures, medical drills should be conducted quarterly and on each shift at a minimum. Additionally, not all drills must include cardiopulmonary resuscitation (CPR), but those techniques must be practiced on a regular basis and at least once a quarter or once on each shift, every year. The center conducted twenty-nine medical drills since the last annual compliance review, which is seventeen more than the required quarterly drills for each shift. The center consistently practices monthly medical drills on each shift. Both CPR and AED demonstration were practiced in accordance with the center's written policy and procedures. Drill documentation included the following information: type of event simulated, time of event, actual time 9-1-1 called, name of supervisor/health care provider "in charge," health care provider response time (if on-site), direct care response time, person concluding drill, time event was concluded, drill deficient practices and plan for rectification, and clinical manager/medical staff review a critique. Emergency numbers, including the statewide Poison Information Center, are located in master control, the shift supervisor office, medical office, and staff conference room, which are all inaccessible to youth. Five non-licensed health care staff training records were reviewed, and each had a CPR/AED/first aid certification and received the required annual training. All licensed medical staff at the center had valid CPR/AED certifications. According to an interview with the registered nurse (RN), the AED is located outside of master control, has instructions with it, and is checked monthly by the LPN. The RN further reported if staff provides first aid/emergency care to a youth it is documented on the report of on-site health care by non-licensed health care staff. Additionally, the RN reported youth who are sent off-site for emergency care are tracked in the episodic log. All five interviewed staff reported they can contact 9-1-1 when they feel it is necessary.

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

The center has a written policy and procedures outlining the process for timely referrals and coordination of medical services to an off-site health care provider for emergency and non-emergency services. One of the five youth individual health care records (IHCR) were

applicable for off-site care. Two additional applicable IHCRs were reviewed for off-site care. The Summary of Off-site Care forms were observed in all three IHCRs, as well as discharge paperwork. Two of the three youth reviewed were referred were documented as emergency care and, in each case, the designated health care authority (DHA) was notified. The off-site emergency care was documented on the episodic care log. The DHA or designee reviewed and signed/initialed all off-site care instructions. Only one of the three youth required follow up care and this referral was tracked by entering it on the Sick Call Log.

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

The center has a written policy and procedures to ensure youth who have chronic illnesses receive regularly scheduled evaluations and follow-up, if necessary. Three of the five youth individual health care records (IHCR) reviewed were applicable for chronic conditions. None of the youth are currently taking prescribed medication, but all three are receiving treatment for a physical health condition. All three youth were classified as a medical grade "1." None of the youth are pregnant or taking anti-Tuberculosis medication. All three youth have been placed on the center's chronic conditions list. Documentation in the chronological progress notes for all three youth reflected periodic evaluations. All three youth's treatment orders were written so they are clearly distinguishable for clinical staff. None of the three youth reviewed were applicable for off-site care and there were no indications of lapses in care or missed periodic evaluations. In all three records, the Department's Problem List was updated. According to an interview with the registered nurse (RN), chronic illnesses are tracked by using the center's Chronic Illness Log.

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

The center has a written policy and procedures addressing medication verification. Three additional youth individual health care records (IHCR) were reviewed as none of the five youth selected were applicable for the review of prescribed medication. All three reviewed youth IHCRs reflected youth were taking prescribed medications upon admission to the center. Documentation reflected youth medications were verified by the parent/guardian upon admission to the center. All three IHCRs reflected documentation in which the licensed health care staff member contacted the community provider to verify the prescribed medications. Three of three youth IHCRs reflected orders were obtained by the designated health authority (DHA) to continue the prescribed medications. In the event a licensed nurse is not on-site, the center has a written facility operating procedure (FOP) nursing protocol developed by the DHA permitting trained non-licensed staff to verify medications and assist with self-administration. The center maintains a list of approved non-licensed staff members who are allowed to assist with medication administration. Each staff member has received medication administration training, which was led by a registered nurse (RN). According to an interview with the RN, medications are verified by contacting the youth's parent's, the pharmacy, and local primary care provider.

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

The center has a written policy and procedures for addressing medication orders and prescriptions. Three additional youth individual health care records (IHCR) were reviewed as none of the five youth selected were applicable for the review of prescribed medication. All three youth records reflected they were taking prescribed medication upon admission to the center. In all three IHCRs reviewed, the initial medication administration record (MAR) matched the medication lists. Each of the three youth's medications had a current, valid order and were given pursuant to the current prescription. Documentation reflected continuation of prescribed medication by the designated health authority (DHA) subsequent to admission to the center. One of the three youth IHCRs reviewed had over-the-counter medications not listed on the Authority for Evaluation and Treatment (AET).

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

The center has a written policy and procedures addressing the storage of medication. Medications are to be kept in a separate, locked area designated for the storage of medication which is inaccessible to youth. The medications were observed to be stored behind two locked doors, in a cart, which also stays locked. The center has staff, designated in writing, who is allowed access to the medical clinic and medication storage area. Medications are stored by type/form. Medications requiring refrigeration were observed stored in a secured refrigerator, which is for medication only. Syringes and sharps were observed to be secured. The center has an agreement with Stericyle, Inc. for the disposal of biochemical waste which meets federal regulations, sections 1307.21 and 1910.2030, and guidelines set forth by the Florida Department of Environmental Protection (DEP). The center maintains a log for expired and discontinued medications. Each month, medical staff use a non-hazardous medication destroyer (Rx Destroyer) for the destruction of expired or discontinued medication.

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

The center has a written policy and procedures outlining the process for inventory of medications and sharps (including narcotics and psychotropics). All medical equipment classified as sharps were observed to be securely stored. A perpetual inventory and weekly inventory of all sharps were available for review. A daily perpetual inventory of medication utilization for all prescription and over-the-counter (OTC) medications was observed. A weekly inventory of all opened OTC medications was reviewed. The written policy and procedures outlines the process for responding to inventory discrepancies. Inventories were reviewed for the previous six months during the annual compliance review. A random selection and count of three different sharps, three different prescribed medications, and three different OTCs. No discrepancies in the counts were noted.

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

The center has a written policy and procedures addressing the storage and inventory of controlled medications. Narcotics and other controlled medications were observed to be stored securely behind two locks. A log of shift-to-shift counts was available for review. Inventories for controlled medications were reviewed for the previous six months and reflected documentation of two signatures twice daily on the counts. The counts for medications remaining after each administration are documented on the youth's individualized Controlled Medications Inventory record. Only two youth at the center are currently taking controlled medications. Both controlled medications were counted by the nurse and matched the counts on the inventories.

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

The center has a written policy and procedures outlining the process for usage of the Medication Administration Record (MAR). Two of the five youth individual health care records (IHCR) reviewed were applicable for a review of the MAR. One additional IHCR was reviewed. Two of the three applicable IHCRs reflected youth were not taking medication upon entry to the center, one reflected the youth was. The standard Department MAR was found in all three IHCRs. Each MAR contained the required elements to include: youth name, date of birth, Department identification number, youth allergies, precaution, medical grade, medical alerts, and current picture. Each MAR clearly indicated the start and stop dates for medication. Staff initials were observed on each entry of medication administered, as well as youth's initials when medication was administered by non-health care staff. Each of the three MARs reflected youth received medication, as ordered. There were no indications of lapses/errors in medication administration for the three youth reviewed. Two of the three youth MARs reflected refusals were properly documented; one youth did not have any instances of refusals. None of the youth IHCRs reflected youth were taking parenteral medication.

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

Medication administration is conducted at the center daily. Medication delivery is the sole responsibility of licensed medical staff. The licensed medical staff administering medication are not required to conduct or supervise any other center activities while administering medication. Medication pass was observed during the annual compliance review, in which three youth attended. Youth requiring medication pass were escorted one at a time to medical by a juvenile justice detention officer (JJDO). The registered nurse (RN) conducting medication pass was not observed pre-pouring any medications. The youth approached the medication cart one by one. The RN verified the Five Rights of Medication Administration for each youth attending medication pass and allergies and alerts were verified for each youth prior to administering the medication. In each instance observed, staff initialed the Medication Administration Record (MAR), youth did not, as youth's initials are not required if a nurse is administering medication.

Five youth were interviewed in regard to medication administration. One youth reported the nurse administers medication and four reported they do not take medication.

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

The center has a written policy and procedures which outlines the process for medication administration by non-licensed staff. The center maintains an up-to-date list of non-licensed staff trained to assist with the self-administration of medication. Training for each of these staff members was conducted by the registered nurse (RN). There was no observation of non-licensed staff administering medication during the annual compliance review. Five youth were interviewed in regard to medication administration. One youth reported the nurse administers medication and four reported they do not take medication. Two of five interviewed staff members reported they administer medications. Three staff reported they do not administer medications to youth.

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

The center has a written policy and procedures outlining the process for monitoring the usage of psychotropic medications. None of the five youth individual health care records (IHCR) were applicable for psychotropic medications; therefore, three additional applicable IHCRs were reviewed. All three applicable IHCRs reflected youth were taking psychotropic medications upon admission to the center. In each instance, documentation reflected the designated health authority (DHA) and psychiatrist were notified. Documentation in the admission chronological progress note completed by the nurse reflected all three youths' medications were verified by the parent/guardian by telephone. Each IHCR indicated psychotropic medications were continued until the psychiatrist conducted an initial diagnostic review. An initial diagnostic psychiatric interview was conducted for all three youth within fourteen days of admission. In the event youth who are prescribed psychotropic medication are in the center for thirty days or more, a medication monitoring/review will be conducted by the psychiatrist every thirty days. None of the youth reviewed had been in the center for thirty days. There were no standing, emergency, or pro re nata (PRN) orders for psychotropic medications.

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

Based on a review of five youth individual healthcare records, infection control training is provided to each youth upon admission. The center has developed infection control procedures which include the prevention, containment, treatment, and reporting requirements for addressing all required categories of diseases. Five staff training records were reviewed and

found evidence each staff received training for Universal/Standard Precautions. The center reported not having three or more records of reportable infectious diseases during the scope of the annual compliance review. The superintendent is responsible for establishing a separate record containing all documentation of youth and staff who have experienced a facility/occupational exposure. All records are maintained confidentially for a period of ten-years. There were no instances in which the local county health department, Centers for Disease Control and Prevention, and/or Central Communications Center (CCC) should have been notified of an infectious disease. A copy of the center's Exposure Control plan is available to all staff. In addition, Hepatitis B immunizations are available to all staff, as indicated by interview with the center's registered nurse.

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

Five youth individual healthcare records were reviewed for evidence of infection control education. All five records found evidence each youth received this training within seven days of their admission to the program. Two youth received the training on the day of admission. Three youth received it the following day of their admission. The infection control education included information for hand washing techniques, Universal/Standard Precautions, Prevention/transmission of communicable diseases, vaccinations, and Center for Disease Control (CDC) guidelines for infection control. Five pre-service and in-service staff training records were also reviewed and found evidence each staff received training on the center's specific Exposure Control Plan. The plan was observed available to all staff. Infection control training is conducted by the registered nurse.

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

The center has an exposure control plan which is written in accordance with the Occupational Safety and Health Administration (OSHA) standards. The plan includes a risk assessment and list of all job classifications in which staff have the potential for occupational exposure, and a list of procedures which would case the staff in the job classifications to have occupational exposure. The exposure control plan also includes the method of staff compliance concerning infection control practices for hand washing techniques, proper disposal for needles and sharps, procedures for maintaining a clean and orderly work site, usage of specified signs and labels to communicate hazards to staff, procedures for handling contaminated laundry, procedures for post-exposure evaluation and follow-up, and a system of medical records keeping for staff with occupational exposure. The review of the exposure control plan found it was reviewed and signed by the superintendent.

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

The center has written policy and procedures for youth who require prenatal care, which indicate the care will begin immediately upon determination a youth is pregnant. Observations of youth living areas found no youth rooms have bunk beds which would pose as a potential danger for pregnant youth. The center had one youth who was applicable for prenatal care during the scope of this annual compliance review. Based on a review of this youth's individual healthcare record, the youth's prenatal care began immediately after determination was made of the youth's pregnancy. Prenatal care was conducted at recommended intervals. The designated health authority (DHA) conducted a medical evaluation for the youth at least every thirty days. A review of the record found the youth had no complaints of issues related to the pregnancy. The record did indicate daily monitoring for danger signs of pregnancy complications by the licensed healthcare staff. The youth was not applicable for a documented plan for post-birth psychological or physical care.

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

The center had one youth who was applicable for requiring prenatal care, during the scope of the annual compliance review. A review of this youth's individual healthcare record found evidence the youth received prenatal, post-partum, and parenting education, which included the following topics: Alcohol and Drug Use, Smoking, Nutrition, Sexually Transmitted Diseases (STD), Contraception, Birthing Process, Basic Baby Care, Child/Infant Development, and Parenting Skills. There was evidence in the record the youth received nutritious foods and in appropriate quantities, as well as routine monitoring of the youth's nutritional and weight status by the licensed healthcare staff. All education was observed documented in the Individual Healthcare Record. An interview with the center's registered nurse (RN) revealed services provided for pregnant youth include education, meals, appointments with obstetricians, and prenatal vitamins. Pregnant youth are provided special diets. The RN also indicated pregnancy education packets are provided all pregnant youth.

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

The center has licensed healthcare staff who provide in-service education on healthcare of female youth to all non-healthcare staff involved in the supervision and treatment of girls. A review of five staff training records found evidence each staff received annual training for these related education topics.

Standard 5: Safety and Security

Overview

All staff and youth movement is monitored, controlled, and authorized by master control. Ten-minute checks are conducted by staff utilizing visual observations, paper, and an electronic wand system downloaded to a computer. Youth counts are conducted, at a minimum, of three times each shift, the beginning, mid, and end of the shift, and documented in the module and master control logbooks. A lock box is in the superintendent's office, which is where the master keys are located, and the log is kept by the maintenance man. Upon entry to the center, staff place their personal keys in their personal lockers in the briefing room. If staff do not have a personal locker, their keys are given to master control in exchange for a number. All detention keys are issued from master control and logged. Shift supervisors conduct the fire, escape, and Continuity of Operations Plan drills. Maintenance personnel track the vehicle maintenance, tool inventory, and any replacement of tools and documents this in the log in the corresponding area. Logs for all flammable, toxic, and caustics materials are kept in accordance to the Occupational Safety and Health Administration (OSHA) guidelines. Maintenance personnel are also responsible for the disposal of any toxic and hazardous materials.

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

Youth supervision was observed through the closed-circuit television (CCTV) system from master control, as well as physically observed from both boys' and girls' modules, dining hall, movement in the main hallway, medical, intake and transportation areas. Youth were accompanied by staff and in sight by a minimum of one staff at all times. Staff were observed requesting, by radio transmission, to move youth from location to location, as well as master control directing and controlling the movement. Counts were conducted at the beginning, middle, and at the ending of the shifts. Logbook reviews documented the counts and movements. Five staff were interviewed and all five believe there have been enough staff at the center to provide safety and security for both the youth and the staff. When asked when counts are completed, all five staff reported at the beginning of the shift and at the end of the shift.

Three of five staff stated they do count in the middle of the shift. One staff added a count is conducted before and after school, another staff stated they do a count before and after meals. One of the five staff said a count is conducted after a release of admission to the center or transportation of a youth off-campus occurs. If the count is not correct, all staff said a re-count is requested, movement would be stopped, and if necessary a Code Green would be called.

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

The center has a total of sixty-four cameras, all operating, which can store video recordings for up to thirty days. Ten-minute checks conducted on August 26 and 30, and September 6 and 13, 2018 for a total of two hours were reviewed utilizing closed-circuit television (CCTV) and found no discrepancies. Checks are conducted by Visual Observation Reports (VORs) and the Silver Guard System (Wand). The Silver Guard system is downloaded nightly, and the information is transferred to paper log document. Observations of two youth on different days on confinement status was observed every ten minutes, as required. Five staff were interviewed, and all five staff stated room checks are to be conducted when a youth (non-suicidal) is placed in their room for sleeping or non-punishment reasons every ten minutes.

5.03 Census, Counts, and Tracking	Satisfactory Compliance

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

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

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

A review of the census in Facility Management System (FMS), accurately reflected the number of youth inside the center. A review of the logbooks yielded counts are documented and tracked correctly to include at the beginning and end of each shift, following routine group movements, randomly once on each shift, following an emergency, and after all admissions and releases. Observations were made of counts being conducted in accordance with policy and procedures. Each of the five interviewed staff reported emergency counts are conducted when a youth is believed to be missing, when visibility is hindered, and after a major disturbance. One staff added an emergency count can take place whenever master control deems necessary.

5.04 Logbook Maintenance	Satisfactory Compliance

The program maintains a chronological record of events, incidents, and activities in logbooks maintained at master control and in each living area in accordance with Florida Administrative Code. Each logbook is a bound book with numbered pages. If electronic logbook software is used by the facility, it is password-protected and configured to prevent entries from being deleted or altered after they are saved.

At a minimum, each logbook entry includes the date and time of the event, the names of staff and youth involved, a brief description of the event, the initials of the person making the entry, and the date and time of the entry. Logbook entries are made in black or blue ink, with no erasures or whiteout areas. No logbook entries are obliterated or removed; errors are struck through with a single line and initialed by the person correcting the error.

Log entries regarding Medical, Special Needs, and Mental Health alerts, or other issues impacting facility safety and security shall be highlighted.

A review of logbooks from master control and modules found the logbooks captured all of the required information and were numbered in sequential order with no missing pages. All logbooks have clearly documented dates, times, locations, officer names, youth names, and the initials of officer entering the comment. Logbook entries were logged in blue or black ink and drills, and reviews from staff, codes, admissions, releases, contact with the Florida Abuse Hotline and Central Communications Center, and emergency incidents were highlighted correctly. There were no white out or obliterated entries found. The master control logbook included all the emergency situations, Protective Action Response (PAR) incidents, Florida

Abuse Hotline calls, Central Communications Center (CCC) contact, drills, alerts, populations counts throughout the shift, youth counts and movements, admissions and releases, presence of law enforcement, youth placed in confinement with the times, and youth placed on precautionary/secure observation with the times.

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.*	

Logbooks from master control and both modules were reviewed for the past six months. The superintendent/designee reviewed all logbooks weekly and provided recommendations as to the completeness and accuracy of the information in the book. Juvenile justice detention officer supervisors (JJDOS) reviewed the logbooks in master control and both modules when assuming responsibility. The juvenile justice detention officers (JJDO) reviewed the logbook when assuming responsibility of the module at the beginning of the shift. Documentation showed the superintendent, assistant superintendent, or the person in charge of the center visited each module at least once during each shift and documented the visit in the logbook on the module. JJDOs, JJDOSs, and administration documented their reviews and their acknowledgement of critical information regarding youth, safety, and security.

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

The center has a written policy and procedures regarding key control. Observations of the key rings on the inventory match the actual key rings in use. A review of the key box located in master control and all keys not in the key box were matched with the key logbook to ensure compliance and no discrepancies were found. All center keys are maintained on a tamper-resistant ring. Master keys are stored in the superintendent's office, where only the

superintendent and assistant superintendent have access. Keys are accounted for twice during each shift and anytime there is a change in assignment to master control. All officers leave their personal keys inside their personal lockers, outside the secure area of the center. All support staff bring their personal keys to master control where they are secured, in return the master control officer issues a chit. Upon departure, support staff issue the chit back to master control to get their personal keys back. Support staff are not permitted to go anywhere inside the center with their personal keys.

There have been no incidents of lost keys or staff leaving the center with the center's keys in the past six months. The master key inventory is maintained and includes the ring number, number of keys, capability of each key, and the whom the key ring was issued. The issuance of keys is documented on each shift with the date and time of issue, name of staff issuing the key ring and to whom, and the time key ring was returned. All employees must receive training in key control prior to receiving center keys, be responsible for those keys and account for those keys at all times during their shift, carry the keys on them at all times, no youth is allowed to handle center keys, and do not leave the center with the keys without authorization from the superintendent. If staff leave the center with keys, they are to notify the shift supervisor immediately and return the keys within two hours of being notified. If keys are lost, staff are to immediately notify the supervisor on-duty in a way youth cannot overhear. Five staff were interviewed and all five staff reported medical, youth property area, mental health, and kitchen keys are all restricted. Two of the five staff stated the case management record keys were also restricted. Four of the five staff replied with other, three specifying the supervisor keys, one stating master control keys, one stating administration keys, and one adding maintenance, vehicle and storage locker keys. When the five staff were asked what the center's daily process is for tracking keys is, all five replied center keys are assigned to staff and logged in the key log, as well as master control conducting an inventory of the keys. As for visitors, all five staff stated that they are to turn their keys into master control in exchange for a chit. If keys go missing, all staff stated that master control is notified and the center, as well as the youth, are searched for the missing keys. All staff stated youth are not allowed to have access to keys. One staff stated staff keys are given to master control upon entry. Three of five staff reported personal keys are securely stored and four said visitor's personal keys are given to master control upon entry. One staff added personal keys are in their locker and some visitor keys are in the lockers out front. Two more staff also added personal keys are kept in administration in lockers. One staff said keys are counted prior to off going shift and every shift change there is a formal count of the keys and documented in the key log.

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

The center has five vehicles, and all vehicles were found to be locked and secured when not in use. All vehicles had an annual inspection by a certified mechanic. The maintenance staff conducted weekly visual checks on the water coolant, lights, oil, emergency equipment, brakes, horn, and cleanliness. The maintenance staff also conducts a monthly visual check on tires, battery, windshield and wipers, and mirrors and maintains documentation of the inspections on the mandatory inspection form. A review of the vehicle logbooks clearly documented vehicle

inspections, transportation and mileage, youth names being transported, as well as identifying the staff member assigned to ride in the back of the vehicle when there was more than one youth being transported. Observation of one transport was able to take place during annual compliance review . The vehicle was equipped with the appropriate number of seatbelts, a seatbelt cutter, window punch, fire extinguisher, and a first aid kit. Staff completed the vehicle inspection, as well as youth and vehicle searches prior to transporting the youth and returning with the youth. Seatbelts were observed being worn properly by both the staff and youth. This action was called into master control through radio transmission to be logged as the official vehicle inspection.

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

A review of the center's policy and procedures regarding missing or damaged items require the superintendent or designee to identify, number, and ensure the item is removed/placed on tool inventory accordingly. An interview with the maintenance staff included line by line review of tool inventory to account for all items assigned to the center. All tools are numbered, which coincide with the tool inventory sheet and are stored in a locked area. All tools are marked with an identification code identifying the tool as Department property. There were no tools listed as missing or not listed on the inventory. Service vendors are always accompanied by designated center staff at all times when in a secure area of the center. An inspection of tool areas was completed and submitted to the superintendent monthly. There is a sign-in sheet completed for the use of all tools.

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

All tools are secured in a shadow box located in the food service director's office, which is also secured. All kitchen knives and sharps are stored in locked cabinets or toolboxes containing an inventory and are accounted for daily. An inventory of all tools to include the issuance and return of those tools was conducted. In interviewing food service staff, they were able to identify in accordance with the policy, accountability of all tools at the beginning and ending of each shift.

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

All five interviewed staff reported the only tools youth can use in the center are mops and brooms. Four of five youth interviewed also stated they are only allowed to use mops and brooms while at the center. One youth reported they are not allowed to use any tools. When the five youth were asked if they clean with any type of cleaning agent such as bleach, laundry soap, window or toilet cleaners, two youth replied yes. Those youth stated the staff put the bleach in the mop bucket and then they mop, or staff sprays the sink and then they wipe it down. Chemicals are secured in closets away from youth access. There was no observation of any youth using chemicals during the annual compliance review.

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

Chemicals were inventoried and are stored in secure areas, both inside and outside, not accessible by the youth. The center's inventory matched the actual items on-site. After reviewing the Safety Data Sheets (SDS) and the center's internal chemicals policy and procedures, all items were observed to have been signed in/out appropriately. All locations where chemicals are stored contain a SDS book to reference each chemical stored inside and outside the center.

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

All chemicals are secured, not accessible by the youth, in accordance with the center's policy and procedures. A review of the chemical inventory sheet was conducted, which identified each chemical issuance and return and is in accordance with the center's policy. All five interviewed staff stated no youth have access to clean with any substance which is toxic, flammable, or poisonous. Two of five interviewed youth reported the staff put the bleach in the mop bucket and then they mop, or staff sprays the sink and then they wipe it down.

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

The center's method of disposing flammable, toxic, caustic, and poisonous items was verified by reviewing the policy and procedures, as well as interviews with both administrators and maintenance staff. The center has five mop sinks/ drain areas located on each of the three youth modules, in the kitchen, and one in the hallway closet. These areas were clean, organized, and free from any open or exposed chemicals. The center reports no chemical spills or disposal of flammable, toxic, caustic or poisonous items in the past six months. Detention centers do not utilize fryers, therefore do not need a container designated for grease.

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

A review of five confinement records all appeared to follow policy and procedures. All five had the confinement room searched prior to placement. The confinement reports were completed within one hour and submitted to the juvenile justice detention officer supervisor (JJDOS), who reviewed the report within two hours for fairness and appropriateness. The JJDOS also reviewed each report and spoke with the youth every three hours. The superintendent/designee reviewed confinements within forty-eight hours, and the confinements were communicated with school personnel. None of the youth were continued on confinement due to the severity of rule violation, past disciplinary history or behavior in confinement. All confinement room windows and cameras were free from obstruction, had no non-fixed items, and youth had no contact with the general population. Youth placed in confinement were afforded the same living conditions, hygiene items, meals, education, and bedding as general population youth. A review of the Facility Management System (FMS) yielded all supervisor reviews, initial and subsequent, were completed timely and included supportive documentation for continued confinement or removal.

The superintendent/designee reviewed all confinements within the required timeframe to include the need to continue or discontinue the confinement. Five staff were interviewed and all five responded when a youth is placed in confinement, you must complete a confinement report, conduct and document ten-minute checks, and search the confinement room. Three of five staff reported you must notify master control, and have it put in the logbook, document the youth's behavior, and search the youth for contraband.

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

A review of seven confinement records all appeared to follow policy and procedures. The confinement room was searched prior to placement, confinement was approved by the superintendent/designee, confinement was approved every twenty-four hours after placement by regional director, and the juvenile justice detention officer supervisor (JJDOS) conducted the three-hour evaluation and conversation and documented the need for continued confinement. No confinements were beyond three days. Youth placed in confinement were afforded the same living conditions, hygiene items, meals, education, bedding, as general population youth. A review of the Facility Management System (FMS) yielded all supervisor reviews, initial and subsequent, were completed timely and included supportive documentation for continued confinement or removal. The superintendent or designee reviewed all confinements within the required timeframe to include the need to continue or discontinue the confinement, as well as document approval from the regional director.

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

A review the center's policy and procedures, as well as drills were all found to be in compliance. Drills included the relocation request, evacuations, and communication with probation to have all eligible youth released on home detention. There were drills conducted prior to and after the hurricane season, one drill each year is completed and sent to regional office as part of a

detention-wide scenario. All drills were logged into the master control logbook, as well as the required drill reporting form. All drills were reviewed by the superintendent and medical and mental health staff. Five of five staff reported they have participated in a fire drill and escape drill within the past six months. Three staff said they were involved in a weather drill. Four staff stated they participated in a major disturbance drill in the past six months. Two staff were in a bomb threat and hostage situation drill. One of five staff said they were involved in a flooding, terrorism, and chemical spill drill this past six month.

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

Drills were completed quarterly and signed by staff as required. All staff completed in-service training in escape prevention, as documented in the Department's Learning Management System (SkillPro), annually. All drills were logged in the master control logbook. All five interviewed staff knew the policy requirements for an escape, although they could not articulate the steps in sequential order. All drills were reviewed by the superintendent and medical and mental health staff.

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

Fire drills are conducted monthly on each shift, which follows policy and procedures. The procedures for the center have been approved by the local fire official. Drills were documented in master control logbook to include the date, time, number of youth evacuated, and the evacuation location. Annual fire inspections, including sprinkler, backflow, and fire alarm system were completed and up-to-date. Evacuation routes are posted in all youth accessible areas, as well as in administration, the training room, multipurpose, master control, intake, kitchen, and the front lobby. All drills are reviewed by the superintendent, medical, and mental health staff. Four of five interviewed staff stated fire drills were conducted monthly. Two of five youth interviewed said they have been instructed on what to do in the case of a fire.

Program Name: Okaloosa Regional Juvenile Detention Center
Provider Name: State Operated
Location: Okaloosa County / Circuit 1
Review Date(s): September 25-28, 2018

MQI Program Code: 828
Contract Number: N/A
Number of Beds: 30
Lead Reviewer Code: 166

Overall Rating Summary

Overall Rating Summary
All indicators have been rated Satisfactory and no corrective action is needed at this time.