STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Orange Regional Juvenile Detention Center

Department of Juvenile Justice
(State-Operated)
2800 S. Bumby Avenue
Orlando, Florida 32806

Review Date(s): March 24 - March 27, 2020

Promoting Continuous Improvement and Accountability
in Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Tamara Mahl-Adkins, Office of Program Accountability, Lead Reviewer (Standard 1, 4, and 5)
Teresa Andersen, Office of Program Accountability, Regional Supervisor (Interviews and Standards 4 and 5)
Paul Czigan, Office of Program Accountability, Regional Monitor (Standard 4)
Gustavo Mazzora, Office of Program Accountability, Regional Monitor (Standard 2)
Margie McKinney, Brevard Regional Juvenile Detention Center, Superintendent (Standard 5)
Bonita Williams, Office of Program Accountability, Regional Monitor (Standard 3)

Program Name: Orange Regional Juvenile Detention Center
Provider Name: State Operated
Location: Orange County / Circuit 9
Review Date(s): March 24 – 27, 2020

MQI Program Code: 247
Contract Number: N/A
Number of Beds: 110
Lead Reviewer Code: 156

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
3.12 Suicide Prevention Training*	

Standard 1: Management Accountability
Detention Rating Profile

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

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

Standard 2: Youth Management
Detention Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Detention Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Detention Rating Profile

Indicator Ratings

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

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Program Overview

The Orange Regional Juvenile Detention Center is a state-owned detention facility, operated by the Department, located in Orlando, Florida. The center serves youth in Orange and Osceola Counties in Circuit 9. Male and female youth who are detained pending adjudication, disposition, or placement in a residential commitment program are housed in the 110-bed center. Youth are provided services which include youth orientation, behavior management, safety and emergency procedures, transportation, mental health, and healthcare services. The center's educational services are provided by the Orange County School Board. The center's management team includes the superintendent, three assistant superintendents, one administrative assistant, eleven juvenile justice detention officer supervisors (JJDOS), and seventy-eight juvenile justice detention officers (JJDO)s. Mental health and healthcare services are provided through the contracted provider, Camelot. Mental health services are provided by one psychiatrist, one designated mental health clinical authority (DMHCA), two licensed mental health professionals, and four non-licensed mental health professionals. Clinical services provided by the center include mental health and substance abuse evaluations, mental health treatment planning, individual, group, and family therapy, mental health crisis intervention services, on-site psychiatric services, and availability for substance abuse services for youth with co-occurring disorders. Medical services are provided by one registered nurse (RN), three licensed practical nurses (LPN), one medical doctor (MD), and one advanced practice registered nurse (APRN). A review of the health care staff's credentials revealed each medical professional's license was current with the Department of Health, Bureau of Medical Quality Assurance. The medical clinic maintains nursing coverage seven days a week, eight hours a day. Food services are provided by Department staff and include menus, meal planning, meal schedules, special diets, nutritional analysis, daily allowance, food preparation, health certifications, food product standards, sanitation, and cleaning. Staff are responsible for the custody and control of youth in their care, providing youth supervision twenty-four hours a day, seven days a week. The center has six living modules which are divided by male and female. There are 154 security cameras at the center, of which 147 were operational. At the time of the annual compliance review, the center had seven vacancies, which included one administrative assistant, one superintendent, one JJDO II , three JJDO I , and one JJDOS.

Standard 1: Management Accountability

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

Thirty-five staff personnel records and one volunteer record were reviewed, and all had a background screening completed prior to the hire/start date. Four of the thirty-six reviewed records required an exemption prior to working with youth; which was obtained. All thirty-five direct-care staff had a pre-employment assessment tool administered prior to the hire date and the passing score was maintained in each personnel record. The Annual Affidavit of Compliance with Level 2 Screening Standards was completed and sent to the Background Screening Unit (BSU) on January 24, 2020; prior to the January 31st deadline. The annual screening for the teachers, who are paid by the Orange County School Board or the Department of Education, was completed on January 24, 2020.

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

The center had one staff eligible for a five-year background rescreening. The background rescreening was submitted to the Background Screening Unit (BSU) at least ten business days prior to the five-year anniversary, as required.

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

A total of three disciplinary actions and management responses were reviewed. One staff was dismissed, one received retraining, and another resigned as a response to the investigation findings. All three staff who received a disciplinary action, as well as all thirty-five new staff who had been reviewed for initial background screenings, had signed the code of conduct at the time of hire and it was maintained in the staff record. A review of the last six months of commendations indicated staff received employee of the month and staff of the year rewards. Most of the commendations were mentioned in the Department's newsletter with pictures on the wall in the center's conference room.

Seven youth were interviewed and asked if staff were respectful when talking with them and other youth. Six indicated yes and one stated sometimes staff are not respectful and scream at the youth; often times there is no valid reason. All seven youth indicated they had never heard staff threaten or use curse words when speaking with them or other youth.

Seven staff were interviewed. Two indicated they had never observed a co-worker using profanity when speaking to youth and the other five stated occasionally they have. The staff stated staff use curse words around the youth; however, it is not directed at them. None said they had ever observed a co-worker using threats, intimidation, or humiliation when interacting with the youth. When the staff were asked how the working conditions had been at this center in the last year, one indicated fair, five good and one very good.

The superintendent was questioned regarding what is included in the center's employee code of conduct and what actions are taken if physical abuse, threats, or profanity towards the youth is used, as well as examples of staff disciplinary action. He indicated the staff must adhere to the code of conduct which prohibits any form of abuse, profanity, threats, intimidation, or personal relationships. If any officer is found to have violated this policy, progressive discipline, removal from youth contact, or more severe actions could be warranted.

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

The center had a total of thirty-seven incidents reported to the Central Communications Center (CCC) in the last six months. Five reports were reviewed. Four of the incidents were reported within the required two-hour timeframe of when the center became aware of the event. The remaining one incident was reported to the CCC one day late and the staff involved received retraining on the requirements of reportable CCC calls. All five incidents were found to be documented in the logbook. A review of additional internal incidents/grievances indicated there were no additional incidents which were required to be reported. The center had a total of seventy-five CCC reports since the last annual compliance review, which was a decrease in the number of reportable incidents from the previous annual compliance review period.

The superintendent interview indicated all reportable incidents must be reported to the CCC within two hours. All incidents include the basic information such as who, what, when, where, and how. If a youth is involved in the incident reported, their information must also be reported. Examples of reportable incidents are program disruption, escape, medical incidents, and complaints against staff.

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

The center had 246 protective action response (PAR) reports in the last six months. A total of twenty-five reports were reviewed. Three of the twenty-five reports were not completed by the end of the staff member's workday due to one participant not completing the statement on the same day. The remaining twenty-two reports were completed in a timely manner. One of the twenty-five reports was missing one staff participant statement. None of the incidents required mechanical restraints, nor did the PAR result in a serious injury to the youth or staff, and none of the youth alleged abuse. All reports were reviewed by a supervisor and a PAR instructor to determine if use of force was consistent with policy. A post-PAR interview was also conducted with the youth by an administrator or designee, within thirty minutes after the incident occurred. None of the reports indicated a PAR medical review was required; however, three of the twenty-five reports had a PAR medical review conducted. The center marked the box indicating a medical review was not required; however, the box was marked by mistake. In all three PAR medical reviews, the findings of the interview were placed in each youth's individual healthcare record, it was labeled "Post PAR Interview," dated with a time, and signed by the individual conducting the interview. In all the PAR reports the superintendent/designee reviewed the report, made comments and corrections, where appropriate, within seventy-two hours of the incident occurring, after all others completed their review.

The center's PAR rate was at the time of the annual compliance review was 22.14, which is above the statewide average of 12.00. The number of PAR incidents increased compared to the last annual compliance review. The staff indicated the population count was up and down since the last annual compliance review, and staff turnover had also resulted in new officers with little experience in PAR.

Seven staff interviews indicated all staff try to talk to youth prior to using physical or mechanical restraints. The superintendent interview indicated the process for monitoring PAR incidents and use of force is for all reports to be completed by the end of the shift and to ensure all reviews are completed within the required time frames.

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

Seven pre-service training records were reviewed, and all records had documentation indicating the staff received the essential training prior to contact with youth, which included training 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 detention facility operations. All staff completed essential skills, orientation, information security awareness, legal, Department of Juvenile Justice (DJJ): the Organization, gang awareness, interpersonal/communication skills, detainee behavior and consequences, and active shooter training, as part of their Phase one training. Four of the seven staff received the 180-day certification at the academy. Two of the remaining three staff received an extension due to medical reasons and one staff had not reached the 180 days since being hired as a juvenile justice detention officer. All completed trainings were entered into the Department's Management Learning System (SkillPro) for all seven staff.

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

Seven in-service training records were reviewed, and documentation indicated all reviewed staff received training in Protective Action Response (PAR) update, cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), suicide prevention with four hours as webinar or instructor-led training and two hours of training in the Department's Management Learning System (SkillPro), professionalism and ethics, and active shooter. All seven staff completed between forty-nine and half and 129.5 hours of annual training, which is above the required twenty-four hours of annual training annually. Two of the seven staff were supervisors and documentation indicated both staff completed the minimum of eight hours of annual

supervisory training in the areas of management, leadership, employee relations, and fiscal. All training was documented in SkillPro. All seven staff also completed training in trauma-informed care, emergence care plan, epinephrine auto-injector, emergency care, medication administration, infection control, exposure control plan, escape prevention, fire prevention plan/disaster procedures, and emergency response. A licensed nurse provides education on girl's healthcare to include monitoring, observation, and emergency care of pregnant youth. Three of seven staff completed semi-annual training on procedures regarding self-inflicted injuries or suicide attempts, including mock suicide drills. Two other staff did not participate in any drills and the remaining two staff only participated in one drill in the last year.

The center has an annual in-service training calendar, which is updated as needed.
The superintendent interview indicated he has received a wide variety of management training in SkillPro, PAR, and CPR. He indicated staff are required to have 120 hours in Phase I training, 120 hours in Phase II training, as well as twenty-four hours of annual in-service training in PAR, CPR, first aid, and all other required SkillPro courses.

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

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

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

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

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

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

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

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

The center's operating procedures include how to enter and update alerts in the Department's Juvenile Justice Information System (JJIS). Seven youth records were reviewed regarding alerts entered, updated, and closed in JJIS by the center. Six of the seven records had alerts entered, updated, and closed as required by the appropriate staff in JJIS, which is also used as the center's internal alert system. In the remaining one record, the staff closed an active alert in error, a week prior to the annual compliance review, and re-opened the alert while the annual compliance review team was on-site; all other alerts were entered, updated, and closed, as required, by the appropriate staff. All alerts were documented in the logbook, as required.

The JJIS alert report is reviewed daily by the supervisors and administrators during shift briefings with the staff and is documented in the shift report, and the logbook, as confirmed by a review of the logbooks. A shift briefing was observed and found all staff received a printout of the current JJIS alert list, as well as the supervisor discussing the JJIS alerts. The medical and mental health staff indicated they review the youth alerts every morning and evening to ensure accuracy. The food service workers receive an updated alert list every morning.

Seven interviewed staff indicated they are informed of alerts (security, safety, medical, and mental health) specific to youth through the logbook and during shift debriefings; six of the seven staff also stated through alert forms. All of the staff stated management informs staff about issues within the center through staff debriefings, six of seven said through logbooks, and three of seven also indicated in email form. The superintendent interview indicated all alerts must be listed in JJIS and updated as changes occur. All staff must have an alert list in their possession. Medical staff shall review the alerts to ensure each alert is correctly tracked and managed. Updates by the medical staff shall be documented in the JJIS alerts as they pertain to the critical alert.

Standard 2: Assessment and Performance Plan

2.01 Admission	Satisfactory Compliance

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

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

The center has a written policy and procedures governing the admission process of youth into the center. A total of seven youth records were reviewed. The Admission Wizard for all seven youth indicated the arrest affidavit/custody order, Detention Risk Assessment Instrument (DRAI), and Suicide Risk Screening Instrument (SRSI) were reviewed for each youth. The Admission Wizard indicated appropriate searches were conducted, telephone calls were afforded, meals provided, medical, and mental health and substance abuse screenings were conducted for all reviewed youth. There were no youth admissions at the center during the time of the annual compliance review; therefore, the admission process could not be observed.

2.02 Orientation	Satisfactory Compliance

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

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

The center has a written policy and procedures regarding youth orientation. Seven youth records were reviewed, and each contained documentation showing the youth received orientation on the day of admission. All records contained an orientation checklist showing all required areas were reviewed with each youth, initialed and signed by each youth, and center staff. A copy of the youth handbook was filed in each record, including a signature page signed by each youth and staff indicating the handbook was reviewed. The orientation process was not observed, as there were no youth admissions during the annual compliance review. Seven

interviewed youth indicated they were provided information about center rules and regulations, daily schedules, education, program and medical services, visitation, the Florida Abuse Hotline, and the behavior management system.

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

The center has a written policy and procedures in place to properly classify youth upon admission to the center. Part of this process is a review of all information regarding the youth's history, sex, height, weight, age, and level of aggressiveness and documentation provided at admission. The process includes gathering information which assist staff in addressing safety and security, and concerns regarding room assignment. Special needs, such as mental illness, intellectual and physical disabilities, history of violent behavior, gang affiliation, criminal behavior, Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB), and medical issues are reviewed.

Seven youth records were reviewed, and each contained a copy of the admission classification form completed on the day of admission. The forms addressed all above information, suicide risk, escape risk, or any other security risk which could impact the youth and/or their living environment. All factors are considered when making room assignments. If a youth's behavior or status changes, youth are reclassified and housed accordingly. One of the records indicated the youth had been a victim of a sexual offense, and this youth was placed in a room alone. A review of the Department's Juvenile Justice Information System's (JJIS) Admission Wizard for each youth documented the appropriate youth alerts. The center identified youth who may be vulnerable to victimization by conducting interviews and using the VSAB assessment. The detention review specialist indicated if a suspected or admitted gang member is received, the superintendent is immediately notified.

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

The center has a written policy and procedures for the classification of gang members. A review of seven youth records indicated two youth were applicable as a gang member upon admission. The center provided an additional record for review of a youth who was classified as a gang member. Upon admission, each of the three applicable youth were screened regarding affiliation or involvement with any street gangs. Each of the three youth records reviewed had a gang alert entered into the Department's Juvenile Justice Information System (JJIS). The notification to the circuit's juvenile probation officer (JPO) gang representative. in all three records took place while each youth was at the Juvenile Assessment Center (JAC). An interview was conducted with the detention review specialist, who serves as the center's gang representative. The detention review specialist advised when a youth who is affiliated with a gang is received or admits to being involved with a gang after admission, all staff are made aware of this through shift debriefings, e-mails, and meetings.

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

The center has a written policy and procedures in place governing the admission of youth personal property to ensure the property is correctly inventoried, stored, returned upon release, or transfer to residential placement. In six of seven youth records, staff verified and secured all personal items in a tamper-proof property bag along with the property list form, documented the description on the property receipt form, including the date, youth's name, Department identification (DJJID) number with the list placed inside the bag, and youth and staff signatures. The remaining youth did not have money or personal items of value, which was indicated on the property receipt form. Money and personal items of value, such as jewelry are kept in a drop safe. Six of the seven youth records reviewed had valuables stored in the drop safe. The drop safe is located under the surveillance of two cameras. The six youth property bags placed in the drop safe were correctly noted in the logbook, with the date, time, each youth's name, DJJID number, and the officer who secured the property. In the event a youth refuses to sign the property receipt form, the supervisor would be contacted and document the refusal on the form. None of the records reviewed had a refusal noted on the property form.

The admission process was not observed, as there were no youth admissions during the time of the annual compliance review. All seven interviewed youth indicated staff checked their personal property and they signed the form indicating it was correct. The superintendent was

interviewed and stated staff follow procedures regarding the inventory, storage, return, and disposal of youth property.

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

The center has a written policy and procedures in place to safeguard each youth's personal property until it is returned to the youth or parent/guardian. A tour of the property room revealed access is limited to assigned staff and the room where the property is kept is properly secured, with each property bag containing a completed inventory form. The drop safe storing valuables is under video surveillance, with two cameras fixed on the safe and one at the entrance to the room where the safe is located. The bound safe logbooks were reviewed and found to be accurate and properly filled out. A review of the Central Communications Center (CCC) reports for the past six months revealed there were a total of thirty-six CCC reports, of which one involved personal property and was still under internal investigation at the time of the annual compliance review.

The admission process was not observed, as there were no youth admissions during the time of the annual compliance review. The superintendent interview indicated the youth's personal property is secured through completing an inventory in the Department's Juvenile Justice Information System (JJIS) and the items are placed in a clear tamper-proof bag. Valuable property is logged, placed in a drop safe, then stored in a locked cabinet. Clothing is also inventoried, logged, and stored in a secured property room. The valuable property is stored in the intake supervisor's office under direct camera view. The intake supervisor and administration team have access to the valuable property. If a youth and/or parent/guardian cannot be located, money and property are inventoried. A money order will be sent to the Regional Office and then to the Department's headquarters. All other property will be donated/disposed of.

2.07 Release	Satisfactory Compliance

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

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

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

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

The releasing officer shall verify the identification of the youth.

The center has a written policy and procedures in place to ensure youth are properly released. In the seven youth records reviewed, all youth were still at the center and not applicable for release procedures; therefore, the center provided three additional records for released youth. In the three additional records, documentation revealed a supervisor reviewed all documents related to each youth's release, as well as the court paperwork. A review of the Department's Juvenile Justice Information System (JJIS) indicated the date of admission and date of termination correlated with the dates documented in each record. The youth's identification was verified prior to release and the identification of the parent/guardian picking up the youth if the youth is under the age of eighteen; a photocopy of the identification was placed in each record. Prior to the release, the youth and parent/guardian, if applicable, was reminded of any future court date(s), and all applicable parties signed the release documents. A youth release was observed during the annual compliance review, and all appropriate steps were completed. A review of the Central Communications Center (CCC) reports for the past six months revealed no youth had been released without authorization.

2.08 Release of Youth Personal Property	Satisfactory Compliance

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

There are procedures in place to ensure the center properly accounts for youth personal property prior to release. In the seven youth records reviewed, all youth were still at the center and were not applicable for release of youth personal property; therefore, the center provided three additional records of released youth. In the three additional records, each youth and parent/guardian signed the receipt of property form, acknowledging they received their personal property upon release. At the time of the annual compliance review, there were no instances of property being held for more than thirty days. A youth release was observed during the annual compliance review, and the appropriate process was completed regarding the release of youth property. The superintendent interview verified staff are trained and know how to process youth property when youth are released.

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

The center has a written policy and procedures in place to ensure medications are given to the individual whom the youth is released to, or the youth, in the event the youth is eighteen years of age or older. None of the three closed records reviewed were discharged with medication or aftercare instructions. The center was able to provide one record for review for a youth who was on medication when released. A medication receipt, transfer, and disposition/discharge form was completed with appropriate signatures, showing who received the medication for the youth; in this case, the youth was discharged to the Department of Children and Families (DCF).

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

The center has a written policy and procedures in place governing detention reviews at the center. The detention reviews are conducted weekly to properly manage youth placed in detention and to share information with involved parties. Due to a miscommunication, the annual compliance review team was unable to observe a weekly detention review. Copies of weekly detention review minutes were reviewed for the past six months. All reviewed meeting notes included an agenda, census count, review list, number of youth awaiting placement, review of previous meeting notes, alert list, upcoming events, and any pertinent follow-up. There were sign-in sheets attached to all meeting notes, indicating who attended in person or on conference call.

The superintendent interview indicated the assigned detention review officer conducts the weekly secure and home detention reviews. The superintendent, assistant superintendent, medical, mental health, probation, education, the Department of Children and Families (DCF) and others deemed necessary attend the meetings. The case reviews are held once a week and the youth's detention status, questionable court orders, medical issues, mental health issues, DCF youth, committed youth, and any other critical cases are discussed.

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

The center has a daily activity schedule outlining the days and times for each youth activity. The schedule provides youth the opportunity to become involved in constructive, beneficial activities daily. These activities include wake-up and bedtimes, personal hygiene, meal times, visitation, education, recreation and physical activity time, groups (including gender-specific programing), shift change, and open program time which is used for leisure activities such as: reading, art, and games. Copies of the daily activity schedule were observed posted in all housing units and

throughout the center. All seven interviewed youth reported the daily schedule is available for them to view. All seven staff interviews indicated the daily activity schedule is followed.

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

The center has a written policy and procedures to ensure adherence to the daily schedule. A review of logbooks and the daily schedule confirmed the daily activity schedule was followed for all activities except education. Logbooks for three different modules on three different dates were reviewed. The staff documented movement from one classroom to another during this time. Ten of the forty-five logbook entries were not documented; mainly during the fourth and fifth periods of education. A review of the closed-circuit television (CCTV) recordings for the same modules and time frames indicated the youth were moved to the classrooms and received the required educational access. Each of the seven interviewed staff and seven youth indicated the daily schedule is followed.

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

The center has a written policy and procedures in place ensuring the youth have access to education while in the care of the Department. A review of logbook entries showed youth movement to education was not being consistently documented. A review of logbooks for three different modules on three different dates found staff documented movement from one classroom to another during this time. Ten of the forty-five logbook entries were not documented; mainly during the fourth and fifth periods of education. A review of the closed-circuit television (CCTV) recordings for the same modules and timeframes indicated the youth were moved to the classrooms and received the required educational access.

Due to the current COVID-19 pandemic, teachers were not at the center; therefore, interviews with education staff were not conducted. This restriction commenced on March 16, 2020, with no current end date announced. Educational materials were dropped off at the center on March 23, 2020, for the youth to conduct independent studies until regular education services can resume. The education program normally operates on a year-round basis, with Christmas, spring break, and several other recognized holidays throughout the year being observed. The education schedule provides a minimum of twenty-five hours of instruction weekly. Interviews with seven youth confirmed they were receiving education while in the center until the COVID-19 pandemic caused classes to be cancelled. Seven staff were interviewed and three advised there was minimal interference of educational instruction. The other four staff were unable to confirm this because they are assigned to the evening shift and are not working when classes

are taking place. The superintendent also advised there was minimal interference of educational instruction.

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

The center has a written policy and procedures for the provision of career education. The center provides Type 1 activity and instruction. Depending on the day of the week and module unit, youth attend life skills training, basic education, responding to anger, critical thinking, communication, and various other courses. This is offered and available daily from 6:30 p.m. to 8:30 p.m.

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

The center has a written policy and procedures in place governing the Behavior Management System (BMS). While touring the housing modules during the annual compliance review, copies of the rules, inappropriate behavior, and expectations were posted throughout the center. The facility operating procedures (FOP) for the BMS was reviewed and approved for statewide use. The FOP outlines rewards and consequences for positive and negative behavior. Documentation of rewards and consequences were reviewed and found to be consistent with the BMS. Youth sign the handbook during admission agreeing to read and familiarize themselves with the rules in the handbook. A copy of the signature page was in each youth record. The center's BMS consists of three levels where youth can earn increased privileges for meeting expectations and following the center procedures. Increased privileges include things such as: extra telephone calls, a later bedtime, movies, and canteen. The youth levels can be dropped if they do not meet the center's expectations. A review of documentation supported the BMS was used appropriately. A review of logbooks indicated youth were given ample warnings and were advised of why their level was being dropped, when appropriate. This is a common practice at this center.

Seven youth were interviewed concerning the BMS. Four youth stated the BMS was very good, two rated it good, and one stated it was fair. Five youth had not received any consequences and two had consequences issued; both stated the consequences imposed were fair, and, in both cases, resulted in a level reduction. Seven staff were interviewed regarding the BMS. Six staff indicated it was effective, with one stating it could be improved with more staff, programs, and opportunities for the youth. The seventh staff stated the BMS was not effective because not everyone understood it and there was no consistency. All seven staff said they spoke with youth regarding consequences, and about alternative acceptable behavior, the youth were given an

opportunity to explain their behavior, and they all knew a reduction in level was a consequence. The superintendent indicated the BMS is a level-based system providing rewards and consequences based on a behavior.

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

The center has a written policy and procedures in place to ensure penalties imposed on youth are not excessive or unauthorized and are used as a positive learning experience. The policy states group punishment will not be used as part of the behavior management system (BMS). A review of documentation indicated the BMS was used appropriately and there was no group punishment.

Seven interviewed youth stated removal of points and levels are utilized as punishment. Two of the interviewed youth had a level reduction as a consequence of inappropriate behavior. Six of the youth said youth could not punish other youth, while one said they could. One youth reported he had been sent to his room for punishment and the door was shut and locked. All youth doors in the center are locked when closed. Seven youth were questioned if handcuffs/leg irons had been used on them or other youth and all reported they never witnessed this. The seven interviewed staff reported the loss of meals, snacks, sleep, or school are not used as consequences for inappropriate behavior. No staff reported observing any staff encouraging youth to beat up another youth, and not having observed any other staff take medication, snacks, meals, or education from a youth for acting out.

2.17 Grievances	Satisfactory Compliance

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

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

The center has a written policy and procedures regarding the grievance process. The grievance procedures consist of three phases: informal, formal, and appeal. The center had a total of six grievances submitted in the last six months. Each of the grievances were entered in the Facility Management System (FMS), were resolved prior to the appeal phase, and were responded within the specified time frame.

All seven interviewed staff were able to explain the process for giving the youth the grievance form, then forwarding the completed form to a supervisor; however, none were able to outline the grievance process, to include the three phases. All seven interviewed youth reported never filing a grievance while at the center. An interview was conducted with the superintendent who further explained each step in the process allows staff to process the grievance with the youth and gives the youth the right to process to the next phase, if needed.

2.18 Trauma-Informed Care	Satisfactory Compliance

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

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

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

The center has incorporated trauma-informed care practices into the daily operations. The center has a soft room, a garden, and offers opportunities for the youth to participate in yoga. The dorms are painted in soft, neutral colors. The seven reviewed in-service and seven pre-service training records indicated all staff had trauma-informed care training entered in the Department's Learning Management System (SkillPro). The superintendent interview confirmed the current practices to promote trauma-informed care throughout the center.

Standard 3: Mental Health and Substance Abuse Services

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

The center maintains a contract with Camelot Community Care who provides services to all applicable youth in the center. Camelot provides a licensed mental health counselor (LMHC) who serves as the designated mental health clinician authority (DMHCA). The DMHCA holds a clear and active license in the State of Florida, as required by Florida Statute, expiring March 31, 2021. The DMHCA has a job description which outlines the duties and responsibilities, supervisory responsibilities, education and/or experience, language skills, mathematical skills, and reasoning abilities. The DMHCA is on-site Monday through Friday and Saturdays, totaling forty hours a week. The DMHCA is responsible for coordination and implementation of mental health and substance abuse services in the center, as stated in the interview. The DMHCA noted being available twenty-four hours a day, seven days a week for the clinical staff at the center.

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

The center has a written policy and procedures to ensure mental health and substance abuse services are provided by individuals with appropriate qualifications. The center currently has two licensed mental health and substance abuse clinical staff. One clinical staff is a licensed clinical social worker and the second is a licensed mental health counselor. Each clinical staff had a clear and active license in the State of Florida, as required by Florida Statute, expiring on March 21, 2021.

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

The center has a written policy and procedures to ensure mental health and substance abuse services are provided by individuals with appropriate qualifications. Clinical supervisors must assure clinical staff working under their supervision are performing services they are qualified to provide based on education, training and experience, and they are responsible for reviewing and signing documents completed by the non-licensed staff. The center has a Chapter 397 license in accordance with Florida Statute to provide substance abuse services expiring on April

1, 2020. The center has three non-licensed mental health and substance abuse clinical staff. Two of the three staff hold a master's degree and one has a bachelor's degree from an accredited university or college in the field of counseling and psychology and all pre-service training completed. Each of the three non-licensed staff received twenty hours of training in administering Assessments of Suicide Risk (ASRs). In addition, the non-licensed clinicians had weekly supervision with the licensed mental health counselor (LMHC) who serves as the designated mental health clinician authority (DMHCA). The last six months of direct supervision was documented on the required Department form and signed by the non-licensed clinician and DMHCA.

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

The center has a written policy and procedures outlining mental health and substance abuse needs of youth whom are identified through a comprehensive screening process and include referrals. The center administers the Massachusetts Youth Screening Instrument-Second Version (MAYSI-2), Community Assessment Tool (CAT) Pre-Screen, and Suicide Risk Screening Instrument (SRSI). Each of the seven youth records contained a MAYSI-2 and SRSI completed at the time of intake, located in each youth record and completed in the Department's Juvenile Justice Information System (JJIS) entirely. Documentation indicated the instruments were reviewed by the detention staff. The center's medical staff and/or mental health staff completed the required sections of the SRSI.

All seven youth records indicated the need for further assessment as a result of the MAYSI-2 and SRSI and staff completed a referral as a result. Six of the seven youth indicated an elevated suicide risk and each youth were referred for an Assessment of Suicide Risk (ASR). All screenings were completed by trained staff. The superintendent and mental health clinical staff were notified of the referrals made.

The superintendent reported the mental health, substance abuse and suicide risk screenings are completed by the juvenile justice detention officer's, supervisor's, nursing, and mental health staff. He reported the MAYSI-2 and SRSI are completed at the Juvenile Assessment Center, by the juvenile probation officer (JPO) or upon admission to the detention center.

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

The center has a written policy and procedures regarding the completion of mental health and substance abuse evaluations for applicable youth. Five of the seven youth were referred for an evaluation/assessment; however, three youth were admitted right before the annual compliance

review and the timeframe of fourteen days had not expired. The center provided an additional applicable record to review for a total of three records. One of the three applicable records included an assessment/evaluation completed by the detention provider and two youth records included an assessment/evaluation provided by a community provider. Each of the assessments/evaluations were complete within thirty days of each youth's admission. For the three youth records, which were admitted right before the annual compliance review, the detention provider emailed the juvenile probation officer (JPO) requesting an evaluation/assessment which had been completed within fourteen days of each youth's admission.

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

The center has a written policy and procedures outlining mental health and substance abuse treatment planning for each youth entering the center. Two of the seven youth records reviewed were applicable for requiring treatment; however, in one of the two records, the youth was admitted right before the annual compliance review and would not have started treatment. Therefore, the center provided two additional youth records for review, totaling three applicable youth records. Each of the applicable youth refused substance abuse treatment; however, did accept mental health treatment. All three youth records included a signed Authority for Evaluation and Treatment (AET) form. The mental health staff had access to each youth to provide treatment services. All three youth requiring treatment were assigned to a mini-treatment team. The treatment teams included all required staff, if available, as indicated by signatures on the forms. Each of the three youth received individual counseling as required by their plan, which was documented on the Department's Mental Health/Substance Abuse form containing all required elements. Each of the youth participated in group sessions while in the program. A review of the last six months of group therapy sign-in sheets indicated none of the groups had more than seven youth attending at any given time.

Two of the seven interviewed youth reported the mental health/substance abuse services were good and the other five indicated not receiving any mental health/substance abuse services. The interview with the designated mental health clinician authority (DMHCA) indicated each youth are provided with individual and/or group services.

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

The center has a written policy and procedures outlining youth who receive mental health and/or substance abuse treatment shall have a discharge summary/transition plan completed to include recommendations and treatment upon discharge. During the annual compliance review, there were no youth scheduled for a mini-treatment team meeting; therefore, a treatment team meeting was unable to be observed.

One of the seven youth required a treatment plan, therefore, two additional records were provided for review, totaling three applicable records. One of the three youth entered the center on medication, and the initial treatment plan was completed within seven days of initiation of treatment. The plan was signed by a mental health professional or a non-licensed staff and reviewed by a licensed clinical supervisor within ten days. The initial treatment plan was documented on the Department's form and included all required information. The reason for referral, diagnosis/symptoms, treatment methods, treatment goals, and psychiatric services were documented on the form. The mini-treatment team members were included in the development of the plan. The youth and clinical staff signed and dated the initial treatment plan.

Each of the three applicable youth records included an individual treatment plan which was completed within thirty days of admission. The youth, clinical staff, and treatment team members each signed the plan. The parents/guardians were mailed a copy, to review, sign, and return; at the time of the annual compliance review none had been returned. The designated mental health clinician authority (DMHCA) signed the plan within ten days of completion. The plans included treatment focused symptoms, treatment goals, strengths/abilities, psychiatric services, pharmacological interventions, and progress notes. Each of the three applicable records required one thirty-day review and were completed as required, including signatures and dated by the clinical staff, youth, and licensed mental health professional. The plans were reviewed by the treatment team and modifications were documented clearly on the form. One of the three youth were applicable for psychiatric services. The youth treatment plan included treatment and services provided by a licensed psychiatrist.

Three closed records were reviewed for mental health/substance abuse treatment discharge summaries. All three discharge summaries were completed on the Department's form, which contained all required elements. In each of the three youth records, there was documentation the youth, parent/guardian, and juvenile probation officer (JPO) were provided a copy of the discharge plan.

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

The center has a written policy and procedures to ensure psychiatric services are provided including psychiatric evaluation, psychiatric consultation, medication management, and medical supportive counseling. The psychiatrist has a clear and active license in the State of Florida, as required by Florida Statute, expiring on January 31, 2022. The contract requires the psychiatrist to visit the center for a minimum of three hours a week. A review of the sign-in logs revealed the psychiatrist was on-site, a minimum of three hours weekly, consulting with youth. The center does not utilize the services of a psychiatric advanced registered nurse practitioner (ARNP). One of the seven youth records reviewed was applicable for psychiatric services. The center provided two additional records for review. The psychiatrist completed an initial psychiatric interview and evaluation for all three applicable youth; the evaluation was completed on the Clinical Psychotropic Progress Note (CPPN) within fourteen days of admission to the center, was signed by the practitioner and dated. The initial psychiatric interview included reason for the referral, history, mental status examination, diagnosis, treatment recommendations, prescribed medication, explanation of the need for psychotropic medication, and frequency of medication management.

All three of the youth records included an in-depth psychiatric evaluation completed within thirty days of the youth's admission. Each CPPN included all three pages which were completed with all required elements. Two of three youth records had a signed Authorization for Evaluation and Treatment (AET) form. One youth is eighteen years of age and did not require an AET form. None of the three youth were in the Department of Children and Families (DCF) custody or received new medications while in the center. The designated mental health clinician authority (DMHCA) reported meeting with the psychiatrist weekly.

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

The center has a suicide prevention plan, which was approved and reviewed by the designated mental health clinician authority (DMHCA) and superintendent on August 14, 2019. However, key positions listed as emergency contacts had changed and were not updated until the annual compliance review. The plan included all required elements, such as identification and assessment of youth at-risk of suicide, referral, communication, immediate staff response, notification, levels of supervision, suicide precautions, staff training, documentation, and review process.

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

The center has a written policy and procedures regarding suicide prevention services. Suicide precautions are the methods utilized for supervising, observing, monitoring, and housing youth identified through screenings, available information, or staff observations as having suicide risk factors or identified through assessment as a potential suicide risk. Youth placed on suicide precautions are maintained on one-to-one or constant supervision. The results from the superintendent interview indicated the center utilizes secure observation for youth who display potential threat to their safety or the safety of others. The superintendent has a review process in place for every serious suicide attempt or serious self-inflicted injury and a mortality review for a completed suicide, which includes all required elements.

Six of the seven youth records were applicable for suicide prevention services; one was not. A review of the Department's Juvenile Justice Information System (JJIS) indicated the appropriate alerts were entered and closed, as required. Each of the six applicable youth identified to be at risk at admission was placed on precautionary observation and a referral was completed. Reviewed documentation reflected staff observations were included on the suicide precaution observation logs, including documentation of safe housing areas, and an Assessment of Suicide Risk (ASR) was completed for each youth in the required time frame. Each ASR was completed by a non-licensed clinical staff under the supervision of the designated mental health clinician authority (DMHCA). None of the youth required a follow-up ASR. The master control logbook documented youth being placed and removed from precautionary observation, as documented in JJIS.

One of the seven youth records reviewed was applicable for secure observation, therefore, the center provided two additional youth, totaling three applicable records. Each of the three applicable youth placements in secure observation were authorized by the superintendent and the designated mental health clinician authority (DMHCA). The secure room was designated in writing, the Health Status Checklist completed, suicide precautions observation log completed entirely, follow-up ASR completed, parent/guardian, and juvenile probation officer (JPO) notified of potential suicide risk. The mental health clinical staff provided supportive counseling to each youth and the level was reduced after the superintendent/licensed mental health professional conference. Each of the youth were removed from secure observation within twenty-four hours of placement.

One of the seven youth interviewed was placed on suicide watch while in the center. The youth reported the staff watched all the time while on precautionary observation. Seven staff were interviewed and reported when a youth expresses suicidal thoughts, staff are responsible of

notifying mental health staff, documenting supervision, placing youth on sight and sound supervision, searching youth room, and talking to the youth.

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

The center has a written policy and procedures for documenting supervision of youth placed on suicide precautions. The center uses the Department's suicide precaution observation log forms for youth placed on precautionary observation. A review of seventeen precautionary observation logs indicated documentation reflected the logs were maintained for the duration of each youth placed on precautionary observation. Each of the logs were reviewed and signed by the shift supervisor and mental health clinical staff. None of the youth displayed warning signs while on observation. Youth supervision while on precautionary observation did not exceed thirty-minute intervals; however, only some were documented in real time. Two youth were interviewed during the annual compliance review. One youth reported not being watched at all times and the other stated being watched while on precautionary observation. A third youth was not interviewed.

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

Seven in-service staff training records were reviewed for completion of the required six hours of suicide prevention training. Each of the staff completed two hours of training in the Department's Learning Management System (SkillPro) and four hours of web-based/instructor-led training annually. A review of twenty-six mock suicide drills for the last four quarters was conducted. Nine of the drills did not include life saving measures, one was conducted during a shift briefing, in four drills, the staff responses were cut and pasted, and another four did not include any staff responses. There was a total of forty-one staff applicable for suicide mock drill participation. Nine of the forty-one staff did not participate in any drills and ten participated in only one drill during the annual compliance review period. One drill for the second shift in the fourth quarter in 2019 was missing. All seven staff interviews indicated the suicide response kits are located in sub control, three stated they are in master control, and two reported the kits are located in the clinic.

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

The center has a written mental health crisis intervention plan which was approved and reviewed by the designated mental health clinician authority (DMHCA) and superintendent on

August 14, 2019. However, key positions listed as emergency contacts have changed and were not updated until the annual compliance review. The plan addressed the notification and alert system, means of referral to include youth self-referral, communication, supervision levels, documentation, and review, as required.

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

The center has a written emergency care plan which was approved and reviewed by the designated mental health clinician authority (DMHCA) and superintendent on August 14, 2019. However, key positions listed as emergency contacts had changed and were not updated until the annual compliance review. The plan addressed immediate staff response, notifications, communication, supervision of youth, authorization to transport for emergency services, transportation for emergency mental health and/or substance abuse evaluation and treatment, documentation, training, and review.

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

The center has a written policy and procedures regarding mental health crisis intervention plan/procedures. The plan details crisis intervention procedures including a notification and alert system, means of referral including youth self-referral, communication, supervision, documentation, and review. The center's plan was reviewed, approved, and signed by the designated mental health clinician authority (DMHCA) and superintendent on August 14, 2019. Since the last annual compliance review, the center had one youth applicable for crisis assessment. The crisis assessment included the reason, mental status, danger to self/others, initial clinical impressions, treatment recommendations, recommendations for follow-up/further evaluation, and notification to the parent/guardian of follow-up treatment. The center entered an alert in the Department's Juvenile Justice Information System (JJIS). The crisis assessment was conducted by the licensed mental health counselor (LMHC) within twenty-four hours after the need was identified.

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

The center has a written policy and procedures regarding youth sent out of the center for a Baker Act or Marchman Act. The center had two youth sent out for a Baker Act since the last annual compliance review. A mental health referral was completed for each youth and the mental status examination was completed by a licensed mental health professional. One youth was placed on suicide precaution, the other on mental health observation until released to law enforcement for Baker Act. Each youth were placed on constant observation upon returning from the Baker Act. One youth was released from secure detention prior to the Assessment of Suicide Risk (ASR) being completed. The other youth was not stepped down for thirteen days, at which time, the youth received an ASR and was stepped down to close supervision. During the thirteen days, mental health staff met with each youth each day. On the fifteenth day, a follow-up ASR was completed, and each youth was stepped down to standard supervision. The alerts for each youth were updated in the Department's Juvenile Justice Identification System (JJIS), as required.

Standard 4: Health Services

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

The program has a written policy and procedures addressing the designated health authority (DHA) and designee. The DHA holds a clear and active license with the Department of Health, Bureau of Medical Quality Assurance, which expires January 31, 2021. He also is certified with the American Board of Internal Medicine. The contract includes the provision of services by an advanced practice registered nurse (APRN). The APRN holds a clear and active license with the Department of Health, Bureau of Medical Quality Assurance which expires July 31, 2020. The APRN's collaborative practice protocol included the DHA as the responsible physician providing general supervision. A copy of the APRN's collaborative practice protocol was maintained on-site. The APRN holds a clinical specialty in pediatric nursing primary care with the Pediatric Nursing Certification Board.

A review of the sign-in log revealed the DHA was on-site weekly. There was one exception; the log documented a gap of fourteen days; five days beyond the requirement of no more than nine days between visits. The contract provider indicated in interviews, a substitute for the DHA is available, the DHA for Manatee juvenile detention center; however, there was no written back-up plan for staffing to ensure provision of adequate and qualified staff to fill in for staff who may be absent from work (for example, unexpected emergency, illness, vacation, or interruption of employment) to ensure services to youth will not be interrupted.

The DHA's responsibility includes communication with center staff regarding youth medical needs, and electronic availability for acute medical needs, emergency care, and coordination of off-site care, with availability twenty-four hours a day, seven days a week. The DHA performs comprehensive physical assessments, conducts sick call, and periodic evaluations for youth with acute and chronic conditions, reviews currently prescribed medications and orders new medications, as well as assists in the development of policies and procedures for medical and dental episodic and emergency care. The interview with the DHA indicated he reviews/approves nursing protocols and medical facility operating procedures, performs comprehensive physical assessment (CPA), and periodic evaluations, as well as conducts sick calls as requested by nursing staff or APRN.

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 program has a written policy and procedures addressing facility operating procedures (FOP). All the medical facility operating procedures received an annual review by the designated health authority (DHA) on August 12, 2019 and the superintendent on August 14, 2019. The psychiatrist reviewed the FOPs related to psychiatric care and medication management. The nursing protocols were reviewed and edited by the DHA August 4, 2019 and reviewed by each nursing staff in August 2019. All four new-hire nursing staff received orientation and signed the nursing protocols upon receipt of training.

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 program has a written policy and procedures addressing authority for evaluation and treatment (AET). A review of seven individual health records revealed none received medical services prior to a valid AET being obtained. Five of the seven youth had an AET. Four of the five AETs were stamped as a copy. One AET was not an original and not stamped as a copy. One youth record did not have an AET on the first day of the review; however, upon admission, healthcare staff sent an email request to the juvenile probation officer (JPO) to assist in acquiring an AET. On the third day of the annual compliance review, the center obtained a signed and witnessed AET for the youth. One of the remaining two youth had no AET in the record; however, there was documentation of a completed Limited Consent for Evaluation and Treatment by the superintendent/designee following completion of an Affidavit of Diligent Effort attached to the Limited Consent. The center maintains an AET tracker, which documents each youth admitted without permission to evaluate and treat. The tracker identifies the date each applicable youth was admitted, the youth's JPO, the number of days the youth has been in the center, and the status of the AET request to the JPO.

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

The program has a written policy and procedures addressing parent/guardian notification. Three of the seven records reviewed were applicable. In one of the three records, the notification was sent to the parent/guardian without documentation to show a telephone call or an attempt to telephone the parent/guardian was made. In one record, the written notification was sent to the parent/guardian and the block on the form was not checked if the parent/guardian was notified by telephone. Staff interviews indicated the telephone call was made, but nursing notes did not confirm the phone call. Four of the seven youth were applicable for psychotropic medication management. In each of the four records, the psychiatrist and/or the nursing staff documented telephone calls or attempted telephone contact on the Clinical Psychotropic Progress Note (CPPN) on page three. One youth received off-site care and the center notified the parent/guardian of the youth's condition.

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

The program has a written policy and procedures addressing healthcare admission screening. All seven youth records contained documentation each youth received a healthcare admission screening within twenty-four hours of admission and completed in the Admission Wizard. The screening was completed by the juvenile justice detention officer (JJDO) and reviewed by a licensed medical professional within twenty-four hours. One of the seven youth had a change in physical custody and the center completed a rescreening upon his return. The center provided

two additional examples of youth with a change in custody; each of the two youth received a new rescreening upon return to the center. The superintendent interview indicated the nurse, doctor, and staff complete the healthcare admission screenings.

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

The program has a written policy and procedures addressing youth orientation to health care. In all seven records each youth received orientation within twenty-four hours of admission. Each youth received orientation regarding access to medical care, sick call, medication process, right to refuse care and how it is documented, what to do in case of a sexual assault or attempted sexual assault, the non-disciplinary role of the healthcare providers, immunization, and review of the list of healthcare contacts to ensure accuracy. One youth admission was a youth who had never been in the center before. This youth also received orientation in the following areas: prevention of accidents, alcohol and substance abuse, sexually transmitted disease prevention, smoking cessation, prevention of communicable diseases, cardiovascular health, physical fitness, human immunodeficiency virus (HIV)/AIDS general information, nutrition basics, dental and personal hygiene, breast and testicular self-exam, family planning, anxiety reduction, coping with depression, coping with anger, emergency versus episodic care, and immunization. Four records also documented receipt of health education in chronic disease information, three youth received special medication instruction, and two had HIV/AIDS pre/post-test counseling information.

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

The program has a written policy and procedures addressing designated health authority (DHA) admission notification. Five of the seven reviewed records indicated the youth were admitted with a medical concern or chronic condition and the DHA was notified within twelve hours of admission. Each notification was documented in the applicable youth's record. Four applicable youth each received a referral for care. Four of the seven youth were on psychotropic medications or presented indications of a mental health need; the DHA and psychiatrist were notified, and each was referred to the licensed mental health professional. The program maintained a chronic conditions screening log and each of the four applicable youth were listed on the log. An interview with the superintendent revealed the doctor, nurse, and staff ensure the healthcare admission screening is completed.

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

The program has a written policy and procedures addressing health related history (HRH). Six of the seven youth records reviewed revealed each contained an HRH form completed within seven days of admission. One youth did not have an HRH form in the record or an Authorization for Evaluation and Treatment (AET) form. However, the center obtained an AET form from the

juvenile probation officer (JPO) and completed the HRH form within the seven days of admission while the annual compliance review team was on-site. Each HRH form was completed by a licensed nurse and reviewed by the designated health authority (DHA) or designee at the same time or prior to completion of the comprehensive physical assessment (CPA).

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

The program has a written policy and procedures addressing comprehensive physical assessments (CPA). A review of seven youth records revealed five contained a current CPA and the designated health authority (DHA) or designee completed a focused evaluation documented in the health record. One youth received a new CPA within seventy-two hours of admission. The remaining youth was admitted without an Authorization for Evaluation and Treatment (AET) form but received a new AET form within five days of admission. The nursing staff referred the youth to the DHA/designee and the youth received a CPA within twenty-four hours of receipt of the AET form. All the fields on each CPA were completed by the DHA/designee during the assessment, including the body mass index (BMI), visual acuity field, Tanner stage, scalp/head, cardiovascular, and medical grade. Five of the seven CPAs documented each youth was given a new Tuberculosis Skin Test (TST). One youth had a recent TST and an update was not required. None of the TSTs resulted in the need for further attention. The one remaining youth received a referral prior to admission for a chest x-ray due to family history, the DHA was notified upon admission, and the center provided transportation to the facility to which the youth had been referred. Informal nursing staff interviews and records revealed the center has not had any youth admitted in the previous twelve months with symptoms suggestive of active tuberculosis requiring medical clearance. However, the center has a process in place to provide the appropriate care.

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

The program has a written policy and procedures addressing sexually transmitted infection (STI) and human immunodeficiency virus (HIV) screening. A review of seven youth records revealed each youth received a screening for STIs and was offered the opportunity for HIV screening. Three of the seven youth requested to be HIV tested and signed a consent. Two youth received HIV pre/post-test counseling, which was documented in each health education record. The remaining youth was placed on the pending list of youth requesting counseling and testing for HIV. The agency providing the service has not been to the center since the youth was admitted. Hope and Help provides HIV testing and pre/post-test counseling. The center maintained documentation the agency has certification of registration from the Department of Health division of disease control and health protection which expires June 10, 2020. The center maintains a log of each youth receiving services. Informal nursing staff interviews revealed the HIV counselors deliver the test results orally to the youth and there are no physical test results to place in the applicable youth's record. Two youth were referred for further testing for a sexually transmitted disease, one of which received a positive test result. The youth was counseled by the nursing staff, and the physician placed the youth on medication. Seven youth

were interviewed regarding HIV/AIDS testing. All seven youth indicated the center allowed youth to request a test.

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

The program has a written policy and procedures addressing the sick call process. Sick call is scheduled daily at 10:00 a.m. However, informal healthcare staff interviews indicated youth are seen anytime during the day when a sick call request is entered. Healthcare staff review the sick call requests before the end of the nursing hours and see any youth requesting sick call. Informal interviews also revealed supervisors receiving a sick call after nursing hours can call the designated health authority (DHA) for direction regarding the youth's treatment. The program provided documentation of training in sick call process for several supervisory staff. A review of seven youth records revealed three had been seen for sick call. Two youth were seen by the registered nurse or advance practice registered nurse (APRN). One of the youth was seen by the licensed practical nurse (LPN) and the nurse called the DHA for direction and treatment of the youth. A fourth youth placed a sick call request but refused care when the clinic requested staff to bring the youth to the nurse. A review of youth records revealed staff consistently utilized the subjective, objective, assessment, and plan (SOAP) format when documenting sick call encounters. There were no youth records with three complaints in a two-week period. Informal staff interviews revealed if the situation arose, the youth would be placed on the list to see the physician/designee. Sick call requests were consistently listed on the Sick Call Index.

Observations of sick call revealed nursing staff requested the youth to be brought to the clinic. A juvenile justice detention officer (JJDO) escorted the youth to the clinic and remained at a distance to provide privacy during the sick call but still supervise the youth. The nurse asked the youth's name and if he had requested a sick call, as well as the reasoning. The nurse examined the youth and took vitals while he was seated at her desk. The sick call was conducted away from other youth and staff in a private manner. The nurse suggested treatment according to the protocol, which the youth refused. The youth signed the refusal form and the nursing note.

Seven youth were interviewed regarding how quickly they can be seen once they make the sick call request. Two youth indicated immediately, four stated within twenty-four hours, and one had not requested a sick call. Five youth indicated the nurse conducts sick call, and the other two youth did not know. The seven youth were asked to rate the care received at the center on a five-point scale with very good being the top. Three youth indicated the care at the center was very good, two rated it as good and another two indicated they had not received any medical services. Seven staff were interviewed regarding sick call. All indicated the nurse responds and conducts sick call.

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

The program has a written policy and procedures addressing episodic first aid emergency care. The program maintained an episodic care log utilizing the Department's form, with a different page for each month. The names of two of the seven reviewed youth records were listed on the episodic care log. A review of each youth's record revealed nursing staff documented the episodic care received in a chronological note. One of the two youth had multiple episodic care events, which were documented in the chronological notes. One of the extra events included a referral for off-site care. In all cases the youth record included parent/guardian notification and follow-up care reviewed by the designated health authority (DHA).

The program has three automated external defibrillators (AED), each of which received monthly inspections documented by the nursing staff. The monthly visual inspection of each of the AED is to ensure the green light is on and the equipment is clean and ready for use. Each AED had an instruction guide stored with the instrument. The AEDs were maintained in master control, the east clinic, and the west clinic. Staff performed a successful self-test of each device during the annual compliance review week. The expiration dates for the three AED batteries and pads were: East - September 2022/March 2021, West - September 2022/March 2021, and master control - December 2022/April 2021 respectively. There were no records indicating when the batteries or pads were changed.

A review of medical drills revealed emergency medical drills were conducted quarterly on each shift. Some quarters had more than one emergency medical drill. A review of the nature of the emergency drills revealed most included the use of cardiopulmonary resuscitation (CPR) and/or the AED on each shift. Both the first and second shift had three drills in the fourth quarter of 2019; however, none of the six drills incorporated the use of CPR or AED.

Emergency numbers were posted in master control and each medical clinic. Processes include any staff can call the emergency telephone numbers, including 9-1-1. A review of staff records confirmed each of the seven in-service and seven pre-service staff received CPR with AED and first-aid training. Reviewed documentation also confirmed each licensed healthcare staff holds current certification in CPR and AED. A review of six first aid kits revealed each kit contained the approved contents. However, two of the kits contained saline solution which was expired. Staff replaced the outdated solution immediately. Staff routinely monitor and restock the first aid kits monthly. Seven staff were interviewed regarding if they could call 9-1-1 in an emergency. All seven staff indicated staff could call.

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

The program has a written policy and procedures addressing off-site care referrals. A review of seven youth records revealed two of the youth were referred for off-site care. The center provided a third record for review of off-site referral. In each of the three records, the Summary of Off-Site Care form was utilized and filed in each youth's record. There was documentation the

designated health authority (DHA) was notified, and the episodic care log included the event. There was documentation in two of the three events the DHA reviewed the off-site care findings; not in the remaining one. One of the three youth required follow-up appointments and the nursing staff documented the referral provided to the parent/guardian.

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

The program has a written policy and procedures addressing chronic conditions and required periodic evaluations. The center maintained a chronic condition log with twelve youth on the list. One of the seven youth selected for review was on the chronic conditions list. Two additional youth were selected for review. One of the three youth was applicable for communicable disease. All three youth were taking medications for their condition, receiving treatment, and classified with a medical grade from two to five. All three youth were seen by the designated health authority (DHA) within the prescribed time frame. One of the three was taking anti-tuberculosis (TB) medication and was seen monthly.

The records of three pregnant youth were reviewed. The DHA/designee provided evaluations for each of the three youth within the prescribed time frame. Evaluations were documented in the chronological notes maintained in the electronic medical record. All off-site evaluations of pregnant youth were filed in the youth's record and in the chronological notes. There were no lapses in treatment noted for youth with chronic conditions. Informal interviews revealed nursing staff notify the DHA upon admission and schedule applicable youth for initial evaluation. When the youth comes for sick call related to the chronic condition, nursing staff notify the DHA.

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

The program has a written policy and procedures addressing medication management. Four of the seven reviewed youth records were for youth taking prescribed medications. Three youth were taking medication upon admission and the fourth youth was Baker Acted shortly after admission and when he returned to the center, came back with medication. Each of the medications were either brought in by the parent/guardian or received from a transferring facility and the nursing staff confirmed the medications had a current, patient-specific label in the original container, a current valid order, and are given pursuant to current prescription.
In each of the four records, the designated health authority (DHA) was contacted and in three records the psychiatrist was notified to obtain the order to resume the specified medications. Prescription verification was found and documented in the progress notes in each youth's record. One applicable youth was in confinement during one of the medication passes and refused his dosage. The youth signed a refusal of medication form.

Staff utilized the Department Medication Administration Record (MAR) for all medications including prescribed and over-the-counter (OTC) medications. A review of the MARs in each record revealed staff and youth initialed each medication administration, and nursing staff documented weekly side-effect monitoring on the MAR. Administration of any OTC medications

were documented on the back of the MAR, including when non-licensed staff provided medication after nursing hours. Two youth records contained refusal forms in accordance with refusal notes on the applicable MAR. The annual compliance review team did not find any standing orders, emergency treatment orders, or pro re-nata (PRN) orders for psychotropic medications at the center. Each of the MARs contained all the required elements and were filled out completely, including a picture of the youth and start/stop dates for each medication. There were no lapses/errors noted. None of the youth required parenteral medication.

Three of the seven youth were prescribed psychotropic medications and received a referral to the psychiatrist for an initial psychiatric interview. Each of the three youth received the initial psychiatric interview within the time frame and a medication review every thirty days by the psychiatrist.

The annual compliance review team observed medication pass during the annual compliance review week. Youth were escorted to the clinic for medication pass by detention staff or supervisors. Nursing staff verified each youth using the six rights of medication administration. Youth approached the nursing staff individually. Nursing staff verified the youth's allergy and alert status. Staff and youth initialed the MAR. Staff observed the youth to make sure medication was swallowed. Staff provided water for the youth to drink. Two youth records contained documentation signed by the youth of medication refusal.

A review of the medication cart revealed the cart is maintained in a locked area. The center maintains a separate medication cart for the west wing and the east wing. Both carts are maintained in the locked clinic area. Each cart contains a double-locked drawer for controlled medications. Medications are stored separated by type/form, for example oral, injectable, topical, drops, and liquids. Prescribed medications are separated into youth-specific sections in the cart. The center maintains a locked refrigerator available for medications requiring cooling storage. There were no youth in the center requiring refrigerated medications. The center procedures include the consulting pharmacist assists in the destruction and disposal of expired or discontinued medications. The center maintains an area in the medication cart for medications ready for disposal. Informal interviews indicated they would be delivered to the consulting pharmacist on his next quarterly visit. Reviewed documentation supported the pharmacist received medications each quarter for disposal/destruction.

Four of seven interviewed youth indicated the nurse gave them medications, the other three indicated they did not take any medication. Seven staff were interviewed regarding who gives medications to youth. Five staff indicated they do not and three indicated they are allowed to give medication to youth.

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

The program has a policy and procedures addressing medication and sharps inventory and storage process. A review of medication and sharps inventory and storage process revealed they maintain two medication carts, one on each wing of the center. All medical equipment classified as sharps are securely stored including a perpetual and weekly inventory. The center also documents a perpetual daily running inventory of medication utilization for all prescription

and over-the-counter (OTC) medications. A review of controlled medications revealed shift-to-shift counts were consistently documented with two signatures. There was one active Medication Administration Record (MAR) with controlled medication; however, the shift-to-shift counts were documented with no lapses or errors noted. The center documented weekly inventory counts for all opened OTC medications. Medications were delivered only by licensed nurses; although the nursing staff had trained supervisors to provide medications after nursing hours, there were no examples for review.

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

The program has a written policy and procedures addressing infection control/exposure control. In all seven youth records reviewed, the youth received infection control training within seven days of admission, which included hand-washing techniques, universal/standard precautions, prevention/transmission of communicable diseases, vaccinations, and infection control.
The center's exposure control plan was written in accordance with the Occupational Safety and Health Administration (OSHA) and included risk assessment and methods of compliance. The center's infection control procedures included prevention, containment, treatment, and reporting requirements to common, infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, tuberculosis, hepatitis A, B, C and human immunodeficiency virus (HIV) infectious diseases caused by blood-borne pathogens. It also contained other outbreaks or epidemics, outbreaks of pediculosis and/or scabies, methicillin-resistant staphylococcus aureus (MRSA) and other antibiotic-resistant micro-organisms, food-borne illnesses, bio-terrorist agents, and chemical exposures in the workplace.

The procedures included documentation universal precautions are followed by staff, protocols for needle-stick post-exposure intervention and treatment, hepatitis B immunizations made available to staff, and staff access to protective equipment. The center had three sexually transmitted infections which were reported to the local health department, as required, as well as the Central Communications Center (CCC). The center did not have three or more cases of reportable infectious diseases requiring notification of the Centers for Disease Control and Prevention (CDC). There was never an instance when ten percent of the population or six individuals who required quarantine or hospitalization. A review of seven pre-service and seven in-service training records indicated all staff received center specific exposure control plan training.

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

The program has a written policy and procedures addressing prenatal care/education. None of the seven youth records reviewed were applicable. The center provided two youth records since the last annual compliance review. In the two records, each youth received prenatal care

immediately upon determination of the youth's pregnancy status and at recommended intervals. Both youth received daily monitoring for danger signs of pregnancy complications during the prenatal vitamin medication pass and routine monitoring of the pregnant youth's nutritional and weight status. In the two records, each youth received education in alcohol and drug use, smoking, nutrition, sexually transmitted diseases, contraception, prenatal care, birthing process, post-partum care, basic baby care, child/infant development, and parenting skills. All provided education was documented in the individual healthcare record (IHCR). The medical staff indicated the center's doctor does not believe in an increase of calories for pregnant youth unless there is a nutritional deficit noted. All seven in-service training records indicated staff received education in girl's healthcare.

Standard 5: Safety and Security

5.01 Active Supervision of Youth (Critical)	Satisfactory Compliance

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

Youth are in sight of at least one juvenile justice detention officer (JJDO) at all times (with the exception of sleeping hours or time secured in rooms).

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

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

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

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

The center has a facility operating procedure (FOP) regarding supervision of youth.
The staff at the center communicate by two-way radio with master control. The center utilizes a roster generated in the Department's Juvenile Justice Information System (JJIS) to track the daily census of the youth. During the annual compliance review week, daily observations of youth were conducted throughout the center which confirmed the active supervision of youth by detention staff. Staff were observed supervising youth during line movements, outside recreation, and in the modules. Each observation found there was always at least two or more detention staff with each group of youth and staff were positioned in a manner providing them full view of the youth in the area. Staff were aware of the number of youth being supervised and requested permission from master control prior to any youth movement. Staff were observed having positive interactions with youth, and there were no inappropriate activities were observed between youth and staff.

A review of the master control logbooks for the past six months confirmed youth headcounts were completed consistently at the beginning and end of each shift, and prior to each youth movement. Seven staff were interviewed, and each reported believing there is enough staff at the center to provide for the safety and security of the youth and staff.

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

The center has a written policy and procedures ensuring ten-minute checks are conducted when youth are in their rooms for sleeping or other reasons. The center had a total of 154 cameras with 147 being operable during the annual compliance review, and a recording capacity of approximately seventeen to nineteen days. The center utilizes an electronic system to document ten-minute checks. Staff use the electronic wand by tapping the wand on the check point sensor located on the outside of each youth's room door. The data from the wand is downloaded daily to ensure no data is lost. Ten-minute room check observations on five different modules from three different shifts, and four different dates and times along with the corresponding ten-minute check log supported checks were conducted at least every ten minutes and in real-time. The juvenile justice detention officers (JJDO) were observed stopping at each door and observing the youth. The JJDO is responsible for pausing at each door to observe the youth behind the closed door before the check point sensor is activated with the wand to ensure there are no issues with the youth. The assistant superintendent was interviewed and validated this practice. Observations of youth living modules and rooms confirmed there were no obstructions over the windows and areas in which direct line of sight was needed. Seven staff were interviewed, and each staff reported room checks are completed every ten minutes.

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

The center has a written policy and procedures ensuring headcounts are conducted as required. Staff must always know the exact number and location of all youth under their supervision. Census counts are taken, called into master control, and documented in the center's master control logbook. The living module logbook records the count of the module. No youth movement is conducted until master control confirms the counts, reconciles the count, and authorizes the center's activity. Interviews with the center's master control operator and assistant superintendent confirmed this practice. A review of the master control logbook for the past six months validated headcounts are documented at the beginning and end of each shift, following any emergency or drill, whenever a population change occurs, prior to any youth movements, and randomly at least once on each shift. Seven staff were interviewed regarding youth counts and each staff responded counts are conducted at the beginning and end of each shift, prior to and following school, and before and after each meal. Each interviewed staff reported emergency counts are conducted when a youth is believed to be missing, when visibility is hindered, such as an electrical outage, and after any major disturbance.

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

The center has a written policy and procedures ensuring logbooks are maintained at master control and in each living area in accordance with the Florida Administrative Code. The center maintains separate logbooks for each living module and master control, as well as one for visitors and for contracted staff. A review of logbooks for the last six months for each living module and master control revealed most of the entries were legible and written in ink. There were no erasures or whiteout areas and the logbooks were bound together with numbered pages. All errors were struck through with a single line, dated, and initialed by the staff correcting the error. Each entry included the date and time of the event or incident with the name of the staff and youth involved, a brief description of the event, and the initials of the staff making the entry. A review of logbook pages indicated some did not include a.m./p.m. with the time entry, and not all safety and security issues were documented, including medical, special needs, and mental health alerts not being highlighted. The master control logbook entries included emergency situations, incidents, drills, receipt of medical and mental health alerts, population counts at the beginning and end of each shift, throughout each shift, group movements, following emergency situations, admissions and releases, presence of law enforcement in the center and documentation regarding youth being placed on precautionary or secure observation, and being stepped down. The center does not utilize electronic logbooks.

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

The center has a written policy and procedures ensuring logbook reviews are conducted as required. The superintendent or designee reviews the logbooks on a weekly basis and

documents any issues and/or discrepancies. The superintendent, assistant superintendent, or staff in charge of the center tour the youth living areas at least once during each shift and document the visit in each area's logbook. The juvenile justice detention officer supervisor (JJDOS) reviews the living module logbooks each shift, including the master control logbook prior to accepting a shift, to document awareness of all current relevant matters in the center. The juvenile justice detention officer (JJDO) assigned to the living module reviews the living module logbook when accepting responsibility for the living area at shift change. A review of the master control and living unit logbooks for the past six months supported these practices.

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

The center has a facility operating procedure (FOP) regarding key control. The center has a process in place which follows the FOP. The center maintains a key inventory for each key, which documents the key number, number of keys on each key ring, the purpose of the key and to whom the key is issued to, and if keys are permanently issued to a specific staff. Each staff who is permanently issued keys must sign an issued key receipt. The center maintains four separate key storage boxes; two in master control, one in the superintendent's office, and one in the supervisor's office. The key storage area in master control maintains keys for nursing staff, medical staff, kitchen staff, youth property, and key tags for visitors. Master control maintains a key logbook for staff and visitors to sign-in and indicate the time the key was taken, the key tag number, and the time the key was returned. Only master control staff have access to these keys. The key box in the superintendent's office maintains spare keys and emergency keys, of which only the captains and superintendent have access to. The key storage area in the supervisor's office maintains keys for floor staff and supervisors. The supervisors maintain a staff key logbook, where the staff sign-in, the time the key was taken, and the time the key was returned. Supervisors are the only staff who have access to the key storage area in the supervisor's office.

A shift change was observed and included the supervisor retrieving the staff members personal keys and providing the center keys in turn; the staff signed the key logbook, which included the number of the key ring provided. All staff and visitors must turn in their personal keys when entering the facility. Each of the three storage areas where keys are kept are secure as well as each key storage box is locked. None of the key storage areas are accessible to youth. A review of three key rings and the key inventory validated the key rings matched the inventory list and were on a color-coded key ring, as required by their FOP. Through interviews with staff, the

process of missing and damaged keys was determined. Damaged keys are reported to the supervisor, who in turn notifies maintenance, and the key is repaired or replaced. The supervisors write it on the white board in their office to track the damaged keys. All facility keys are maintained on tamper resistant key rings and are color-coded according to the FOP. A review of Central Communications Center (CCC) reports for the last six months validated there have been no lost keys during the annual compliance review period. According to the captain, if keys are lost, they immediately review the logbook to see which staff controlled the key last; this staff member is contacted to determine if they have the missing key. If this staff does not have the missing key, movement at the facility is stopped, and a search for the key ensues. If the key is not found within two hours, the CCC is contacted.

All staff are trained on key control upon hire; it is part of the pre-service training. A review of sign-in sheets for two different dates validated six new staff members were trained on key control. In addition, all staff who are issued keys review the FOPs which document all requirements of staff who are issued keys. The center utilizes Microsoft SharePoint to create and maintain all shift reports. A review of shift reports for each shift validated the distribution of keys to each staff is documented on each shift report, along with the date and time the key was issued and returned, the name of the staff issuing the key, the name of the person receiving the key, and the number of the key ring issued. The center indicated damaged keys were reported to the supervisor, noted in the center's Key Control Book on the Spare Key List documenting when a spare key was used to replace the damaged key. Maintenance staff repair or replace the damaged keys.

The center maintains invoices regarding replacement of damaged keys. Inactive key rings are included on the master key inventory and are maintained in a secure lock box, which is only accessible to supervisors. A daily inventory for inactive keys was captured on the shift reports up until November 2019, when shift reports were captured in the Department's Facility Maintenance System (FMS). As of November 2019, for this center, and January 2020, for centers statewide, the staff began to capture shift reports in SharePoint. The SharePoint system does not have a component to capture the inventory of inactive keys or account for the number of all keys on each shift.

Seven staff interviews indicated all staff provide keys to master control upon entry, as well as all visitors, and the personal keys are securely stored. All stated keys are tracked daily in a key log, and youth do not have access to keys. All seven also mentioned staff will notify master control of missing keys, the facility is searched for the missing keys, as well as youth. Six staff indicated a chit or token is provided to visitors in turn for their personal key and damaged keys are replaced. One staff also stated there is an inventory of keys conducted.

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

The center has a written policy and procedures ensuring vehicles to transport youth are properly maintained, inspected annually, and in good repair. The center's facility operating procedures

(FOP) prohibits tobacco usage in vehicles. The maintenance mechanic is responsible for weekly and monthly vehicle inspections. The center has a total of seven vehicles; of the seven, five vehicles were present during the annual compliance review. The five vehicles are used for youth transportation and all were observed to have the appropriate number of seat belts, the emergency equipment such as a first-aid kit, fire extinguisher, jumper cables, and each vehicle key had a seat belt cutter and window punch attached to it. All the vehicles had fire extinguishers which passed the annual inspection. All vehicles had an annual safety inspection conducted by a certified automobile mechanic.

Observations of the five vehicles verified four of the vehicles were locked when not in use and one was found unlocked. Each vehicle was observed to have a binder which contained the vehicle mileage log, mechanical restraint key, gas card, vehicle policy, and vehicle registration. Each vehicle was inspected prior to transporting youth using the Department's approved checklist. The last six months of reviewed documentation supported this practice. A review of the last six months of weekly visual vehicle inspection checks were conducted. All the vehicles were checked for proper level of water coolant, lights, oil, emergency equipment, brakes, horn, interior/exterior, and cleanliness of the vehicle.

A review of the last six months of mandatory maintenance forms was conducted. All the monthly vehicle checks included the tires, battery, windshield, wipers, windows, mirrors, and other visual damage. Reviewed documentation supported a pre-trip inspection is completed on each vehicle by staff. Each vehicle is inspected prior to transporting youth using the Department's approved checklist and all staff and youth must utilize seat belts. Four staff were interviewed and confirmed the practice for transport.

During the annual compliance review week, the team was unable to observe a transport. A total of five transportation logbook entries were reviewed. All maintained documentation the vehicle had been searched for contraband before and after transport, a cellular phone was provided, included the destination, the transportation beginning and end time, the number of youth transported, and the staff's name. It did not state which staff was riding in the back with the youth, when it was more than one youth.

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

The center maintains a written policy and procedures ensuring tools and equipment are properly maintained, stored, and inventoried. The center's tools are maintained in a locked shed outside the secure area only accessible to the maintenance mechanic staff and administrators. Tools are stored on a shadow board and marked with an identification number. A perpetual tool inventory is maintained by the center to document what tools are being used by the maintenance staff including the times the tools were checked-out, the location of the tools, and times the tools were returned. An interview with the maintenance mechanic confirmed inventory is conducted monthly by maintenance staff and reviewed by the superintendent or designee. The center's kitchen tools, inclusive of knives, are securely stored in a locked box in the kitchen, with an inventory sheet.

A perpetual inventory of kitchen tools is maintained, and counts are documented three times each day. A tool disposal/replacement report is completed for any maintenance or kitchen tools

in need of disposal or replacement, which the maintenance or food service manager signs and provides to the superintendent for approval. Additionally, when tools are lost or if there is suspicion a youth may be in possession of a tool, the juvenile justice detention officer supervisor (JJDOS) is notified immediately, and a search is conducted. A review of the monthly inventory sheets confirmed there were no missing maintenance or kitchen tools, nor any discrepancies. An informal interview with the center's assistant superintendent and maintenance mechanic confirmed there have been no missing tools in the past six months.

During the annual compliance review week, observations of interactions with service vendors and staff were completed. The staff always accompanied service vendors, and positively identified them prior to allowing them access to any secure areas. Seven staff were interviewed regarding center practice for lost or damaged tools. All reported they would notify their supervisor and the maintenance mechanic.

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

The center has a written policy and procedures ensuring youth do not have access to any tools, including kitchen or medical equipment. The center only allows youth to have access to mops, brooms, buckets, cleaning rags, and other common household items for general cleaning. Youth are constantly supervised when utilizing these items. Observations during the annual compliance review supported this practice. Seven youth were interviewed, and each confirmed they are not allowed to use any tools. Seven staff were interviewed, and confirmed youth are only allowed to use mops and brooms and they do not have access to any tools.

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

The center has a safety plan to address the inventory of flammable, toxic, caustic, and poisonous items. Flammable, toxic, caustic, and poisonous items were maintained in a locked,

secure storage area with limited access; not accessible to youth. Safety Data Sheets (SDS) logbooks are located with the stored chemicals. All items are inventoried weekly by the maintenance mechanic and securely stored when not in use. Each item observed had an SDS on record. Observation of the secure storage area and the inventory list indicated all items matched the inventory list. The SDS and inventories were compared to the items on-site and were found to be accurate and complete.

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

The center has a written policy and procedures ensuring limited access to flammable, toxic, caustic, and poisonous items. Youth do not have access to any materials which are flammable, toxic, caustic, and/or poisonous. The center maintains a list of authorized staff who are allowed access to the chemical storage area. An informal interview with the center's assistant superintendent confirmed flammable, toxic, and caustic materials are stored in secure areas in the kitchen and maintenance storage, and are only accessible to the maintenance mechanic, supervisors, administrators, and the food service director. Observations conducted during the annual compliance review found no toxic, flammable, or poisonous materials stored in any places accessible to youth. Seven staff were interviewed, and each reported youth are not allowed to use any toxic, flammable, or poisonous substances. Seven youth were interviewed, and each confirmed youth are not allowed to use any cleaning materials such as bleach, laundry soap, window, or toilet cleaner.

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

The center has a policy and procedures regarding disposal of flammable, toxic, caustic, and poisonous items. There were no reports of chemical spills at the center or disposal of applicable materials in the past six months. The maintenance mechanic was interviewed and confirmed all poisonous, toxic, caustic, and flammable items are disposed of at Orlando Recycling or Universal Waste. The maintenance mechanic further confirmed the center did not dispose of any items in the past six months.

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

The center has a written policy and procedures regarding the confinement of youth in the event the youth's behavior threatens the physical safety of self or others. During a tour of the center, the confinement rooms were observed and were found to be free of obstructions and contained only fixed items. Youth in confinement were afforded living conditions available to those in the general population; however, no youth in confinement are allowed contact with the general population. The windows and cameras were free of obstructions/scratches, so the youth could be visually observed.

A total of fifty youth confinements under twenty-four hours and after September 5, 2019 were reviewed. Each confinement report documented only one youth was placed in a confinement room and a search conducted. Searches were also documented in the Department's Juvenile Justice Information System (JJIS) Facility Management System (FMS). In all fifty confinements, the supervision was documented on the Visual Observation Report (VOR) at a minimum of every five minutes for the first hour and included an initial confinement supervisor review within two hours of the incident, for each youth. The review included the reason for the confinement and was completed prior to the end of the shift. All fifty confinements contained additional reviews conducted at least every three hours by a supervisor with the youth, included a reason for continued confinement, as well as continued counseling of the youth and consideration for removal from confinement. All the reports included the superintendent documenting the need for continued confinement based on each youth's behavior, and the superintendent reviewed the confinement within forty-eight hours. Eleven of the eighteen applicable confinements found youth did not receive education materials during a time each youth was missing school and after notifying the education department each youth would be absent due to confinement. Seven staff were interviewed and stated they must complete the report, search the room, and conduct five-minute checks on each youth for the first hour, and then ten-minute checks.

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

The center has a written policy and procedures regarding confinements over twenty-four hours. A total of ten youth confinements over twenty-four hours were reviewed. None of the confinement reports exceeded three days. Each of the confinement reports were located in the Department's Juvenile Justice Information System (JJIS). The reports included documentation the rooms were searched prior to placement and were approved by the superintendent or designee. The juvenile justice detention officer supervisor (JJDOS) conducted a conversation with the youth and completed an evaluation every three hours, and the confinement beyond twenty-four hours was approved by the regional director. Each confinement was reviewed by a mental health staff every twenty-four hours. In one of the ten confinements, the youth was released ten-minutes past the three-hour evaluation time frame.

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

The center had a disaster preparedness plan, which is part of the operating procedures. In the last year the center completed three Continuity of Operations Planning (COOP) drills which include the type of drill, the date and time, participants, scenario, findings, and recommendations. Two of the drills were actual severe weather events. Seven staff interviews indicated they all participated in at least one COOP drill in the last six months.

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

A review of the center's escape prevention plan indicated the Department's policies and procedures regarding escape were included. The center conducted at least one quarterly escape drill, which were documented in the center's logbook. All seven in-service training records reviewed indicated all completed the annual escape prevention training. Seven staff interviews indicated all participated in an escape drill in the last six months.

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

The center has a written policy and procedures ensuring fire prevention and safety of the center. Annual inspections are conducted by the fire marshal. The center's fire prevention and safety plans were reviewed and approved by the state fire marshal on October 3, 2019. The center has evacuation egress plans posted throughout the center. Each egress plan defined primary and secondary exit routes, and the locations of emergency equipment, such as fire extinguishers. A review of the drills and logbook documentation for the past six months confirmed each shift conducted fire drills every month as required, except for one month, one shift did not conduct their monthly fire drill, as required. Seven staff were interviewed, and all participated in a fire drill in the last year. Six reported they had participated in at least one monthly fire drill and one staff stated they did not.