STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

# BUREAU OF MONITORING AND QUALITY IMPROVEMENT

## PROGRAM REPORT FOR

## Orange Regional Juvenile Detention Center

***Department of Juvenile Justice***

**(State-Operated)**
**2800 South Bumby Avenue**
**Orlando, Florida 32806**

***Review Date(s): June 11-14, 2019***

PROMOTING CONTINUOUS IMPROVEMENT AND ACCOUNTABILITY IN JUVENILE JUSTICE PROGRAMS AND SERVICES

## Rating Definitions

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

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

## Review Team

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

Bonita Williams, Office of Program Accountability, Lead Reviewer (Standard 1)
Pam Adams, Office of Program Accountability, Regional Monitor (Standard 4)
Teresa Andersen, Office of Program Accountability, Deputy Supervisor (Standard 5)
Dawn Buchanan, Youth Opportunity Investments, Assistant Facility Administrator (Standard 2)
Paul Czigan, Office of Program Accountability, Regional Monitor (Standard 5, Interviews)
Tamara Mahl-Adkins, Office of Program Accountability, Regional Monitor (Standard 4)
Kamille Payne, Office of Program Accountability, Regional Monitor (Standard 3)

Program Name: Orange Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: Orange County / Circuit 9
Review Date(s): June 11-14, 2019

MQI Program Code: 247
Contract Number: N/A
Number of Beds: 110
Lead Reviewer Code: 148

# Methodology

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

## Persons Interviewed

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

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

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

## Documents Reviewed

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

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

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

## Observations During Review

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

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

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

## Comments

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

# Standard 1: Management Accountability
# Detention Rating Profile

## Indicator Ratings

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

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

# Standard 2: Youth Management
# Detention Rating Profile

## Indicator Ratings

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

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

## Indicator Ratings

| Standard 3 - Mental Health and Substance Abuse Services | | |
|---|---|---|
| 3.01 | Designated Mental Health Clinician Authority (DMHCA) | Satisfactory |
| 3.02 | * Licensed MH/SA Clinical Staff | Satisfactory |
| 3.03 | Non-Licensed MH/SA Clinical Staff | Satisfactory |
| 3.04 | MH/SA Admission Screening | Satisfactory |
| 3.05 | MH/SA Assessment/Evaluation | Satisfactory |
| 3.06 | MH/SA Treatment | Satisfactory |
| 3.07 | Treatment and Discharge Planning | Satisfactory |
| 3.08 | * Psychiatric Services | Satisfactory |
| 3.09 | * Suicide Prevention Plan | Satisfactory |
| 3.10 | * Suicide Prevention Services | Satisfactory |
| 3.11 | * Suicide Precaution Observation Logs | Satisfactory |
| 3.12 | * Suicide Prevention Training | Satisfactory |
| 3.13 | * Mental Health Crisis Intervention Services | Satisfactory |
| 3.14 | *Emergency Care Plan | Satisfactory |
| 3.15 | *Crisis Assessments | Satisfactory |
| 3.16 | * Baker and Marchman Acts | 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 | Satisfactory |
| 4.05 | Notification - Clinical Psychotropic Progress Note | Satisfactory |
| 4.06 | Immunizations | Satisfactory |
| 4.07 | Healthcare Admission Screening Form | Satisfactory |
| 4.08 | Medical Alerts | Satisfactory |
| 4.09 | Suicide Risk Screening Instrument | Satisfactory |
| 4.10 | Youth Orientation to Healthcare Services | Satisfactory |
| 4.11 | DHA/Designee Admission Notification | Satisfactory |
| 4.12 | Healthcare Admission Rescreening | Satisfactory |
| 4.13 | Health Related History | Satisfactory |
| 4.14 | Comprehensive Physical Assessment | Satisfactory |
| 4.15 | Female-Specific Screening/Examination | Satisfactory |
| 4.16 | Tuberculosis Screening | Satisfactory |
| 4.17 | Sexually Transmitted Infection Screening | Satisfactory |
| 4.18 | HIV Testing | Satisfactory |
| 4.19 | Sick Call Process - Requests/Complaints | Satisfactory |
| 4.20 | Sick Call Process - Visits/Encounters | Satisfactory |
| 4.21 | Restricted Housing | Satisfactory |
| 4.22 | Episodic/First Aid Care | Satisfactory |
| 4.23 | Emergency Care | Satisfactory |
| 4.24 | Off-Site Care/Referrals | Satisfactory |
| 4.25 | Chronic Conditions/Periodic Evaluations | Satisfactory |
| 4.26 | Medication Management - Verification | Satisfactory |
| 4.27 | Medication Management - Orders/Prescriptions | Satisfactory |
| 4.28 | Medication Management - Storage | Satisfactory |
| 4.29 | Medication and Sharps Inventory | Satisfactory |
| 4.30 | Medication Management - Controlled Medications | Satisfactory |
| 4.31 | Medication Administration Record | Limited |
| 4.32 | Medication Administration By Licensed Staff | Satisfactory |
| 4.33 | Medications Provided By Non-Licensed Staff | Satisfactory |
| 4.34 | Psychotropic Medication Monitoring | Satisfactory |
| 4.35 | Infection Control - Surveillance, Screening, and Management | Satisfactory |
| 4.36 | Infection Control - Education | Satisfactory |
| 4.37 | Infection Control - Exposure Control Plan | Satisfactory |
| 4.38 | Prenatal Care - Physical Care of Pregnant Youth | Satisfactory |
| 4.39 | Prenatal Care - Nutrition and Education of Youth | Satisfactory |
| 4.40 | Prenatal Staff Education | Satisfactory |

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# Standard 5: Safety and Security
# Detention Rating Profile

## Indicator Ratings

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

* 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).

## 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 161 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, two administrative assistants, ten juvenile justice detention officer (JJDO) supervisors, and sixty-six JJDOs. Mental health and healthcare services are provided through the contracted provider, Maxim Healthcare Services, Inc. who subcontracts with Camelot. Mental health services are provided by two licensed therapists who serve as the designated mental health authority, one additional licensed therapist, and two non-licensed mental health staff. Clinical services provided by the center include mental health and substance abuse evaluations, mental health treatment planning, individual, group and family therapy, mental health crisis intervention services, on-site psychiatric services, and availability for substance abuse services for youth with co-occurring disorders. Medical services are provided by one medical doctor who serves as the designated health authority, an advanced registered nurse practitioner, one registered nurse, and four licensed practical nurses. The medical clinic maintains nursing coverage every day, from 7:00 a.m. to 7:30 p.m. Food services are provided by Department staff and include menus, meal planning, meal schedules, special diets, nutritional analysis, daily allowance, food preparation, health certifications, food product standards, sanitation, and cleaning. Staff are responsible for the custody and control of youth in their care providing youth supervision twenty-four hours a day, seven days a week. The center has six living modules which are divided by male and female. There are 147 security cameras at the center, of which 135 were operational. Many improvements have been made to the facility which include new paint throughout the center, new doors for youth rooms, renovation of all youth living modules, designation of an honors module, and overall maintenance and appearance restoration. At the time of the annual compliance review, the center had thirteen vacancies which included nine JJDO IIs, three JJDO Is, and one assistant superintendent.

## Strengths and Innovative Approaches

- Once a month during the school year, Orange County Public Schools teachers and school administrators at the Orange Regional Juvenile Detention Center attend visitation night. The teachers and school administrators bring in food and provide information to the parent/guardian and family members visiting youth at the center. The goal is to update families on the educational progress of their youth who are in the facility and provide information about re-enrolling their youth back into school following their release from the center. This innovative practice is an above and beyond effort by the Orange County Public School system to assist youth and families through this difficult experience with the transition between the schools to ensure there is a seamless transition and to minimize any disruption to the youth's education.

- A new behavior management system was implemented during the last year with Adapt and Transform.

- The Junior League of Greater Orlando visits the center every other week and works with the female mod each time they visit. The Junior League offers different services and opportunities for the youth.

- The center renovated one of the youth modules and changed it into an Honors Mod, which was implemented in July 2018. The Honors Mod is a reward to youth who have succeeded in the behavior management program with additional privileges and activities. The new mod has a very positive impact on behavior at the facility.

- The center is utilizing the Kula for Karma grant, which pays for yoga and meditation several times a week for the youth girls and Honor's Mod.

- The Orange County School Board teachers are working with the youth to cultivate a garden to help improve the aesthetic of the outside space at the center and teach the youth valuable skills.

- Chalkboard paint was applied in each youth room for graffiti reduction as well as a positive method of self-expression and artistic opportunity.

- An advisory board was created and maintained during the past year which contributes to positive employee recognition, donations for youth, new events for youth, and volunteers to assist at the center.

# 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. A contract provider may hire an employee to a position that requires background screening before the screening process is completed, but only for training and orientation purposes. However, these employees may not have contact with youth or confidential youth records until the screening is completed, the rating is eligible and the employee demonstrates that he or she exhibits no behaviors that warrant the denial or termination of employment. An Annual Affidavit of Compliance with Level 2 Screening Standards is completed annually.* | |

The center has facility operating procedures in regard to the process of conducing background screenings for new hires, which includes volunteers and mentors, if applicable. Since the last annual compliance review, Orange Regional Juvenile Detention Center had a total of thirty-five new hires to include medical and mental health staff. The center did not have any new volunteers or mentors since the last annual compliance review. Each of the new hires completed a background screening located in the Background Screening Unit (BSU) prior to their hire. The background screening included criminal history, Central Communications Center (CCC), and Staff Verification System checks. None of the new hires were applicable for exemptions. Out of the thirty-five new hires, twenty-six were applicable for the pre-employment assessment tool for direct care. The remining nine staff were either non-direct care staff, medical, or mental health staff. One of the twenty-six new hires did not pass the pre-employment assessment tool; however, the center received approval to hire. New hires are to pass the pre-employment assessment tool with a seventy percent or higher. Five of the thirty-five new hires were employed by the medical and mental health provider, Maxim Healthcare Inc.; therefore, their background screenings were entered into the Agency for Healthcare Administration Clearinghouse. The contract employees, one therapist, and four medical staff did not require pre-employment assessments; as they are licensed staff and exempt. Each of the five contract staff completed an eligible background screenings which were entered in the Clearinghouse employment roster. The program submitted the Annual Affidavit of Compliance with Level 2 Standards on January 8, 2019 to the BSU. In addition, the program submitted annual screening for the teachers hired by Orange County Public School system on January 22, 2019.

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

The center has facility operating procedures in regards to the process of conducting five-year rescreening for applicable staff. A review of the Background Screening Unit (BSU) revealed the center had eight staff eligible for five-year rescreening. Each of the eight staff had a rescreening completed. The center submitted the rescreening ten days prior to anniversary date for each applicable staff.

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

The center has facility operating procedures to ensure staff comply with the staff code of conduct which governs staff interaction with youth in the center. The code of conduct prohibits any form of abuse, profanity, threats, harassment, intimidation, or personal relationships with youth. A review of seven new staff members personnel records contained a signed copy of acknowledging receipt of the code of conduct upon their hire. Three of the seven new staff reviewed had a disciplinary action for violating the code of conduct for violation of law or agency rules and poor performance. The management responded to the violations with one oral reprimand, one written reprimand, and one termination. One of the violations included the staff receiving money from a youth and not reporting it to supervisors. The center reported this violation into the Central Communications Center (CCC) within the required time frame. The center present awards to staff who have displayed good work ethics on a monthly basis. In addition, the center present a Provider of the Month, Volunteer of the Quarter, and Honorary Orange Tough Awards to staff who have earned them.

The superintendent reported during an interview, everyone is a mandated reporter and when they have knowledge of any allegation the Florida Abuse Hotline must be contacted, complete an incident report, inform the regional director and call the CCC within two hours. If the allegation is against a facility staff member, the individual should be removed from youth contact pending the investigation.

During interviews, seven staff reported they are to notify the supervisor when a youth wants to call the Florida Abuse Hotline. Three staff reported they allow the youth to make the call through the supervisor in which the supervisor will make the call. Four staff reported staff are allowed to call, if needed. Two staff reported never observing staff use profanity. Two staff reported once and three reported occasionally. None of the staff reported observing staff use threats, intimidation, or humiliation when interacting with youth. In the past year, one of the seven interviewed staff reported conditions were poor. Three staff reported fair and three reported very good conditions. Seven youth were interviewed during the annual compliance review. Two of the seven youth reported never being stopped from calling the Florida Abuse Hotline. Five youth reported never having to report abuse. Six of the seven youth reported staff are respectful when

speaking to youth and one youth reported staff are not. Four of the seven youth reported hearing staff use profanity occasionally, two reported once, and one reported never. None of the interviewed youth reported hearing staff threatening another youth.

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

The center has facility operating procedures for the process of notifying Central Communications Center (CCC) within two hours of the incident or becoming aware of the incident. In the past six months, the center had a total of 164 CCC's reportable incidents. A review of six CCC's was conducted for compliance. Each of the six CCC incidents were reported within the two-hour time frame. Incidents ranged from medical incidents, program disruption, and complaint against staff. Three of the six CCC's were documented in the logbooks and three were not. The program agreed with the findings and staff will be retrained on this issue. During the annual compliance review, the team did not observe any incidents requiring an incident report.

The superintendent reported during an interview, everyone is a mandated reporter and when they have knowledge of any allegation the Florida Abuse Hotline must be contacted, complete an incident report, inform the regional director, and call the CCC within two hours. If the allegation is against a facility staff member, the individual should be removed from youth contact pending the investigation.

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

Since the last annual compliance review, the center had a total of 157 Protective Action Response's (PAR). A review of sixteen PAR reports were reviewed for this review period. All PAR reports are entered into the Department's Juvenile Justice Information System. The center's PAR rate during the annual compliance review period was 14.06, which is above the statewide Detention PAR rate of 11.75. The center had an increase in PAR incidents during the annual compliance review period. To address the increase, the assistant superintendent reported they are training staff to use verbal intervention to de-escalate situations in trying to lower the number of PAR's. None of the sixteen PAR reports had documentation of the use of mechanical restraints. The PAR reports were completed by the end of the shift and included all statements from staff involved. One of the reviewed sixteen PAR's, a staff member was injured during the incident. None of the PAR's had documentation of allegations of abuse by the youth. Each of the reports were reviewed within seventy-two hours of the incident by all required parties. Fourteen of the sixteen PAR reports indicated the post-PAR interview was conducted within thirty minutes of the incident. The superintendent or designee reviewed all PAR's and documented comments or corrections.

The superintendent reported in the interview, supervisors are required to review and sign all PAR reports during their shift and administrators are required to review and sign all PAR reports within forty-eight hours. PAR fidelity forms and video must be submitted to regional office for improper PAR and/or injuries to youth or staff. An interview with seven staff reported using verbal intervention prior to using physical restraints or PAR.

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

The center has facility operating procedures to ensure new staff receive proper training prior to interaction with the youth. Seven new staff were reviewed for pre-service training. Each of the seven new staff completed their certification within 180 days of hire. Each of the new staff completed the required training prior to having any contact with youth. All new staff completed Phase One training, three staff completed the Phase Two training and were certified detention officers. Two of the four staff have not completed Phase Two training and are currently in the Phase Two academy. The remaining two staff are waiting on the next academy. Each of the four staff who have not completed Phase Two training were within the first 180 days of their employment.

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

The center has facility operating procedures to ensure staff continue annual required trainings. Seven staff which included three supervisors, were reviewed for in-service training for the calendar year 2018. The program has a written in-service training plan which was submitted and approved by the Department's Office of Staff Development and Training on January 19, 2018. The program had an annual training calendar which is updated, as needed. The staff received training in Protective Action Response (PAR), cardiopulmonary resuscitation (CPR), first aid, suicide prevention, and professionalism and ethics for the calendar year 2018. The three supervisors completed the required eight hours of supervisory training. All in-service training was entered in the Department's Learning Management System (SkillPro). The superintendent was interviewed and reported receiving training in leadership development, human trafficking, information security awareness and required annual trainings. In addition, the superintendent reported all staff are required to complete Phase I and Phase II as part of their pre-service training and twenty-four hours of required in-service training as outlined by the in-service training plan.

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

The center has facility operating procedures to ensure alerts are reviewed, responded to appropriately, and documented. Seven youth records requiring alerts were reviewed. Two of the seven youth currently have open alerts and five have closed alerts in the Department's Juvenile Justice Information System (JJIS). The alerts consisted of medical, suicide risk, mental health, vision, and diet. Each alert was verified, entered, and closed by the appropriate staff. All alerts are updated as needed and reviewed by all center's staff. The updated alerts are discussed and given to staff at shift change. This is evident by review of shift reports for the past six months. An interview with seven staff reported, they are informed of alerts through review of the logbook, shift debriefing, alert forms, JJIS, and email. All seven interviewed staff reported being informed of issues within the center through logbook, staff debriefing, meetings, and emails.

# Standard 2: Assessment and Performance Plan

| 2.01 Admission | Satisfactory Compliance |
|---|---|

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

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

The center has facility operating procedures regarding the process of youth admission into the center. Each of the seven youth case management records reviewed, the admission wizard documented the staff reviewed all required documents. In addition, each of the seven youth received a telephone contact with their parent/guardian. All records indicated the required documents were reviewed by the admitting officer. Three intakes were observed during the annual compliance review which validated youth are frisk searched, stripped searched by officer of the same gender, and medical, mental health and substance abuse screenings were conducted. All three youth were observed receiving meals within forty-five minutes of the intake process. The youth's admission included a youth handbook, gang questions, and youth visitation information.

| 2.02 Orientation | Satisfactory Compliance |
|---|---|

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

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

The center has facility operating procedures regarding youth orientation process. Seven youth case management records were reviewed and each contained documentation the youth participated in an orientation on the day of admission. All records contained an orientation checklist with all required elements. All orientation checklists reviewed were initialed and signed

by the youth and intake staff. All records contained a copy of the youth handbook, including a signature page signed by the youth and staff indicating the handbook was reviewed, and a copy provided to the youth. All records included a personal property inventory and a list of contraband items. All youth admissions were documented in the wizard and facility logbook. An interview with three youth indicated their orientation started on the day of their admission. All interviewed youth indicated their orientation included the program rules, procedures, and program schedule. One of the youth further indicated they signed a lot of papers.

| 2.03 Classification | Satisfactory Compliance |
| --- | --- |

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

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

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

The center has facility operating procedures for the process of the classification of youth entering the center. In admission, the classification is held to assist staff in identifying the physical characteristics of the youth, special needs, maturity, age, history of violence, gang affiliation, past criminal behavior, and/or sexual aggression/vulnerability to victimization. Safety and security risks are identified to assist the staff in guiding the decision-making process, determining youth's living unit assignments, and room assignment. Seven youth case management 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, as well as suicide risk, medical risk, escape risk, or any other security risk which could impact the youth and/or their living environment. There was documentation in all reviewed records the center reviewed the Department's Juvenile Justice Information System alerts, the youth's electronic wizard documents, and contacted the youth's parent/guardian for initial call. All admission classification forms were signed by the youth and intake staff. An interview with the intake supervisor confirmed factors such as mental health status, physical health status, cognitive performance, age, and prior victimization are all considered when classifying a youth and assigning a youth to a dormitory and sleeping room.

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

The center has facility operating procedures in place for the classification of gang members. A review of seven youth case management records indicated two youth were applicable as a gang member upon admission to the program. The center was not able to provide additional records for review of youth who were classified as gang members or affiliates either at admission or after admission. Upon admission, each of the youth were screened for being a gang member or affiliate with any street gangs. Both youth had the gang alert entered into the Department's Juvenile Justice Information System prior to latest admission. When a youth enters with a gang alert, all staff are made aware of this through shift debriefings, emails, and meetings.

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

The center has facility operating procedures in place to outline the process of notifying the appropriate parties of youth entering the program with suspected gang affiliation, or documented gang membership for youth who are observed engaging in gang activities while in the program. Seven youth case management records were reviewed; however, only two youth was applicable for gang affiliation or membership. The program was not able to provide any additional youth records for review of gang identification and notification. There was documentation in the two applicable records the youth admitted gang involvement during admission to the program or after their admission. There was documentation in each record gang notification for the youth's assigned gang juvenile probation officer and gang representative for detention.

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

The center has facility operating procedures in place to ensure the youth's personal property is inventoried to ensure all property will be returned upon release or residential placement. All seven records reviewed, staff verified and secured all personal items in a tamper-proof property

bag along with the property list form, the description on the property receipt form, the date, the youth name, the Department of Juvenile Justice (DJJ) identification number with the list placed inside the bag, the youth signature, and the staff initials who placed the items in the property bag and sealed it. The drop safe is under the surveillance of two cameras. One of the seven youth, the parent/guardian picked up the youth's property on behalf of the youth. The parent/guardian identification was obtained, copied, and the parent/guardian signed the release of property form.

All youth property bags were placed in the drop safe, logged in the logbook to include the date, time, youth's name, DJJ identification number, and the officer who secured the property. In the event a youth refuses to sign the property receipt form, the supervisor will be contacted and will be documented on a refusal form. The facility did not have any refusals at the time of the annual compliance review. The youth's other personal property, including the youth's clothes were placed in an assigned green bag as documented on the property sheet. All seven interviewed youth reported, staff checked their personal property and signed the form indicating it was correct.

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

The center has facility operating procedures in place to ensure the youth's personal property will be controlled and safeguarded during their stay. During observation of an admission, it was observed the drop box is located under the vision of two video surveillance cameras. At intake, the youth's personal property is maintained in a locked file cabinet until a supervisor is able to move the property into the personal property room which is secured. The center had one incident since the last annual compliance review of a youth's personal property allegedly being lost or stolen on May 20, 2019. The incident was reported to the Central Communications Center.

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

The center has facility operating procedures in place to ensure youth are not inappropriately released from secure detention and youth is eligible for release. One of the seven youth reviewed was released. The center provided two additional youth records of youth who were released. The supervisor reviews all documents related to the youth's release included but not limited to all future court dates, admission and termination dates, face sheet, all court orders, check for warrants, email, the Department's Juvenile Justice Information System, juvenile probation officer supervisor and probation detention review specialist, verify the release wizard is completed, and ensure no dual holds were completed on the three releases reviewed. In all three youth reviewed, each youth received their property upon release and was released to the appropriate individual. A youth release was not able to be observed during the annual compliance review. During the past six months, the center had one incident of an unauthorized release on May 3, 2019. The incident was reported to the Central Communications Center (CCC), as required.

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

The center has facility operating procedures in place to ensure youth and parent/guardian account for all youth's personal items. One of the three youth records reviewed were applicable for release of property. The center provided two additional records for review. All three records reviewed had signed property receipts from youth and their parent/guardian. There was documentation in the youth's closed record documenting receipt of property. The center had one example of property held over thirty days and there was documentation of attempts to contact the youth in regard to retrieving property left at the center.

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

The center has facility operating procedures in place to ensure medications are given to the individual whom the youth is being released. None of the three closed records reviewed were discharged with medication or aftercare instructions. An additional two records were provided by the center of youth who were on medication but not discharged as of yet; therefore, were not applicable. A nurse was interviewed and explained if a youth is being released on medications, the release will review any upcoming appointments or health needs with the youth and their parent/guardian.

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

The center has facility operating procedures in place to ensure weekly detention reviews are conducted which included home and secure detention youth. A review of detention review meetings was conducted for the past six months. All meeting minutes were maintained in the Department's Juvenile Justice Information System. There was documentation of attendance of

all required parties as documented on the sign-in sheets. During the detention review meetings, the team discusses each youth in home and secure detention and their status, such as release and pending commitment. During the annual compliance review, a detention review meeting was observed. The meeting is held every Thursday at the detention center. All parties in attendance signed the sign-in sheet. It was observed the team reviewed each youth case and discussed any issues needing to be addressed.

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

The center has facility operating procedures in place to ensure youth activities and the youth are constructively involved. The daily activity was posted throughout the facility. The center has a daily activity schedule and a weekend/holiday activity schedule outlining the days and times for each youth activity. Daily activities include personal hygiene, meals times, visitation, education, recreation and physical activity time, groups (including gender-specific programing), restorative justice programming, life and social skills competency, indoor activities, and religious services. The Facility Management System (FMS) supports restorative justice, life and social skills, and gender-specific groups are being provided to the youth. Six of the seven interviewed youth reported the daily schedule is followed. One youth reported the schedule is not followed.

| 2.13 Adherence to Daily Schedule | Satisfactory Compliance |
|---|---|
| *Facility staff shall adhere to the daily activity schedules. Documentation of all activities shall be made in all applicable logs.*<br><br>*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.*<br><br>*Any cancellation of visitation shall be approved by the superintendent.* | |

The center has facility operating procedures in order to ensure adherence of the daily schedule. A review of logbooks and the daily schedule for the previous six months confirmed the daily activity schedule was followed for all activities except education. Entries in the logbook indicates youth were late to school or there was no documentation of when the youth left school on a consistent basis. The center was made aware of this issue and agreed with the findings. Observation of adherence of daily schedule was not able to be observed during the annual compliance review. Other activities such as recreation, meals, groups, and personal hygiene were documented on a consistent basis. Six of the seven interviewed staff reported the daily schedule is followed. Six of the seven interviewed reported the center has a daily schedule and it is followed. One youth reported the schedule is not followed when youth are locked down.

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

The center has facility operating procedures to ensure youth have access to education while in the center. The review of logbooks documented entries of either youth movement to education was late or no documentation of youth movement from education; therefore, confirmation of how many hours youth are in education daily could not be determined. An interview with seven youth confirmed, they are receiving education while in the center. Education staff reported school is cancelled if the center does not have enough staff. The education program operates on a year-round basis, with  Christmas, spring break, and several recognized holidays throughout the year. Youth attend classes daily where they work on earning a regular diploma, a General Education Development (GED), or credit recovery. The instructors assess each youth when they enter the center to determine where each youth is in their schooling. During the interviews, all seven youth reported the center provides education and they attend school Monday through Friday.

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

The center has facility operating procedures to ensure the center is providing career education. The center is Type 1 which means life skills group, activities, and instruction are provided. In addition, the education programing includes communication, interpersonal, and decision-making skills. The youth participates in the Florida Food Handler course and Digital Information Technology, where youth earn certificates upon successful completion. All seven interviewed youth reported taking life skills, career choices, math, science, history, reading, social studies, and employability skills courses.

| 2.16 Behavior Management System | Satisfactory Compliance |
|---|---|
| *The program provides a system of rewards, privileges, and consequences to encourage youth to fulfill the program's expectations.*<br><br>*Each facility shall implement and maintain a behavior management system to meet the needs of the youth and the facility. The system shall be approved by the regional director and shall include rewards for positive behavior and consequences for inappropriate behavior.*<br><br>*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 facility operating procedures in place in regard to the Behavior Management System (BMS). Training documentation was reviewed and validated staff were trained on Adapt and Transform Behavior on October 24, 2018 and BMS on August 29, 2018. The review team conducted a tour during the annual compliance review and noted there was a copy of the BMS on each dorm. 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 extra telephone calls, a later bedtime, movies, and canteen. The youth levels can be dropped levels if they do not meet the center's expectations. A review of documentation

supported the BMS was used appropriately. Logbooks indicated youth were given ample warnings and were advised of why their level was being dropped when appropriate.

Youth sign the handbook during admission agreeing to read and to familiarize themselves with the handbook. The Adapt & Transform Behavior which gives examples and explains to the youth appropriate and non-appropriate behaviors. The center provided the behavior matrix on expectations and consequences when youth do not adhere to the rules. Postings of the rules are on the dorms. Norms and the expectations are posted in the living area, the classrooms, the dining hall, line movement, and the recreation yard. Youth can lose a level for negative behavior and earn a reward for positive behavior such as extra phone calls, ice cream socials, and advancement to the next level. The center provided pictures of multiple activities involving youth who reached level three. Youth are monitored daily by a level card which is completed by the detention officers. During observation of daily activities, it was noted two youth were not following direction by detention staff and the other additional youth was being disrespectful to education staff. Each youth was placed in confinement and dropped a level.

Six of the seven interviewed staff reported believing the BMS is effective. One staff reported they did not believe it was effective. All seven staff reported as part of the center's BMS, they discuss alternative behaviors and consequences. Youth are given the opportunity to explain their behavior. The staff reported only points and a level can be taken from youth as their consequence. All staff reported receiving feedback on the implementation of the BMS on a weekly or as needed basis. An interview with seven youth on the rating of the BMS, two youth rated the BMS as fair, three as good, and two as very good. Six youth reported when they received consequences it was fair. One youth reported the consequences were not fair.

| 2.17 Unauthorized Use of Punishment (Critical) | Satisfactory Compliance |
|---|---|

*The center's behavior management system restricts certain types of penalties on youth who demonstrate negative behaviors.*

*Group punishment shall not be used as a part of the facility's behavior management plan. However, corrective action taken with a group of youth is appropriate when the behavior of a group jeopardizes safety or security, and this should not be confused with group punishment.*

*Corporal punishment shall not be used in detention facilities. All allegations of corporal punishment of any youth by facility staff shall be reported to the Florida Abuse Hotline, pursuant to Chapter 39, F.S., and the Central Communications Center.*

*The use of drugs to control the behavior of youth is prohibited. This does not preclude the proper administration of medication as prescribed by a licensed physician.*

The center has facility operating procedures in place to ensure the youth's consequences for negative behaviors will serve as both a positive and learning experience. The policy indicates group punishment will not be used as part of the behavior management system (BMS). A review of documentation throughout the annual compliance review week supported the BMS was used appropriately and there was no group punishment. Six of the seven interviewed staff reported inappropriate behavior includes the loss of meals, snacks, sleep, or school are not used as consequences. One staff reported if a youth is in confinement they cannot go to school. No staff reported observing any staff encouraging youth to beat up another youth. Seven interviewed youth stated, removal of points and levels are utilized as punishment. Six youth reported they had been sent to their rooms for punishment and one youth reported they had not. Five of the

youth who had been sent to their rooms stated the door was shut and locked. The additional youth stated the door was shut. All youth doors in the center are locked when they are shut. Seven youth were questioned if handcuffs/leg irons had been used on them or other youth. Three youth reported yes and four reported they never witnessed this. A review of three Protective Action Response (PAR's), validated all three had documentation of checks and approval prior to placements.

| 2.18 Grievances | Satisfactory Compliance |
|---|---|

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

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

The center has facility operating procedures in regard to the process of youth submitting grievances. The grievance procedure includes three phases such as informal, formal, and the appeal phases. 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. The center had three grievances submitted in the last six months. Each of the grievances were entered in Facility Management System (FMS). The center had two of the three original grievances. The center reported they were unable to locate the third grievance at the time of the annual compliance review. All seven interviewed staff were able to explain the grievance process to include the three phases. All seven interviewed youth reported never filing a grievance while in the center.

| 2.19 Trauma-Informed Care | Satisfactory Compliance |
|---|---|

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

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

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

The center has facility operating procedures in regard to trauma-informed care. The center has two soft rooms, a garden, offers a therapy dog ministry, and opportunities to participate in yoga. The dorms have neutral colors to bring in soft light and are trimmed in soothing colors. Each of

the seven in-service and pre-service staff had trauma informed care training entered in the Department's Learning Management System (SkillPro). The center provides care to youth in custody and acknowledges the role trauma played in the youth's life. Services should be based on an understanding of vulnerability which can trigger trauma in the youth. The superintendent interview confirmed the current practices to promote trauma-informed care and further described there are multiple volunteers and organizations who come into the center to engage the youth and the therapists. The techniques used are therapeutic Jenga and kinetic sand to address youth's needs.

# Standard 3: Mental Health and Substance Abuse Services

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

The center has a contract with Maxim Healthcare Services Inc. to provide mental health services and a designated mental health clinician authority (DMHCA) to coordinate services at the center. The contract further provides for one full-time staff and one part-time staff to serve as the DMHCA in order to provide coverage sixty hours a week. The DMHCA is scheduled forty hours a week as the full-time DMHCA is identified as such on the center's documentation, which was verified through an interview. The part-time DMHCA is not documented as such on the center's documentation; however, the contract specifies the DMHCA position is covered by one and a half full-time employee positions. The full-time DMHCA is a licensed mental health counselor (LMHC) and the part-time DMHCA is a licensed clinical social worker (LCSW). Both DMHCAs have active licenses through the State of Florida, expiring on March 31, 2021. An interview with the full-time DMHCA further verified their role in the center as providing oversight and coordination of mental health services, supervision of non-licensed staff, and provision of mental health services including completion of Assessments for Suicide Risks (ASRs), supportive services, and individual therapy. The role of the DMHCA was confirmed through review of the contract and the DMHCA's position description. A review of the sign-in and sign-out log found the full-time DMHCA is not consistently on-site forty hours a week; however, documentation was provided the DMHCA is on intermittent leave through the Family Medical Leave Act (FMLA). The part-time DMHCA is documented as being on-site at least twenty hours a week. Both DMHCAs are on-site a sufficient time to ensure services are provided.

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

The center has a contract with Maxim Healthcare Services Inc. to provide licensed healthcare staff who deliver mental health and substance abuse services. The center has three licensed staff, two licensed mental health counselors (LMHCs), and one licensed clinical social worker (LCSW). One of the LMHCs is a Certified Addictions Professional (CAP) and provides substance abuse groups in the center. All three staff have clear and active licenses in the State of Florida with expiration dates of March 31, 2021.

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

The mental health provider, Maxim Healthcare Services Inc., employs two non-licensed staff to provide mental health services under the supervision of the licensed designated mental health clinician authority (DMHCA). Both of the non-licensed staff are master's-level clinicians and registered mental health clinical interns with the State of Florida. One of the non-licensed staff has a master's-level degree in Mental Health Counseling and the other staff has a master's-level degree in Clinical Mental Health Counseling. Documentation was provided verifying the staff were both trained in the administration of Assessments of Suicide Risk (ASR). A review of supervision documentation verified the staff received weekly supervision for at least one hour each week during the annual compliance review period.

| 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.*<br><br>*Detention center superintendent has established procedures for a thorough review of preliminary screening conducted by the Office of Probation and Community Intervention.* | |

The center has facility operating procedures regarding the assessment of youth for mental health and substance abuse needs upon admission. Seven youth mental health records were reviewed and found each was screened using the Massachusetts Youth Screening Instrument-Version Two (MAYSI-2) and the Suicide Risk Screening Instrument (SRSI). Two of the seven youth were screened using the Positive Achievement Change Tool (PACT) Mental Health and Substance Abuse Referral Form; however, the PACT was discontinued May 1, 2019 and not applicable for the remaining five youth. Neither youth who received a PACT were applicable for positive results on the screening which would have necessitated further assessment. Both the MAYSI-2 and SRSI were completed in the Juvenile Justice Information System (JJIS) in each record. Documentation was found in each youth record, a mental health clinician reviewed all admission documents. In each youth record, the SRSI included complete entries in all required sections. Four of the SRSIs were completed by medical staff. Two were completed by a registered mental health clinical intern and one was completed by a licensed clinical social work (LCSW). In five youth records, the SRSI was found completed within twenty-four hours of admission. In two youth records, the SRSI was completed one day late. Three youth had positive responses on the SRSI and each was placed on suicide precautions and were referred for and received follow-up assessment through administration of an Assessment of Suicide Risk (ASR), as required. There was documentation to support the superintendent was notified of the need for further assessment for each youth. One youth did not have positive results on the SRSI; however, the licensed practical nurse (LPN) who conducted the screening created a referral for the youth to receive an ASR. The youth received the ASR which was administered by an LCSW within two hours of the SRSI; however, the youth was not placed on suicide precautions. Two of the seven youth had an indication of elevated suicide risk upon completion of the MAYSI-2 and both were referred for an ASR, as required. Six of the seven youth were

noted on the MAYSI-2 as needing follow-up assessment for mental health and substance abuse needs and each were referred for a comprehensive evaluation. The detention center and mental health were notified.

| 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 facility operating procedures regarding mental health and substance abuse evaluations. The designated mental health clinician authority (DMHCA) has established a practice of tracking the youth in need of a comprehensive assessment. Upon identification of need for the assessment at admission, the juvenile assessment officer forwards the information to the detention center. To ensure no youth in need of an evaluation are missed, the mental health staff review all admission documentation of each youth who is admitted to the center and adds them to the tracking list if an assessment is needed. At ten days, the DMHCA reaches out to the community provider for an update on the assessment. When the thirty-day deadline for completion approaches; if the community provider has not conducted the assessment, the DMHCA assigns a mental health staff at the center to complete the assessment using the Substance Abuse and Mental Health (SAMH) assessment which is completed in the Juvenile Justice Information System (JJIS) electronic medical record. Seven youth mental health records were reviewed and six were referred for a comprehensive assessment upon admission. One youth was referred for a comprehensive assessment after being in the center for more than thirty days and identified as in need of treatment services. Three of the comprehensive assessments were completed within the required time frame using the SAMH assessment form. The remaining four youth assessments were not due for completion; however, the DMHCA demonstrated compliance with tracking the status of the assessments.

| 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.*<br><br>*Each youth determined to need mental health treatment, including treatment with psychotropic medication, or substance abuse treatment while in a detention center, must be assigned to a mini-treatment team.* | |

The center provides mental health and substance abuse treatment to any youth determined in need of services and any youth in the center for more than thirty days. Seven youth mental health records were reviewed and three were applicable for requiring mental health and substance abuse services. One was identified as needing services upon admission and two were referred for services upon identification the youth would be in the center for more than thirty days. For each of the three youth records an Authorization for Evaluation and Treatment (AET) and a Substance Abuse Consent and Release of Information form were maintained in the mental health record. Upon referral for services, each youth was assigned to a mini-treatment team which included the youth, the designated mental health clinician authority (DMHCA),

additional mental health staff, the psychiatrist, medical, a detention officer, and the youth's parent/guardian, when possible. Documentation demonstrated each of the three youth received individual and group therapy in accordance with their treatment plan, which included at least three treatment services a week. During the annual compliance review period, the center implemented consistent mental health and substance abuse groups. A review of documentation found each group contained no more than ten youth in a group. Each group was facilitated by a mental health staff member. During an interview, the DMHCA reported the center added mental health therapeutic treatment services during the annual compliance review period. The center added two soft rooms and revamped the mental health office space to utilize for therapy and group sessions. Additionally, the mental health staff is utilizing innovative therapeutic strategies; such as use of a kinetic sand box and therapeutic Jenga which provides prompts for youth individual sessions. Seven youth were interviewed and five reported the mental health services at the center were very good. One youth reported the services were good and one youth reported not receiving mental health services.

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

Seven youth mental health records were reviewed and three were applicable for treatment services which would require completion of treatment planning. Two were referred for being in the center for thirty days and the other youth was referred upon admission. None of the three records reflected an initial treatment plan was completed upon identification of the youth being in need of services; however, each of the youth's individual treatment plans were completed on the day the youth's services were initiated. The center reported any youth who is referred for services is immediately entered into a mini-treatment team and a treatment plan is completed. Most of the referrals for youth to initiate treatment services are for youth in the center longer than thirty days. A comprehensive assessment has already been completed to assist in completion of the treatment plan. The one youth who was identified in need of services upon admission, the designated mental health clinician authority (DMHCA) completed a treatment plan immediately due to the high needs of the youth; therefore, an initial treatment plan was not required. Each of the three treatment plans was completed by a licensed clinician and included all required elements. Each treatment plan included services to be provided by the licensed psychiatrist which was supported by Clinical Psychotropic Progress Notes (CPPN) completed by the psychiatrist for each youth. The psychiatrist is a part of each youth's mini-treatment team and plan creation. The review coincides with the psychiatrist's visits to the center, so each youth can be regularly seen and updates made to the plan as necessary. A review of each youth's progress notes reflected each youth received the services stipulated on the treatment plan. Each plan was signed and dated by all required parties including the youth, mental health staff, treatment team members, and parent/guardian. One of the three youth was applicable for treatment plan reviews; however, thirty days had not passed since the completion of the individual treatment plan for the remaining two youth. The applicable youth mental health record documented the youth was due for two treatment plan reviews and each was completed within

the required time frame. During the first review, the youth's parent/guardian brought prescribed psychotropic medications to the center for the youth to begin taking and the addition of the psychotropic medication monitoring was clearly identified on the review. Each review was signed and dated by all required parties. A mini-treatment team was unable to be observed during the annual compliance review, as the meetings were held prior to the review team arriving on-site. Three closed youth records were reviewed for discharge planning and each reflected the discharge summary was completed on the Department's form and provided to the youth's juvenile probation officer and parent/guardian upon release.

| **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 contract with Maxim Healthcare Services Inc. to provide mental health services including the provision of a psychiatrist to provide psychiatric services to youth at the center. The psychiatrist holds a clear and active license with the State of Florida, Department of Health with a specialty in child and adolescent psychiatry, which expires on January 31, 2020. An advanced register nurse practitioner is not used by the center to provide any psychiatric services. A review of the mental health sign-in and sign-out log, confirms the psychiatrist is on-site at least once every two weeks as prescribed in the center's contract. Seven youth mental health records were reviewed and three were applicable for psychiatric services. One was referred upon admission and two were referred upon being in the center for thirty days. For each of the three applicable youth, the initial and in-depth psychiatric evaluation was completed at the initial meeting with the youth, within seven days of referral for services and included all required elements. Each youth had a valid Authority for Evaluation and Treatment (AET) in the youth record which provided consent for psychiatric services. Two youth were applicable for psychotropic medications. One youth were admitted into the center with medications and one youth's parent/guardian brought medications to the center after the youth had been in the program for over thirty days. Medication information and required monitoring was documented on page three of the Clinical Psychotropic Progress Note (CPPN) in each youth record. Both youth records included documentation the youth's parent/guardian gave consent for the youth to continue their psychotropic medications. None of the medications were changed while the youth were in the center. One youth was applicable for additional psychiatric evaluations. Each evaluation was documented on the CPPN and included all required elements.

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

The center has a suicide prevention plan which details suicide prevention procedures including all required elements of identification and assessment, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and review process. The plan was reviewed and approved by the superintendent and designated mental health clinician authority (DMHCA) on July 31, 2018.

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

The center has a suicide prevention plan in place which outlines the procedures for youth identified as at-risk which includes a review process for any instances of a serious suicide attempt, self-inflicted injury, or completed suicide. A review of seven youth mental health records found five were applicable for suicide prevention services. Four of the five youth were identified as a suicide risk as a result of admission screening and one was identified at-risk due to staff observations. Each of the five youth had alerts in the Juvenile Justice Information System (JJIS) which were initiated upon discovery of the risk, which identified the youth's suicide risk and documented the youth's precautionary observation (PO) status, and was closed appropriately following the youth's removal from PO. One of the four youth identified at admission did not have positive responses on admission screening; however, the youth was referred for an Assessment of Suicide Risk (ASR). The youth received an ASR within two hours; but, was not placed on PO as required. Each of the remaining four records reflected the youth was placed on PO upon identification of risk and maintained on the appropriate level of supervision until an ASR determined the youth was able to be stepped down to a lower level of supervision. Each of the reviewed PO logs was completed in their entirety and signed by a qualified mental health professional. A review of logbooks found three of the four instances of PO were documented. Entries maintaining each youth on PO until an ASR was conducted and the youth was stepped down to lower levels of supervision were found for each of the five youth. A referral was found for each of the five youth to receive an ASR which documented the designated mental health clinician authority (DMHCA) and superintendent were notified and conferred to maintain the youth on PO. Each ASR was conducted within twenty-four hours and three youth were subsequently stepped down to standard supervision. One of the youth was maintained on PO and a follow-up ASR was conducted prior to stepping the youth to close supervision and another follow-up ASR prior to the youth transitioning to standard supervision. The last youth has been maintained on PO since admission to the program. For each of the five youth a conference was held prior to the reduction of supervision and the results and recommendations of the ASR were clearly documented. The five youth had a total of nine ASRs and seven were completed by a licensed mental health clinician; two were completed by a registered mental health clinical intern (RMHCI) and reviewed by the DMHCA within the required time frame. The two RMHCIs who completed the ASRs had documentation of training and supervision in the completion of the assessments. None of the youth were discharged from the center prior to receiving an ASR.

One youth was applicable for secure observation and two additional records were provided for review. Each of the three instances of secure observation included documentation the placement was authorized by required parties, the secure room was designated, a health status checklist was completed, the parent/guardian was notified, and the youth received an ASR

within eight hours of placement. One of the youth was transitioned to PO following the initial ASR. One youth was maintained on secure observation past twenty-four hours following approval by the DMHCA and one youth transferred out of the center prior to being transitioned to a lower level of supervision. Supportive services were provided by mental health staff and youth were not transitioned to a lower level of supervision without a conference between the superintendent and DMHCA. Each of the secure observation logs reviewed were filled out in their entirety, included all required elements, and clearly documented the youth was on secure observation. A review of alerts and logbooks verified youth instances of secure observation were documented, as required.

Seven youth were interviewed, two reported they had been on PO while at the center and each said staff were always watching them. One additional youth was interviewed during the annual compliance review and verified they were always supervised while on PO. Seven staff were interviewed and each reported if a youth expresses suicidal thoughts they would notify the DMHCA, place the youth on constant sight and sound supervision, and document the supervision. Additionally, six staff reported they would search the youth's room and one reported they would submit a mental health referral.

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

Seven youth mental health records were reviewed and four were applicable for placement on precautionary observation (PO). The four youth maintained on PO had a total of forty precautionary, close, and secure observation logs. Thirty-nine of the forty logs included the level of supervision, safe housing areas were met, reviewed and signed by the supervisor and mental health staff, and included checks of the youth at thirty minute intervals. Any warning signs for the youth were documented on the back of the supervision logs. One PO log was unable to be located by the center and covered the time period between when the youth was placed on PO and the youth received the first assessment of suicide risk (ASR). A review of the youth's alerts and the logbook verified the youth was placed on PO and the youth's risk was communicated with staff even though the one log was unable to be located.

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

The center has a suicide prevention plan which includes the training requirements for staff. Seven staff in-service training records were reviewed and each included documentation the staff completed at least four hours of instructor-led and two hours of training in the Department's Learning Management System (SkillPro). A review of mock suicide drills from July 2018 to June 2019, found sixty-six of the sixty-nine applicable staff participated in at least two drills within the last year. Two staff participated in one drill and one staff did not document participation in any drill. Multiple drills were held on each shift each quarter of the annual compliance review period. Each of the drills was documented on a drill form, included a narrative of the drill, start and end times, and signatures of staff who participated in and reviewed the drill. At least one drill a quarter for each shift included the provision of life saving measures and methods for contacting

back-up support and emergency services; however, some of the drills did not clearly identify the response to the emergency situation. The drills were made available to staff who were not able to be present in order to review the drill. Seven staff were interviewed regarding the locations of the knife-for-life and each reported a knife-for-life is kept in each unit's sub-control. Additionally, three staff reported there is a knife-for-life in master control and medical.

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

The center has a crisis intervention plan which included all required procedures for notification and alert system, means of referral, communication, supervision, documentation, and review. The plan was reviewed and approved by the superintendent and designated mental health clinician authority (DMHCA) on July 31, 2018.

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

The center has an emergency care plan which included the required topics of immediate staff response, notifications, communication, supervision, transportation, documentation, training, and review. The plan was reviewed and approved by the superintendent and designated mental health clinician authority (DMHCA) on July 21, 2018. The plan is accessible to all staff and is located in the superintendent's office, each assistant superintendent's office, and the mental health office.

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

The center has a crisis intervention plan in place which includes the use of assessments to evaluate youth in crisis. The center had one crisis assessment during the annual compliance review period. The youth was referred for a crisis assessment which was completed on the

Department's Crisis Assessment form and included all required elements. A licensed mental health counselor (LMHC) completed the crisis assessment and entered an alert into the Juvenile Justice Information System, as required. The assessment determined the youth was not in need of further services.

| **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 an emergency care plan in place which includes procedures for youth determined to be in need of Baker or Marchman Act placement. The center had three Baker Acts and no Marchman Acts during the annual compliance review period which was provided for review. Each youth was maintained on one to one supervision prior to being transported to the Baker Act facility and was placed on precautionary observation (PO) once they returned to the center. A referral was made to mental health upon the youth's return for an assessment of suicide risk (ASR), which included a mental status evaluation. Each youth was maintained on PO until an ASR determined they could be transitioned to close supervision and then to standard supervision. One youth was released from the center while on PO and the Department form was provided to the youth's parent/guardian notifying them of the need for an ASR by a community provider due to continued suicide risk. A review of logbooks and alerts in the Juvenile Justice Information System (JJIS) found each youth's transport to and from the Baker Act facility, placement, and removal from PO was documented, as required. Two of the three youth PO logs were not able to be provided as the youth had been admitted to residential programs; however, the logbooks, alerts, and mental health chronological notes reflected the youth received the proper level of supervision upon their return from the Baker Act.

# Standard 4: Health Services

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

The center has facility operating procedures and a contract with Maxim Healthcare Services, Inc. to have a board certified licensed physician, acting as the designated health authority (DHA), who holds an unrestricted license and meets the requirements for independent practice in Florida. The DHA's license was found to be current with an expiration date of January 31, 2021. The advanced registered nurse practitioner (ARNP) is the DHA's designee who holds an unrestricted license in Florida which expires on April 30, 2021, with a specialty in family medicine. The ARNP has collaborative practice protocols in place and stored on-site. The DHA has supervisory responsibilities to perform assessments, sick call, periodic evaluations, review of medications, development of policies, and communication to the staff. The DHA reviews, signs, and dates all documentation completed by the ARNP within thirty days. A review of sign-in logs from the annual compliance review period found the DHA is on-site at least once a week at the designated times which are posted throughout the center for youth access. The DHA never goes nine days without being on-site and coverage is always arranged with Maxim Healthcare Services, Inc. on-call physician to perform clinical services on-site in the event the DHA is on vacation. An interview with the DHA confirmed they are on-site at least two hours a week.

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

The center has facility operating procedures (FOP) for health-related protocols. The designated health authority (DHA) performs an annual review of all treatment protocols and documents with a signature and the date of the review. All new staff receive a comprehensive orientation to the FOPs which are delivered by a registered nurse. The nursing staff reviews, signs, and dates the cover page of all FOPs, protocols, and health procedures annually. In the event of a change to policy between annual reviews, each nurse signs and dates the change. Only the psychiatrist can review psychiatric services, psychiatric FOPs, and psychiatric medications. The FOPs were last approved by the DHA, superintendent, and psychiatrist, when applicable on June 5, 2018. The revised FOPs will be sent to the center in July; therefore, the center plans for the superintendent and the DHA to complete the annual review once the new FOPs are received.

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

Seven youth individual healthcare records (IHCRs) were reviewed and each maintained the Authority for Evaluation and Treatment (AET) or court order. In four of the seven records, a copy of the original AET was filed in the IHCR. Two of those had the word "copy" stamped on the form with one included the word "scanned" stamped on the form. There was nothing to identify

the form as a copy on the remaining record. The two records which have the required word "copy" stamped on the AET, the nursing staff rectified the discrepancy and stamped the word "copy" on the form during the annual compliance review. One of the remaining three records reviewed had an original AET. One IHCR had a limited consent for evaluation and treatment form as the juvenile probation officer (JPO) was unable to contact the parent/guardian to sign the AET. The last IHCR contained a court order for medical treatment due to the youth being in the Department of Children and Families custody; authorizing routine medical and mental health screenings, physical examinations, ordinary medical care for minor illnesses/injuries, administration of all current medications including psychotropic medications.

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

Seven youth individual healthcare records (IHCR) were reviewed and four were applicable for parental notifications. The remaining three IHCRs documented there were no parental notifications needed as the medications given did not require parental notifications. In the four applicable records, parental notifications included the reasons for administration of over-the-counter medications which were not covered by the Authority for Evaluation and Treatment (AET), changes in the condition/medication for youth with chronic conditions, and for off-site medical care visits. Documentation found notifications were made telephonically and were witnessed. Written parental notifications were mailed to the parent/guardian, but none of the parental notifications were returned with a parent/guardian signature.

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

The center has facility operating procedures regarding parental consent and notification for youth receiving new psychotropic medication, discontinuances, or psychotropic medication adjustments. The center staff indicated the psychiatrist does not regularly start a new psychotropic medication or make a change to a current one; therefore, there were no examples of parent/guardian notifications required for new, discontinued, or adjustments made to psychotropic medications.

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

In all seven youth individual healthcare records (IHCRs) reviewed, the youth's immunization history and status was verified and the immunization history was filed. None of the records were applicable for immunizations not being up to date or a parent/guardian not consenting to immunizations for religious or other reasons.

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

In all seven youth individual healthcare records (IHCRs) reviewed, the most recent Medical and Mental Health Admission Screening form was utilized on the day of admission by the juvenile detention officer (JJDO). In each of the seven records, a nurse reviewed the document within twenty-four hours of the screening being conducted. The superintendent interview indicated the JJDOs complete the wizard admission screenings and medical staff completes a healthcare admission screening.

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

Five of the seven youth individual healthcare records (IHCRs) reviewed were applicable for medical alerts. Two youth did not have any medical alerts. For the five applicable records, the center utilizes the Juvenile Justice Information System (JJIS) to document all youth alerts which were found correctly entered or updated. The alerts for the five youth included allergies, medication interactions, pregnancy, chronic medical conditions, visual impairments, or medication side effects. The nursing staff verified the alerts and documented in the chronological notes. The superintendent interview indicated the center's medical alert process is for alerts to be entered by officers and medical staff based on assessments, observations, and/or information provided by the youth and/or parent/guardian. These alerts are reviewed during each shift briefing. Dining hall staff receive a copy of the alerts for dietary needs or allergies. Seven staff were interviewed and indicated they are made aware of youth alerts through an alert form, the log book, shift meetings, intake documentation, and emails sent out to staff.

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

In all seven youth individual healthcare records (IHCRs) reviewed, the Suicide Risk Screening Instrument (SRSI) was completed by either a nurse or a mental health staff. In five of the seven records, the SRSI was completed within twenty-four hours of admission. In the remaining two records, the SRSI was completed one day late due to an oversight.

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

In all seven youth individual healthcare records (IHCRs) reviewed, the youth received a health care orientation on the day of admission. The orientation covered the topics of access to medical care, sick call, what constitutes an emergency and when to notify staff, medication process to include side effect monitoring, the right to refuse care and how it is documented,

what to do in the case of sexual assault or attempted sexual assault, and the non-disciplinary role of the health care providers.

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

None of the seven individual healthcare records (IHCRs) reviewed reflected the youth was in need of emergency care. In all seven records the designated health authority (DHA) was notified within twelve hours of admission which was documented in the (IHCR) Five of the youth were identified as possessing a chronic condition or a medical concern. Two were taking a psychotropic medication upon admission in which notification and a referral to the DHA was completed as required for each youth.

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

None of the seven individual healthcare records (IHCRs) reviewed were applicable for healthcare admission rescreening. Three additional records were received from the center for review. In the three applicable records, the youth had a change of physical custody since arrival to the center. A healthcare admission rescreening was completed by a juvenile detention officer (JDO) and a nurse reviewed the document within twenty-four hours of screening.

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

In all seven youth individual healthcare records (IHCRs) reviewed, the most recent Health Related History (HRH) Department form was completed by a licensed nurse. The designated health authority (DHA) or the advanced registered nurse practitioner (ARNP) reviewed each HRH and documented this review on the Comprehensive Physical Assessment (CPA). In all seven records, the HRH was completed before the CPA. In six of the seven records, the HRH was completed within seven days of admission. In the remaining one record, the center was unable to complete the HRH until the signed Authority for Evaluation and Treatment (AET) was received, in which the HRH was completed twelve days after admission.

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

In five of the seven youth individual healthcare records (IHCRs) reviewed, the center had a Comprehensive Physical Assessment (CPA) conducted within the last year which was updated, reviewed, and initialed by the designated health authority (DHA) or the advanced registered nurse practitioner (ARNP) within seven days of admission. In the two remaining records, a new CPA was completed. One was completed within the required seven days of admission. The remaining youth CPA could not be completed until the signed Authority for Evaluation and

Treatment (AET) was received twelve days after admission. In all seven records the CPA was completed in full, the Department Problem List was updated as needed, and if a youth refused part of the exam, the DHA/ARNP documented “refused” on the CPA and had the youth sign the refusal. In five of the seven records the youth had a medical grade between two and five and was placed on the center’s alert system. The remaining two youth were classified as medical grade one.

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

One of the seven youth individual healthcare records (IHCRs) reviewed was applicable for female-specific screenings. The center provided two additional examples. All three applicable records were reviewed and each youth received a pregnancy test for which verbal consent was obtained. The center indicated there are no gynecological exams completed on-site. If the youth requests an exam, the youth is referred to an off-site provider. Seven youth were interviewed and two were applicable. Both of the applicable youth reported they could receive female-specific care at the center.

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

One of the seven youth individual healthcare records (IHCRs) reviewed included a Tier I Tuberculosis (TB) screening, which was completed within seventy-two hours of admission. One youth’s screening was unable to be completed until the signed Authority for Evaluation and Treatment (AET) was received which was received twelve days after admission. The remaining five records had a previous TB test maintained in the IHCR conducted within the last year. In all seven records, the TB test was documented on the Infectious and Communicable Disease (ICD) form, as well as the Comprehensive Physical Assessment (CPA). All were negative.

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

In all seven youth individual healthcare records (IHCRs) reviewed, the youth were screened for Sexually Transmitted Infections (STI) during admission. One youth IHCR documented a need for further evaluation and the youth was referred to the designated health authority (DHA). The screening results were documented on the Infectious and Communicable Disease (ICD) form and maintained in the IHCR.

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

In all seven youth individual healthcare records (IHCRs) reviewed, the youth was offered counseling and testing for the Human Immunodeficiency Virus (HIV). Three of the seven youth consented to HIV testing. One youth received testing in which pre-test and post-test counseling was documented on the Individual Health Education Record. In the remaining two records, the youth were admitted to the center within one week of the review and had not received the test. The center does not maintain HIV results. The center utilizes an outside provider to conduct the HIV testing, as well as the counseling services. The center provided the HIV certificate which expires on June 10, 2020. All seven youth interviews indicated they can ask for an HIV test.

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

Sick call is conducted daily between the hours of 8:30 a.m. and 10:30 a.m. and throughout the day as needed by a nurse. The staff indicated the designated health authority (DHA) will conduct sick call when on-site. In five of the seven youth individual healthcare records (IHCR)s reviewed, the youth had a sick call and the sick call request form was documented in Subjective, Objective, Assessment and Plan (SOAP) format and filed in the IHCR. None of the youth presented with similar sick call complaints three or more times or severe pain in which staff was unfamiliar with. The medical staff indicated sick call forms are submitted electronically; however, when the Juvenile Justice Information system (JJIS) system is down, paper versions of the Department forms are completed by hand. The center has a facility operating procedure indicating when licensed health care staff are not on-site, the supervisor on duty will review all sick call requests for issues requiring immediate attention. Seven youth were interviewed and five indicated they can be seen within one day when making a sick call request. One youth stated immediately and another youth within two days.

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

Five of the seven youth individual healthcare records (IHCRs) were reviewed, the youth had a sick call. In four of the five applicable records, the youth was seen by the licensed nurse practitioner (LPN) and the sick call was reviewed by either the designated health authority (DHA) or the advanced registered nurse practitioner (ARNP) within twenty-four hours. In the fifth record, the youth was seen by a registered nurse (RN). In four of the five eligible records, the sick call was documented on the sick call log and the youth signed the sick call log upon being seen. One youth did not sign the log which was reported as an oversight. One sick call was observed. The youth was escorted to the clinic by a juvenile detention officer (JDO) and the nurse identified herself, asked the youth their name, and the reason why they were at the clinic. The nurse conducted an exam and at the end of the exam the youth initialed/signed a form. The youth was seen in the clinic with no other youth present. The juvenile detention officer (JDO) remained in the room during the exam by the entrance of the clinic. Six of the seven youth interviews indicated the nurse conducts sick call. The remaining youth stated they never had to

place a sick call. All seven staff interviews indicated the nurse conducts sick call and two staff stated the doctor can conduct sick call.

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

The center has a policy and procedures for nursing staff to make daily visits to each youth in confinement to inquire about any health-related complaints. These visits are documented in the individual health care record (IHCR) of each youth and the Facility Management System (FMS). Any treatment provided is detailed in the narrative of the IHCR and medication is provided as ordered. Three confinement reports were reviewed and each had documentation the medical staff counseled or administered medications to applicable youth while in confinement.

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

The center has a policy including the maintenance of first aid kits and automated external defibrillators (AEDs). The program did not have any episodic/first aid care provided by non-healthcare staff. In the seven youth individual healthcare records (IHCRs) reviewed, there were four episodic care events conducted by healthcare staff. The documentation conformed to the Subjective, Objective, Assessment and Plan (SOAP) documentation. Three of the four events were documented on the center's Episodic Care Log. One was not included and reported as an oversight by the center. A review of first aid kits in each of the modules, clinical office, the intake office, each vehicle, and each master control room indicated they are monitored monthly and expired items are replaced. All first aid kits are sealed with blue breakaway tabs. If the seal is broken, the center does an incident report and emails the assistant superintendent.

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

The center has a policy and procedures to provide emergency care. The facility has three automated external defibrillators (AEDs) which were reviewed in the west clinic, west control, and, east clinic. The instructions for the AEDs are on pamphlets inside the machines and each machine provides voice instruction. The AEDs are checked by a contracted company for batteries, shock pads, and maintenance. The batteries and pads expiration dates were reviewed with the nursing staff to show green lights on all three machines were reviewed. The AED in building one medical office has a battery expiration date of 2021. The month is unknown and cannot be seen in the AED battery display. Medical staff advised the last time the contracted company was on-site was August 2018. Copies of AED checks were retained for six months. Suicide kits were reviewed on youth modules and the clinic in each building which included all required items. First aid kits were in each of these locations with a kit in the intake office. The first aid kit on one module needed an inventory list which was corrected by staff during the annual compliance review.

Mock medical drills are required to be performed on every shift, at least once a quarter including CPR/AED skill demonstration. Cardiopulmonary resuscitation (CPR) techniques are trained

annually. One year of drills were obtained and reviewed and found drills were conducted for each shift, at least once a quarter. The mock drills include all necessary elements; however, they are not all documented in mock drill scenario. Four of the drills were written as if the drill was reviewed with staff rather than if the drill was really being conducted. In one drill, the supervisor documented this deficiency and noted in feedback for the drills to be formatted in actual mock of real life situations. The center has several emergency numbers which are stored in a cabinet in the medical office and inaccessible to youth. All non-licensed and licensed staff are currently certified in CPR, AED, first aid, and administration of an Epinephrine Auto-Injector. All staff can call 911 when necessary.

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

Two of the seven youth individual healthcare records (IHCRs) reviewed were applicable for off-site care events; therefore, the center provided one additional record. In the three eligible records, the Summary of Off-Site Care form was utilized and filed in the IHCR including all documents associated with the off-site care event. None of the three events were emergency care events. In two of the three records, the designated health authority (DHA) reviewed and signed the off-site care findings/instructions/information. In the third record, the youth went to the off-site care event during the annual compliance review and the DHA was not able to review the documentation. In two of the three records, the youth required a follow-up appointment. One of two youth just returned from the off-site care event; therefore, no appointment was scheduled. The remaining youth left the center prior to the arrangement of the follow up appointment.

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

One of seven youth individual healthcare records (IHCRs) reviewed had chronic conditions; therefore, the team requested two additional examples. The center was able to provide only one additional record applicable during the annual compliance review period. A review of the two eligible records indicated the youth received periodic evaluations at no greater than three month intervals for taking prescribed medications on an ongoing basis. Both youth were placed on the chronic conditions list and documentation of the periodic evaluations were filed in the IHCR. The treatment orders were documented which clinical staff could clearly distinguish them where applicable. The Department Problem List was updated.

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

The center has a policy regarding medication verification by licensed and non-licensed staff. The policy states when youth are admitted and medical staff are not on duty, staff will refer to the physician's protocol for trained non-healthcare staff to receive and verify medications and assist the youth with self-administration. A telephone order must be obtained and documented

by the incoming nurse on the next shift. The protocol should only apply to critical medications for which a missed dose would compromise the youth's health. Two of the seven individual healthcare records (IHCRs) reviewed were applicable for youth admitted to the center on prescribed medications; therefore, the team requested one additional example. In all three applicable records, the documentation for prescription verification was filed in each of the IHCRs, documented on the admission chronological notes, and a licensed nurse obtained an order from the designated health authority (DHA) to resume the medications.

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

One of the seven individual healthcare records (IHCR) reviewed was applicable for youth admitted with medications and the initial Medication Administration Record (MAR) matched the medication list. In all seven records reviewed, the youth received medications while at the center. In six of the seven records, the medications were given pursuant to a current valid prescription order. In the remaining record, the center was unable to locate the MARs for three different medications and three different months and; therefore, unable to determine the medication administration. In all seven records, the documentation the designated health authority (DHA) continued, changed, discontinued or prescribed new medications was maintained in the individual healthcare record (IHCR).

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

The center has facility operating procedures to store medical equipment classified as sharps in a secure area which is inaccessible to each youth. Staff who have access to this area are the nurses, licensed practical nurses, and the supervisor for after-hours for obtaining access to over-the-counter (OTC) medications. Medications are stored separately by youth, type, and form. Medications requiring refrigeration are stored in a secured refrigerator used for medication only. There is a weekly inventory of sharps and a daily inventory of medication. There are weekly counts of opened OTC medications and a method for identifying and correcting inventory discrepancies.

A review of inventory was completed for the annual compliance review period found three sharps, three prescription medications, and three OTCs were observed for counts by a nurse. In the sharps inventory, there were multiple overwrites throughout December 2018, January 2019, and February 2019. There were strike throughs and corrections with no initials for two different types of sharps in May 2019. The center acknowledged the issue and have hired a new nurse manager. The center has a company, which handles the center's disposal of medications and bio-hazardous waste. The disposal company is contacted when the center has waste on-site to be disposed of. The company handles the disposal of expired or discontinued medications for the center.

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

The center has a policy and procedures for all medications and any medical equipment classified as sharps to be inventoried and stored securely. A daily and weekly inventory of all sharps was conducted. The center's inventories for the annual compliance review period were reviewed, as well as, the area used to store sharps. The nurses conducts weekly counts of the medications and the nurse supervisor conducts an additional weekly count as a method for identifying any potential inventory discrepancies. If discrepancies are found, they are reported to the designated health authority (DHA) and superintendent. Three sharps, three over-the-counter (OTC) medications, and three prescription medications were reviewed. The reviewer observed the nurse conduct counts and compare the counts of the items to the inventory for each of them. The counts matched with the corresponding inventory.

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

The center has facility operating procedures to store narcotics and controlled medications behind two locks in the bottom drawer of the medicine carts. Shift to shift counts were conducted and the records were reviewed for the annual compliance review period. The number of pills and doses remaining are documented for each youth. Inventories were reviewed for December 2018 through May 2019 with two nurses' signatures confirming the inventories are checked twice daily. A count of three controlled medications was observed during the annual compliance review, conducted by the nursing supervisor. The counts and inventories matched.

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

In one of the seven youth individual healthcare records (IHCRs) reviewed, the youth was admitted with medications. The remaining six received medications while at the center. In six of the seven records, the Department's Medication Administration Record (MAR) was utilized for all medications given. The MARs contained the youth name, the Department identification number, date of birth, youth allergies, precautions, medical grade, medical alerts, and current picture of the youth. In the six records, the MARs indicated start and stop dates, all entries were initialed by the nurse and the youth, if applicable the nurse monitored side effects weekly, there were no lapses or errors in medication administration indicated, and refusals were properly documented. In the remaining record, the center was unable to locate the MARs for two months which covered administration of two medications each.

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

None of the seven youth individual healthcare records (IHCRs) reviewed were applicable for parenteral medication. Medication pass was observed for four youth. The medication delivery was the sole responsibility of the nurse during the time of administration. A juvenile detention officer (JDO) escorted each youth separately to the clinic. The Five Rights of Medication administration were verified for every youth. The nurse inquired about side effects and any problems regarding the medications or any other medical issue. Both the nurse and youth initialed each Medication Administration Record (MAR) entry. After the oral medications were delivered, the nurse ensured the youth swallowed the medication by having the youth drink water, open their mouth, and move their tongue back and forth. None of the medications were pre-poured. Oral medications were placed in a small container before the youth received the medication. Topical medications were given on a gauze pad to administer to the affected area. None of the youth refused medication during the observation. Five of seven youth interviews indicated the nurse gives youth medications. The remaining two youth stated the doctor gives medication.

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

The center has a policy regarding medication administration by non-licensed staff. Trained non-healthcare staff can assist youth with self-administration of oral prescription medications or over-the-counter medication when licensed nurses are not available on-site. The Five Rights of Medication Administration will be maintained. The designated staff assisting youth with medication delivery will not conduct or supervise any facility activities during this time. There is a structured process for youth to approach the non-healthcare staff individually. Seven staff interviews indicated they could call 9-1-1 if they felt they needed to. Five of seven youth interviews indicated the nurse gives them medications. The remaining two stated the doctor gives medication.

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

Two of the seven youth individual healthcare records (IHCRs) reviewed were applicable for youth prescribed psychotropic medications at the time of admission. The center provided one additional record for review. In the three applicable records, the youth had a current prescribed psychotropic medication at the time of admission. The medications were continued until the psychiatrist conducted an initial diagnostic interview within fourteen days of admission, which was documented on the Clinical Psychotropic Progress Note (CPPN). In one record, the youth remained at the center for more than three months and was receiving medication monitoring every thirty days by the psychiatrist. In all three records, a referral was made to the psychiatrist

within twenty-four hours of the evaluation. The center did not have standing orders, emergency treatment orders, or pro re nata (PRN) orders for psychotropic medications.

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

The center has facility operating procedures to control infectious disease, chemical exposures, bio-terrorist agents, and other outbreaks or epidemics through prevention, containment, treatment, and reporting requirements related to infectious diseases according to the Occupational Safety and Health Administration (OSHA) and the Centers for Disease Control and Prevention. There is a policy for universal precautions which is followed by all staff and a needle stick intervention and treatment. Healthcare staff are offered Hepatitis B immunizations through the contracted healthcare provider. Protective equipment is provided and infectious disease and sexually transmitted infections(STI) are reported to the health department and the Central Communications Center (CCC). There were no applicable diseases during the annual compliance review period. The center has a separate file location for the documents of each youth and each staff who is exposed to infectious disease to maintain files confidentially for ten years, if needed.

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

In six of the seven youth individual healthcare records reviewed, the youth received infection control training within seven days of admission, as well as hand washing techniques, universal/standard precautions, prevention/transmission of communicable diseases, vaccinations and Center for Disease Control (CDC) guidelines for infection control training. In the remaining record, the center completed the training once the signed Authority for Evaluation and Treatment (AET) was received which was twelve days after admission. All seven in-service and seven pre-service training records indicated the staff received training in the center's specific Exposure Control Plan.

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

The center has facility operating procedures (FOPs) for an exposure control plan which is in compliance with Occupational Safety and Health Administration (OSHA) standard, listing all job classifications and tasks offering the opportunity for exposure. The center provides hand washing, disposal of sharps, a clean work site, and hazard labels. The center has a procedure for contaminated laundry, post-exposure evaluation, and medical record keeping procedures. The exposure control plan is reviewed and signed by the superintendent or designee annually

and was last signed in June 2018. The plan includes risk assessment and a method of compliance in conjunction with the FOP.

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

The center has facility operating procedures to provide prenatal care at recommended intervals. Two female youth records were reviewed and applicable for pregnancy care. The designated health authority (DHA) was notified and orders were given to begin prenatal care at admission. Both were classified as high-risk and were provided prenatal care at required intervals. A post-birth psychological and physical care plan were found for each youth. The center did not have any additional pregnant youth at the center long enough to receive care during the annual compliance review period. Both applicable youth were provided routine daily monitoring and observation by the licensed healthcare staff. Neither of the two youth were applicable for medical evaluations every thirty days as they were not in the center for more than thirty days.

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

The center has facility operating procedures to provide nutritious foods daily, prenatal, post-partum, and parenting education including all necessary elements. The center had two applicable youth. Of the two youth, the licensed healthcare staff provides routine monitoring of each youth's nutritional and weight status. All education is documented in the individual healthcare record (IHCR) of the Health Education Record. There were no other applicable youth during the annual compliance review period.

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

The center has facility operating procedures for all non-healthcare staff involved in the supervision or treatment of each pregnant youth to receive appropriate education. A licensed nurse provides in-service education on girls' health involving monitoring, observation, and emergency care of pregnant youth for non-healthcare staff. Seven staff training records in the Department's Learning Management System (SkillPro) and supporting training documentation were reviewed and noted prenatal education were completed for each staff.

## Standard 5: Safety and Security

| 5.01 Active Supervision of Youth (Critical) | Satisfactory Compliance |
| --- | --- |

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

*Youth are in sight of at least one Juvenile Justice Detention Officer (JJDO) at all times (with the exception of sleeping hours or time secured in rooms).*

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

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

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

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

The center has facility operating procedures for youth supervision. The review team observed youth movement, counts, staff supervision, and positioning each of the four days of the review. Examples of large group movement/supervision included unit movement to meals, education, recreation, and to the unit. Examples of individual or small group movement included to the clinic, outside visitor, mental health, mental health group, intake for transport, or special project. Youth interaction with staff and teachers appeared to be positive. All observed movements were preceded by a request for permission to master control to move youth. Youth movement consistently was not completed until cleared by master control. A review of logbooks revealed counts were consistently conducted as required, and movement documented. The team observed census counts taken at the beginning and end of shifts and randomly throughout the four days. Youth movement was not conducted during youth counts. Youth were consistently within sight of the juvenile justice detention officers (JJDOs). In large group rooms, staff were consistently positioned on opposite sides and at the perimeter facing inward.

Seven staff were interviewed regarding when youth counts are conducted and the steps taken if the count is not correct. All seven staff indicated youth counts are conducted at the beginning and end of each shift, before and after school and before and after meals. Staff indicated several steps to take if the count is not correct including to conduct another physical head count, advise master control and the supervisor, stop movement, check the logbook to see if youth are signed out, and check the head count sheet and compare it with the logbook and physical head count. Through an interview with the assistant superintendent, it was determined the method of tracking the daily census is through utilization of the Department’s Tableau system and the actual count on-site.

| 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.*<br><br>*Staff conducts observations in a manner ensuring the safety and security of each youth and documents real-time observation manually or electronically. Documentation must include the actual time of each visual observation and initials of the staff conducting the check; pre-printed times are not acceptable.*<br><br>*There shall be no obstructions (e.g., clothing, memos, pictures) over windows and areas where direct line of sight is needed.*<br><br>*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 facility operating procedures for the process of conducting room checks. This indicator was reviewed from the re-review conducted January 29 -3 1, 2019. The information applicable for the annual compliance review is for the period after the last date of the re-review. The center has 147 cameras of which twelve were not in operation during the annual compliance review. The camera system has the ability to maintain thirty days of video. The center utilizes a wand system to track ten-minute checks. A review of wand print outs for six different dates which occurred over the past thirty days and seven hours for each date, validated checks were conducted at a minimum of every ten minutes with the exception of one. One check on May 26, 2019 on Mod B-5 occurred between 4:36 a.m. – 4:51a.m. was missed. There was a check at 4:36 a.m. and the next check at 4:51 a.m., which was five minutes late. This was confirmed on the wand sheet and video footage. Video footage for the same six dates each for one hour, validated all checks were conducted at least every ten minutes. It was validated each staff paused and looked in each room for every check. Specific module's wand sheets for the months of February, March, and April 2019 were reviewed for twelve hours in both February and March 2019, and seven hours for April 2019. All checks for the above times were completed within the required ten minutes. Seven staff were interviewed and questioned how often room checks are conducted while youth are sleeping. All seven indicated 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 facility operating procedures in regard to the process of tracking and documenting the youth census and counts. This indicator was reviewed for the period since the last date of the re-review conducted January 29 - 31, 2019. Master control logbooks and module logbooks were reviewed for the months of February through May 2019. A review of the logbooks validated headcounts, youth movement, daily census, beginning and end of shift counts, emergency counts, youth movement, randomly during each shift, and anytime youth population changes were documented. A member of the review team observed youth counts and a facility wide count and validated they were conducted randomly. Seven staff were interviewed when emergency counts are conducted. All seven indicated when a youth is believed to be missing, when visibility is hindered, and after a major disturbance. In addition, one staff indicated when there is bad weather. Another staff indicated if there is a discrepancy in the master count.

| 5.04 Logbook Maintenance | Limited Compliance |
|---|---|

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

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

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

The center has facility operating procedures in regard to maintenance of logbooks. This indicator was reviewed for the period since the last date of the re-review conducted January 29 - 31, 2019. Master control logbooks and module logbooks were reviewed for the months of

February through May 2019. Upon review, it was determined all entries were made in ink with no erasures or whiteout, each were initialed by the staff making the entry, and there were no missing pages. Each page was dated at the top, times were entered as a.m. or p.m. and not in military time, and mental health and medical alerts were entered. Errors was struck through with a single line and initialed by the staff. Each reviewed logbook documented the required entries such as emergency situations, incidents, mental health and medical alerts, population counts, admission and releases, names of youth placed on and released from confinement, and precautionary observation with the exception of youth movement to and from education. In addition, three of the six Central Communications Center (CCC) were not located in the logbooks. A review of sixteen entries revealed there was incomplete entries confirming school attendance was conducted. Seven entries did not document youth starting, ending, or attending school. Five entries did not document school or why the youth were not in school and two entries documented the youth started school but there was no entries of the youth leaving school.

| **5.05 Logbook Reviews** | **Satisfactory Compliance** |
|---|---|
| *The superintendent or designee reviews all logbooks on a weekly basis.*<br><br>*The supervisor(s) reviews the facility logbook maintained at master control when he/she accepts responsibility for the facility.*<br><br>*The Juvenile Justice Detention Officer (JJDO) Supervisor(s) reviews logbooks maintained in each living area daily.*<br><br>*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 facility operating procedures in regard to documentation required in logbooks. This indicator was reviewed for the period since the last date of the re-review conducted January 29 - 31, 2019. Master control logbooks and module logbooks were reviewed for the months of February through May 2019. Superintendent weekly reviews were documented throughout each reviewed logbook. The juvenile justice detention officer supervisor (JJDOS) review of each module logbook was documented and when the JJDOS accepted responsibility for the shift change was also documented. The superintendent or designee for the center documented each time they toured each module, which was completed on each shift.

| 5.06 Key Control | Satisfactory Compliance |
|---|---|

*Each facility is responsible for maintaining inventory and control of all facility keys.*

*All keys shall be placed on a tamper-resistant key ring designed to inhibit the removal of keys.*

*Emergency key rings shall be maintained separately from other facility keys, in master control, in a secure location designated by the Superintendent. These keys shall be notched or otherwise identifiable by touch.*

*The key(s) on these rings shall provide egress through facility exterior doors providing access to evacuation areas.*

*A key inventory shall be maintained by the Superintendent or designee at all times.*
*(For the entire indicator statement, please reference the Monitoring and Quality Improvement FY 2016-2017 Detention indicators.)*

The center has policy and procedures for key control. This indicator was reviewed for the period since the last date of the re-review conducted January 29 - 31, 2019. Staff were consistently in control of keys. There were no instances in which keys were observed loose or out of the staff's control. All seven staff during an interview indicated personal keys are securely stored, visitor's personal keys are given to master control upon entry, there is daily tracking of keys using the key log, program keys are assigned to staff, youth do not have access to keys, staff notify master control of missing keys, youth are searched for missing keys, and a key is replaced for damaged keys. Five of the seven interviewed staff indicated the center performs an inventory of keys, while four of the seven interviewed staff indicated a chit or token is provided for visitors in exchange for personal keys. One staff additionally added, staff give personal keys to the supervisor who has a key to the key box. The supervisor issues keys for the shift. Additional informal interviews confirmed staff coming on shift receive shift keys from the supervisor who issues the keys in the supervisor's office.

The review team observed three staff key rings for one supervisor and two juvenile detention officers. Each staff had a secure key ring with the number of the key ring stamped on the brass key fob, which also had the number of keys stamped on it. The stamped number and the number of keys on each ring were the same for all three key rings reviewed. There were no instances during the annual compliance review period in which staff took home a set of center keys or a set of center keys were missing or lost. Staff interviews indicated when a key is damaged or broken, the supervisor informs maintenance and the key is replaced. The center maintains a supervisory key log used for documenting when supervisory staff receive staff's personal keys and issues shift keys. The center maintains a supervisory key log used for documenting when supervisory staff receive staff's personal keys and issues shift keys. ~~Accurate~~ Some entries did not include the time staff turned in keys. An example on page 142, twelve entries of keys issued did not document the time the keys were turned in. On page 143, two lines did not document the time the keys were turned in.

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

The center has facility operating procedures for vehicles and maintenance. This indicator was reviewed for the period since the verification conducted on March 14, 2019, after received a rating of limited compliance during the re-review conducted on January 29 – 31, 2019. All vehicles had an annual inspection and regular maintenance documented. Five vehicles were reviewed for the required contents including one sedan and four vans. All the vehicles contained an inspected fire extinguisher, first aid kit which was fully stocked, and window punch/seatbelt cutter. All seat belts were in good working order. Vans were clean and in fair material condition. One van had a side scrape on the sliding passenger door which had been documented on the inspection form. The center maintained documentation of maintenance staff conducted a weekly visual inspection of each vehicle which is reviewed by administration monthly. The weekly inspection form includes all required areas such as engine oil, water/coolant, transmission fluid, lights/signals, brakes, horn, and interior/exterior. A review of three vehicle logbooks, one for nine days, one for fifteen days and a third for five days, revealed staff consistently documented an inspection of the vans by one staff at the beginning of the day when each vehicle was in use. The inspections prior to each transport inconsistently included all elements required in detention operation procedures including inspecting the vehicle for contraband, making sure the cage area of the vehicle is physically checked for objects and/or contraband, ensuring the vehicle has sufficient gasoline to reach the destination, verifying seatbelts are securely anchored, testing the security screen is secure, confirming the vehicle folder contains the vehicle logs, vehicle and mechanical restraint keys, gas credit card, vehicle registration, ensuring a cell phone is assigned to the vehicle and is charged and turned on prior to departure, ensuring the inspection is documented in the vehicle log book, and ensuring all youth are searched prior to being placed in a vehicle. The seventy-two trips/inspections were reviewed and noted, forty-nine were not conducted by two staff and thirty did not document an inspection, sixty-one documented youth were searched, and fifty included contraband search/results. None of the inspections included a check of sufficient gasoline, confirmation of vehicle logs, vehicle and mechanical restraint keys, gas credit card, vehicle registration, and charged and turned on cell phone.

One transport was observed during the annual compliance review of two staff transporting two youth to court. One staff searched the van, documented the search in the logbook, and moved the van to the secure sally-port. One staff searched a male youth and applied leg shackles, and waist chain, and handcuffs. The female youth was already cuffed when the team arrived to intake. The staff escorted the two youth to the van, assisted the youth when entering the van, and buckled each youth with seatbelts. One staff sat on the seat in between the two youth for the transport. The team observed the staff buckling their own seatbelts prior to transport. The team was unable to observe the return of a transport.

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

The center has facility operating procedures for tool inventory and management. This indicator was reviewed for the period since the verification conducted on March 14, 2019; after receiving a rating of limited compliance during the re-review conducted on January 29 – 31, 2019. A review of the tool shed revealed each tool had an identifying mark/number code corresponding to the tool inventory. Procedures were in place for broken or defective tool removal and replacement. Staff interviews indicated if a tool was missing, the supervisor would be notified, a search of the area would be conducted, and all movement would stop until the tool was found. Procedures also include strict control of tools can be used to cause death or serious injury. The center maintained a check-in and check-out log for all tools. The center maintained a daily inventory of all tools completed by the maintenance mechanic. The inventory was up-to-date, signed, and initialed by the maintenance mechanic. There were no tools missing on the inventory. There were no tools observed which were not on the inventory.

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

The center has facility operating procedures for kitchen tools. This indicator was reviewed since the verification conducted on April 29, 2019; after receiving a rating of failed compliance during the re-review conducted on January 29 – 31, 2019. Procedures include strict control of all kitchen sharps including storage in a locked cabinet. A review of the storage revealed the knives were maintained in a cabinet with a clear observation window. Each instrument was marked and corresponded with the inventory sheet. The center has two separate and working kitchens involved in independent meal preparation. A review of both kitchens revealed staff on duty performesa daily inventory of kitchen tools for both the sharps/knives and for the utensils. There were some gaps in the inventory for May 2019; however, interviews and logbooks documented the gaps were during the times when the kitchen was closed and one kitchen prepared cold meals for both sides of the center. A knife count is not required for a kitchen on the days the kitchen was not in use.

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

The center has facility operating procedures for youth access to and for the use of tools and cleaning items. This indicator was reviewed since the last date of the re-review conducted January 29 - 31, 2019. Operating procedures indicate youth are forbidden to use or access any tools, including kitchen or medical equipment; however, procedures also indicate youth may use cleaning items such as mops, brooms, buckets, and other common household items under direct supervision. The review team did not observe youth using mops and brooms or other cleaning items during the annual compliance review. Seven staff were interviewed regarding youth use of tools. Five of the staff indicated youth are allowed to use mops and brooms for cleaning purposes. One staff indicated youth could use scrub brushes. One staff indicated youth are not allowed to use tools. Three staff provided further responses such as youth can use brooms under staff supervision while other youth are locked down., Youth can also use mops and brooms if not on precautions. Seven youth were interviewed regarding the use of tools. All seven youth indicated they are allowed to use mops and brooms for cleaning. One youth indicated they were allowed to utilize mops and brooms as the youth was on level three and assigned to the honor dorm. Further informal interviews with administrative staff indicated there was no requirement for youth to be on a certain behavioral level to use mops and brooms.

| 5.11 Inventory of all Flammable, Toxic, Caustic, and Poisonous Items | Satisfactory Compliance |
|---|---|
| *The Superintendent is responsible for the implementation of a safety plan addressing proper use, storage, and disposal of chemicals, including flammable, toxic, caustic, and poisonous items.*<br><br>*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.*<br><br>*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.*<br><br>*No hazardous chemicals should be mixed, as this could result in an explosion or emission of toxic gas.* | |

The center has facility operating procedures for inventory of all flammable toxic, caustic, and poisonous items. This indicator was reviewed for the period since the verification conducted on May 24, 2019; after receiving a rating of limited compliance during the re-review conducted on January 29 – 31, 2019. The inventory of the flammable, toxic, caustic, and poisonous items was completed and consistently performed weekly. The inventory was managed as a perpetual inventory documenting items taken out and items resupplied with the date of the action identified. A review of selected items in the chemical storage lockers indicated the inventory was

accurate. Each locker contained a safety data sheet for each item in the locker. All flammable items were maintained in a red locker outside the building and marked flammable.

| 5.12 Access to all Flammable, Toxic, Caustic, and Poisonous Items | Satisfactory Compliance |
|---|---|
| *Flammable, toxic, caustic, and poisonous fluids and other dangerous substances may only be drawn or acquired by authorized personnel.*<br><br>*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 facility operating procedures for access of all flammable toxic, caustic, and poisonous items. This indicator was reviewed for the period since the last date of the re-review conducted January 29 – 31, 2019. A tour of the center revealed all chemicals were maintained in areas which were inaccessible to youth. The supervisor maintained small spray bottles of cleaning agent in the supervisor's office for daily use. Chemicals were consistently maintained in locked cabinets or offices. Seven staff were interviewed regarding youth permitted to clean with substances which are toxic, flammable, or poisonous. All seven staff indicated youth are not allowed to clean with toxic, flammable or poisonous items. Seven youth were interviewed regarding the use of cleaning agents such as bleach, laundry soap, window, or toilet cleaners. Six of the seven youth indicated they are not allowed to clean with cleaning agents. One youth indicated staff spray on the cleaning agent and the youth wipes the facility down.

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

The center has facility operating procedures for disposal of all flammable toxic, caustic, and poisonous items. This indicator was reviewed for the period since the last date of the re-review conducted January 29 – 31, 2019. The center has a contract with outside agencies to provide for removal of flammable toxic, caustic, and poisonous items. The procedures include only trained staff shall be responsible for disposal. All disposals shall comply with federal regulations. Kitchen staff interviews revealed the program does not fry any foods. There is no kitchen grease waste disposal needed. Staff further indicated the soiled mop water is disposed of in the facility drain. The center provided documentation of two receipts of disposal including one to South Waste grease trap in March 2019 and Republic Services for bulk waste and electronics recycling in June 2019.

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

The center has facility operating procedures in regard to youth placed in confinement. This indicator was reviewed for the period since the last date of the re-review conducted January 29 -

31, 2019. The center utilizes confinement for behavioral issues with youth. Each confinement room has been remodeled and includes educational information on the walls such as sudoku, word search, and math time table. Each confinement room was observed during the annual compliance review and the windows and cameras in each room were free from obstruction. None of the rooms contained non-fixed items.

A review of sixteen confinement reports from the Department's Facility Management System for youth in confinement under twenty-four hours was completed during the annual compliance review. Each report provided a detailed incident description, names of youth who were involved, and name and comments from staff who were involved in the incident. Fifteen reports indicated the confinement room was searched prior to youth placement. One indicated the room was not searched prior to confinement. All sixteen reports indicated the juvenile justice detention officer supervisor(JJDOS) completed the confinement report within the required one hour and reviewed the report for fairness and appropriateness within the required two hours Fourteen reports documented all required supervisory checks were completed within the required three-hour time frame. Majority were completed every two hours instead of the required three-hour reviews. One supervisory check, the youth entered confinement at 1:30 a.m. and the first supervisory review was completed at 7:00 a.m., the following morning. The next review was not completed until 7:05 p.m. and the reviews were completed every two hours for the remaining time the youth was on confinement. The superintendent review documented their acknowledgement of this in their review of the confinement indicating this was due to staff shortage. The second confinement where the supervisory review was late, the youth did not have supervisory reviews from 10:00 a.m. until the youth was released at 6:00 p.m. on the same day; however, when the report was reviewed by the designee for the superintendent, it was documented all reviews were in on time. The superintendent/designee documented reviews within the required forty-eight hour time frame for all reviewed confinements. Of the sixteen reports, seven were applicable for notification to school personnel and offering education; however, documentation was not provided for six. The center utilizes a form titled Education Confinement Checks Orange Regional Juvenile Detention Center. A review of these forms for the annual compliance review period, only documented one of the seven instances where education was offered to the youth while in confinement. Further, the center did not provide documentation validating education personnel were notified of any of the seven youth's confinement.

Seven staff were interviewed and all indicated they are required to complete a confinement report, conduct and document ten-minute checks, and search the confinement room when a youth is on confinement. One staff also indicated they have to complete an incident report and another staff indicated they must search the youth. Through an interview with the assistant superintendent at the center, it was determined no youth while in confinement have contact with the general population.

| 5.15 Confinement Over Twenty-Four Hours | Satisfactory Compliance |
|---|---|

*Confinement beyond twenty-four hours must be approved by the Superintendent or designee.*

*The Superintendent shall approve confinements extended beyond twenty-four hours and every twenty-four hours afterwards. Reasons for extended confinement must be clearly documented on the confinement report.*

*The JJDOS(s) shall continue to evaluate and document the youth's status every three hours. Current youth behavior and/or conversation with the youth shall be documented on the confinement report as evidence for the need to continue or terminate confinement.*

*If it is necessary to extend the confinement beyond twenty-four (24) hours, permission is needed from the Regional Director or designee. The Regional Director will notify the Assistant Secretary. This must be done every twenty-four (24) hours.*

*The length of confinement shall not exceed three days unless the release of the youth into the general population would jeopardize the safety and security of the facility as documented by the Superintendent. No youth shall be held in confinement beyond three days without a confinement hearing, conducted by an employee of the Department who holds a management or supervisory position.*

The center has facility operating procedures for confinement over twenty-four hours. This indicator was reviewed for the period since the last date of the re-review conducted January 29 - 31, 2019. Fourteen confinement reports were pulled for review during the annual compliance review from the Department's Facility Management System for youth in confinement over twenty-four hours. Each report provided an incident description, names of youth who were involved, and name and detailed comments from staff who were involved in the incident. All fourteen reports indicated the confinement room was searched prior to youth placement and each were approved by the superintendent for over twenty-four hours. The fourteen reports all obtained regional director approval every twenty-four hours as required and twelve completed all three-hour supervisory reviews, as required. All mental health reviews were documented as being completed as required.  No youth exceeded three days on continuous confinement.

| 5.16 Continuity of Operations Planning (COOP) Drills | Satisfactory Compliance |
|---|---|

*COOP drills shall be conducted and documented, at minimum, twice a year, with one drill being completed prior to the hurricane season, which begins June 1st.*

A review of the center's continuity of operations planning (COOP), verified all annexes were attached and signed by the center's superintendent on July 11, 2018 and by director of detention services on August 30, 2018. This indicator was reviewed for the period since the last date of the re-review conducted January 29 - 31, 2019. The center conducted two drills during the last four months. A severe thunderstorm/tornado drill in March 2018 and a hurricane drill in May 2018. The hurricane drill was a twenty-four hour drill which documented a detailed scenario, completed emergency checklist, hurricane preparedness documents, and sign-in sheets. The severe weather drill documented the scenario, sign-in sheets, and a review of the drill. Each drill was logged in the master control logbook. Both drills were noted in the logbook. Seven staff were interviewed on their participation in any drill related to weather, major disturbances, bomb threat, hostage situations, chemical spills, flooding, terrorism, escape, or fire. All seven staff indicated they participated in drills within the last six months.

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

The center's escape plan is incorporated in the center's continuity of operations planning (COOP) and includes all required elements. In addition, the center's facility operating procedures (FOP) for escape drills details the center's escape plan. This indicator was reviewed for the period since the last date of the re-review conducted January 29 - 31, 2019. The center conducted two drills monthly for the months of February through May 2019, exceeding the quarterly requirement. Each drill documented a detailed scenario, synopsis of response, critiques, and sign-in sheets. A review of seven staff in-service training records documented all staff received four hours of COOP training, to include the center's escape response plan. A review of the logbooks validated all escape drills were documented. Seven staff were interviewed on their participation in an escape drill within the last six months. Six staff indicated they participated in an escape drill and one staff reported they did not.

| 5.18 Fire Drills | Satisfactory Compliance |
| --- | --- |
| *Management has implemented a disaster preparedness plan and fire prevention plan.*<br><br>*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 fire prevention plan which was signed by the superintendent on September 4, 2018 and by the local fire marshal on August 28, 2018. The fire drills were conducted on each shift for the months of Please verify re-review dates. Each drill documented a scenario, synopsis of response, critiques, and sign-in sheets. Seven staff were interviewed if they participated in a fire drill within the last six months. All seven staff indicated they participated in a fire drill within the last six months. A review of the logbooks validated all fire drills were documented with the exception of three. One in February 2019 and two in May 2019. Seven staff indicated fire drills are conducted at least monthly. Three youth indicated they have been instructed on what to do in the case of a fire and four youth indicated they have not.

Program Name: Orange Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: Orange County / Circuit 9
Review Date(s): June 11-14, 2019

MQI Program Code: 247
Contract Number: N/A
Number of Beds: 110
Lead Reviewer Code: 148

## Overall Rating Summary

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

| Limited Ratings | Failed Ratings |
|---|---|
| 4.31 Medication Administration Record | |
| 5.04 Logbook Maintenance | |
| 5.07 Vehicles and Maintenance | |
| 5.14 Confinement Under Twenty-Four Hours | |