STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Okaloosa Regional Juvenile Detention Center

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

Review Date(s): Septmber 10-13, 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 which do not result in reduced or substandard service delivery; or systemic exceptions with corrective action already applied and demonstrated.
Limited Compliance	Systemic exceptions to the requirements of the indicator; exceptions to the requirements of the indicator which result in the interruption of service delivery; and/or typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator which typically requires immediate follow-up and response to remediate the issue and ensure service delivery.

Review Team

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

Ken Phillips, Office of Program Accountability, Lead Reviewer (Standard One)
Warren Garrison, Office of Program Accountability, Regional Monitor (Standard Five)
Katrina Harper, Circuit 1, Juvenile Probation Officer Supervisor (Standard Two)
Patrick McKinstry, Office of Program Accountability, Regional Monitor (Standard Three)
Juan Youman, Office of Program Accountability, Regional Monitor (Standard Four)

Program Name: Okaloosa Regional Juvenile Detention Center
Provider Name: State Operated
Location: Okaloosa County / Circuit One
Review Date(s): September 10-13, 2019

MQI Program Code: 828
Contract Number: N/A
Number of Beds: 38
Lead Reviewer Code: 145

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.05 Protective Action Response (PAR)	2.13 Educational Access
2.12 Adherence to Daily Schedule	

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)	Limited
1.06	Pre-Service/Certification Requirements *	Satisfactory
1.07	In-Service Training	Satisfactory
1.08	Entering Alerts(JJIS) and Sharing of Alert Information *	Satisfactory

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

Standard 2: Youth Management
Detention Rating Profile

Indicator Ratings

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

* 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 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 *	Non-Applicable
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

* 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 4: Health Services
Detention Rating Profile

Indicator Ratings

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

* 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 5: Safety and Security
Detention Rating Profile

Indicator Ratings

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

* 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 Okaloosa Regional Juvenile Detention Center is a state-owned detention facility, operated by the Department, located in Crestview, Florida. The center has a Juvenile Assessment Center (JAC) located within, which provides assessment and screening services for youth. The JAC is operated by G4S services, a contracted provider. The center maintains male and female youth who are detained pending adjudication, disposition, or placement in a residential commitment program are housed in the thirty-five 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 Okaloosa County School Board. The center's management team includes the detention superintendent, one assistant superintendent, one staff assistant, and six juvenile justice detention officer (JJDO) supervisors. The center has one maintenance mechanic who is responsible for tool and chemical control, as well as day to day facility maintenance issues. Mental health and healthcare services are provided through a contracted provider, Maxim Healthcare Services, Inc. Mental health services are provided by a licensed mental health professional and mental health clinical staff person. The center has a designated mental health clinical authority who serves as the licensed mental health counselor (LMHC). The LMHC responds to referrals and requests as pertaining to youth in need of mental health and substance abuse services. The center also has a non-licensed mental health professional who is under direct supervision of the LMHC. Psychiatric services are provided by a licensed psychiatrist who is contractually required to be on-site one hour weekly. Medical services are provided by one full-time registered nurse (RN) and one full-time licensed practical nurse (LPN). The center has a medical doctor who services as the designated health authority (DHA). The DHA is a part-time contracted employee who is required to be on-site at a minimum of one hour a week and is available by telephone twenty-four hours each day, seven days a week. 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 three living modules and/or wings within the secure area which are divided by male and female. There are sixty-four security cameras at the center, of which all were operational. On-site observations made during the annual compliance review, found the center was in overall fair condition. The kitchen area, dining hall, living mods, and administration officers were clean. Some graffiti was observed in the male mod within youth rooms. Shower and bathrooms appeared clean with the plumbing and fixtures working properly. At the time of the annual compliance review, the detention superintendent reported nine vacancies, which included three other personnel services direct care, two juvenile detention officer I positions, and four juvenile detention officer II positions.

Standard 1: Management Accountability

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

A review of the current staff roster found there were twenty employees, six volunteers, and two contracted staff members requiring a background screening since the previous annual compliance review. A review of twenty-eight personnel records found each individual was background screened and found eligible prior to their hire date. None of the twenty-eight records reviewed were applicable for requiring exemption prior to working with youth. Ten of the twenty-eight individuals were considered direct care staff and required the pre-employment assessment tool. A review of the ten personnel records found all ten had been administered and taken the Ergo-metrics assessment as part of the pre-hiring requirements. Each of the ten personnel records also contained the staffs' passing score for the assessment. The center provided documentation of the Annual Affidavit of Compliance with Level Two Screening Standards, which was completed and forward to the Background Screening Unit (BSU) on January 3, 2019. The center's educational instructors are employed through the local county school board. The center also completed and submitted the Affidavit of Compliance with Level Two Screening Standards for school board personnel on January 3, 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.	

A review of the employee, contracted employee, and volunteer roster found three staff and one volunteer were eligible for a five-year background rescreening. A review of all four personnel records found evidence each of the staff received the rescreening, which was completed and submitted prior to their five-year anniversary date. Each was submitted to the Background Screening Unit (BSU) Clearinghouse at least ten days prior the five-year anniversary date.

1.03 Staff Code of Conduct	Satisfactory Compliance

Center staff adheres to a code of conduct prohibiting any form of abuse, profanity, threats, harassment, intimidation, "horseplay," or personal relationships with youth.

Officers shall maintain the confidentiality afforded to all youth and shall not release any information to the general public or the news media about any youth in the center or who has been in the custody of the Department.

Officers shall not verbally abuse, demean or otherwise humiliate any youth, and shall not use profanity in the performance of their job.

Officers shall not engage in or allow horseplay, either verbal or physical with and/or between any youth.

Officers shall not engage in personal relationships nor discuss personal information related to themselves or other officers with any youth.

Management takes immediate action to investigate or address all allegations or violations of the code of conduct.

The center has a written policy and procedures addressing staff requirements and code of conduct. A review of five staff personnel records found each staff signed for the center's code of conduct upon their date of hire. Since the last annual compliance review, a total of four staff received disciplinary action for violation of the center's code of conduct. A review of the four records found each staff received a written reprimand as a result of the action displayed. None had more than the one violation. The center's administration provided documentation or evidence of staff who received commendations since the last annual compliance review. The center provided six staff names who have been named as employees of the month for the previous six months. The center's superintendent stated during an interview, the code of conduct ensures all communication and interaction between youth and staff are professional and respectful in nature. Providing directions for behaviors which are not acceptable and lists all standards of conducts for State employees. Five interviewed youth all reported staff were respectful when speaking with them or other youth. One of five youth stated never hearing staff use profanity. Four of the five youth reported they have heard staff profanity occasionally. None of the five interviewed youth reported they felt threatened in the center. All youth reported feeling safe. Four of the five interviewed staff reported they have never heard a co-worker use profanity when speaking with youth. One staff stated hearing staff use profanity once, but this was not directed at the youth. All five interviewed staff denied ever hearing other staff using threats or intimidation when dealing with youth. The results of the youth and staff interviews were discussed with the center's administration, who reported they will address any issues of profanity with staff members during team meetings.

1.04 Incident Reporting (CCC) (Critical)	Satisfactory Compliance

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

The center has a policy and procedures which addresses incident reporting and reporting requirements for the Central Communications Center (CCC). The program had a total of twenty-

six CCC reports for the previous six months of the annual compliance review This number was decreased from the last annual compliance review which indicated a total of twenty-nine. A total of five randomly selected incidents were reviewed for completion of the reporting requirements. Based on a review of the five CCC reports, all were reported within the two-hour time frame as required. A review of master control logbooks found each of the five reports were also documented as required. A review of internal incidents and grievances was completed and the result did not discover any additional information which should have been reported to the CCC. Five staff were interviewed and were able to summarize the process for allowing youth to contact the Florida Abuse Hotline or CCC if they wish to report allegations of abuse. The staff stated they would notify the supervisor and allow the youth to make the call. In addition, the supervisor or staff can make the call. The superintendent stated youth have the right to contact the Florida Abuse Hotline and no youth is ever denied a call. The superintendent further stated, as mandatory reporters staff are obliged to report any instances of abuse. The CCC is contacted by the supervisor or administrator when incidents meeting reporting guidelines occur within two hours of the incident occurring.

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

The center had a total of 106 Protective Action Response Reports (PAR) during the scope of the annual compliance review. This is an increase since the center's previous annual compliance review. An interview with detention administration revealed the increase was primarily due to an influx of youth from other surrounding detention centers which have been temporarily closed due to damage caused by weather conditions in those places. In addition, the administration reported an increase in gang population of youth from these surrounding counties. The administration reported these PAR incidents have begun to decrease in recent weeks and administration will continue to monitor them. The center's PAR rate during the annual compliance review period was 20.56, which is above the statewide average of 11.75. A total of eleven PAR reports were reviewed for documentation requirements. Four of eleven reports did not have statements from staff members completed by the end of their workday. Two of eleven reports were missing at least one statement from a staff involved in the incident. Eight of eleven reports did not include the review by the superintendent/designee within seventy-two hours of the incident, as required. Six of the eight reports were signed and reviewed late and two were not signed by the administrator or designee. There was no indication the reports were reviewed by a supervisor or PAR certified supervisor to determine if use of force was consistent with policy for two of the eleven total PAR reports. Five staff were interviewed concerning the use of PAR in the center. All five stated they try to talk with youth prior to using physical restraints of mechanical restraints. An interview with the detention superintendent revealed, PAR reports are reviewed on video and reports are reviewed in the Facility Management System (FMS) to ensure documentation supports the actions which occurred and whether the PAR was reasonable and necessary when physical interventions took place.

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

A total of five staff training records were reviewed for inclusion of pre-service training requirements. All training was documented within the Department's Learning Management System (SkillPro). Four of the five staff were certified within 180 days of their hire date. The remaining staff was still within 180 days of their hire date and was scheduled for the academy on September 23, 2019. Each of the five staff completed the requirements for Protective Action Response (PAR), cardiopulmonary resuscitation (CPR), first aid, and automated external defibrillator (AED). All five completed mental health and substance abuse services training and suicide recognition, presentation, and intervention requirements. All five records included evidence for training in Prison Rape Elimination Act (PREA), human trafficking, Department of Juvenile Justice (DJJ) detention facility operations and emergency plans and procedures. All five staff training records included completion on all phase one training to include essential skills, orientation information security awareness, legal, DJJ the organization, gang awareness, behavior management, active shooter training, and communication skills.

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

The center has an annual in-service training calendar which is updated as changes occur. The center submitted their annual in-service training plan on January 19, 2018, which was reviewed and signed by the Office of Staff Development and Training. A total of five staff training records were reviewed for 2018 in-service training requirements. The reviewed records included two supervisory staff. All training was documented within the Department's Learning Management System (SkillPro). Each of the five staff completed annual training requirements for Protective Action Response (PAR), cardiopulmonary resuscitation (CPR), first aid, and automated external defibrillator (AED). Each had suicide prevention, which included two hours in SkillPro and four hours of instructor-led training. All five records included training in active shooter and professionalism and ethics. A review of the two supervisory staff training records found each had the eight additional hours of training for areas such as management, leadership, personal accountability, employee relations, communication skills, and fiscal training. The superintendent stated along with annual SkillPro and instructor-led courses, additional management training is provided during superintendent meetings or webinars. The superintendent further stated, staff are required annually to complete thirty-three hours of instructor-led courses and fourteen hours of SkillPro courses. Supervisors and administrators are required to take eight hours of supervisor electives within SkillPro.

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

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

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

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

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

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

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

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

The center has a written policy and procedures addressing the input and updating of alerts within the Juvenile Justice Information System (JJIS). The process of updating alerts is located within policy and the JJIS business rule. A review of unit logbooks found evidence youth alerts are documented upon the start of the shift. The center has an internal alert board located within the shift briefing conference room. The board contains internal alert information for youth who are a security risk as well as youth on close observation or precautionary observation status. In addition, on-site observations found alerts were posted in the kitchen area for dietary staff to be notified of youth who have dietary restrictions or food allergies. Alerts are discussed with all staff members during each shift briefing. All staff are provided a hard copy of JJIS youth alerts during these meetings. The staff are required to keep these with them during the shift. Observations of shift briefings, as well as shift briefing minutes were made during the annual compliance review to confirm this practice. Five staff interviews were completed. Staff reported they are informed of youth alerts though logbooks, shift debriefings, alert forms, JJIS, the alert board, and mental health. The staff were responded management keeps them informed of issues within the center through shift debriefings and meetings. A sample of five youth were reviewed for completion and documentation of alert information in JJIS. All five youth had JJIS alerts documented with no issues noted. All alerts were removed or updated by the appropriate staff member. All alerts were reviewed as part of the shift report process. All alerts were verified prior to entering them into JJIS. All alerts matched in JJIS and the center's internal alert system.

Standard 2: Assessment and Performance Plan

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

Five youth records were reviewed for admission procedures. All five contained an arrest affidavit or custody order. All had a completed Detention Risk Assessment Instrument (DRAI) and Suicide Risk Screening Instrument (SRSI). A review of the Admission Wizard found each of the five youth were frisked and strip searched by an officer of the same gender. Each youth received a telephone call upon admission. Meals were also served for newly admitted youth when the admission was completed two or more hours prior to their next scheduled meal. Medical, mental health, and substance abuse screening was completed for all five youth reviewed. An admission was observed during the annual compliance review to confirm the process. The youth received a meal immediately after admission. The youth's telephone contact to their parent/guardian was observed completed and staff were seen explaining the admission process with the youth.

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

Five youth records were reviewed for completion of the orientation process. For each youth, orientation was completed within twenty-four hours of the admission. Each youth signed an orientation acknowledgement to document the contents have been discussed with them. A copy was found in each of the five youth records. Orientation was provided verbally and in writing. The orientation included explanation of detention center rules and regulations, youth rights,

visitation, telephone call procedures, grievance procedures, access to mental health and medical services, access to the Florida Abuse Hotline and/or Central Communications Center (CCC), the behavior management system, and possible new law violations for destruction of property. Each new youth is given a copy of the orientation brochure which also details all the required areas. Observations were made of the orientation and admission process during the annual compliance review. Discussion was done with the newly admitted youth to confirm the orientation process was made known to the youth by detention staff. The youth reported they was given five days in detention.

2.03 Classification	Satisfactory Compliance

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

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

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

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

The center has a written policy and procedures to address the classification process. Five youth records were reviewed for classification requirements. The classification process includes a review of information concerning the youth's history and status. Consideration of potential safety and security concerns in room assignment selection includes the youth's sex, height, weight, age, and maturity level. In addition, consideration is given to youth with special needs, physical disabilities, intellectual disabilities, a history of violent behavior, their criminal behavior, Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB), medical issues, security issues, and gang affiliation. A review of five youth records found each youth was assigned a room based on their classification requirements. Two of five youth were applicable for and contained documentation of a reclassification due to changes in behavior or status within the center. All youth with a history of committing sexual offenses or is a victim of a sexual offense, are placed in a room alone. The center completes the VSAB to determine youth vulnerability to victimization. The VSAB is completed again after thirty-days. The detention administration is informed of how to identify and address local youth gangs. Updated gang information in provided to staff so youth can be appropriately classified during admission and gang-related problems may be averted. A review of the Juvenile Justice Information System for

alerts for gang members was made to confirm alerts and updated notes are made for youth who have been identified as a gang member or suspected gang member.

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

The center has a process for sharing gang information with the assigned juvenile probation officer (JPO). All staff are required to observe the youth for gang-related issues. Two of five youth records reviewed were applicable for notification requirements of the JPO circuit gang representative. For the two applicable records, each included a referral for youth suspected of gang involvement which was shared by email with the assigned JPO designated as the circuit gang representative indicating suspicions of gang activity. Each record included documentation detention staff included in the email all pictures, copies of written statements, drawings, and/or graffiti.

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

A total of five youth records were reviewed for admission requirements of youth personal property. There is an itemized Personal Property Receipt form and valuable Property Receipt form maintained for each youth which includes the youth and staff signatures and a letter of acknowledgement regarding unclaimed property signed by the youth. For each youth record, there was documentation all money and personal items of value were verified and secured in a clear tamper-proof property bag. The bad includes the date, youth name, Department of Juvenile Justice identification number, and a listing of items contained. The bags are placed in a drop safe. The center also maintains a drop safe logbook which includes the date, time, youth name and identification number, and the officer's name who secured the items. None of the five youth records indicated the youth refused to sign the Property Receipt form. Other personal property was placed in an assigned locker and documented on the Property Receipt form. Each form is maintained in the youths' active case record. An admission was observed to confirm the practice of securing and maintaining youth personal property. The detention superintendent was interviewed and stated, the center inventories all youth personal property and stores it in a secure room in the center where only supervisors and administrators have access to. The center sends out letters giving youth thirty-days to pick up unclaimed property prior to its disposal. If the property is not picked up, it is either donated to a non-profit or discarded. If there is currency, it is forwarded to the Bureau of Unclaimed Property. Five interviewed youth all confirmed staff checked their personal property and staff had each sign a form stating the personal property was correct.

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

The center maintains all youth personal property in a separate storage area. Observations of the area found it to be secured. Only supervisors and administration have access to the storage area. The center has a drop-safe which is under video surveillance. Clear tamper-proof bags are also used to store property. An admission was observed during the annual compliance review to confirm the practice of securing youth personal property. A review of Central Communications Center (CCC) reports for the previous i six months did not reveal any incident involving youth personal property. The detention superintendent was interviewed and stated, personal property is secured by staff when conducting a youth admission. A property receipt is signed by the youth and admitting officer and placed in the secured property room where only administrators and supervisors have access. A camera monitors the exit and entrance to the property room. All property is logged in the safe logbook.

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

Three closed youth records were reviewed for release procedures. All three records contained evidence the on-duty supervisor reviewed all paperwork prior to each youth's release. The juvenile justice detention officer supervisor reviews all release paperwork provided from the court. Each youth's identification was verified prior to their release. Each record included evidence the parent/guardian picking up the youth was confirmed prior to the release. Each youth was reminded of any future court dates. All required parties signed the appropriate release forms. A review of the Juvenile Justice Information System (JJIS) found all dates of admission and termination documented within the case record correlated with the dates in JJIS. An observation of a youth release was made during the annual compliance review. A review of the youth's record determined the staff copied a picture of the person receiving custody of the youth due to the youth being under the age of eighteen. A review of Central Communications Center (CCC) reports for the scope of the annual compliance review found no reported evidence of any unauthorized release from the center.

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

A total of three closed youth records were reviewed for release of the youth's personal property. All three records had indication the youth and parent/guardian signed and received the property upon the release. Samples of property held for more than thirty-days were reviewed and found documented within the Facility Management System. Observations of the release process were made during the annual compliance review. The youth was seen removed from the dorm area and escorted to the intake room. The youth's property was pulled and was allowed to dress in their personal clothing. The youth was observed signing the property sheet. The youth did not have medications prescribed. The parent/guardian signature was obtained and the youth was released. The detention superintendent was interviewed and stated, the center inventories all youth personal property and stores it in a secure room in the center where only supervisors and administrators have access to. The center sends out letters giving youth thirty-days to pick up any unclaimed property prior to its disposal. If the property is not picked up, it is either donated to a non-profit or discarded. If there is currency, it is forwarded to the Bureau of Unclaimed Property.

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

A total of three closed youth records were reviewed from release of medication and aftercare instructions. All three records contained documentation verifying youth were release to an appropriate person with a valid identification. All receipt of medications were signed by the individual receiving the youth. Each youth and person receiving the youth were reminded of any health or welfare issues including medical, mental health, or substance abuse needs or appointments. The center's process from releasing youth with prescription medications was reviewed. Three selected youth records contained acknowledgement of receipt forms to determine medications were given to the youth and parent/guardian upon the youth's release. The release documentation included a list by the nurse showing the name and amount of the medications. The nurse and the parent/guardian signed the form which is also uploaded into the Juvenile Justice Information System (JJIS).

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

Observations of weekly detention reviews were made during the annual compliance review. A review of weekly detention review documentation was completed for the scope of the annual compliance review. The documentation included notes on what was discussed, tasks assigned, and the staff member responsible. Based on observations, the weekly reviews have consistent documentation of participation by all parties who have a specific responsibility for the youth. The detention superintendent was interviewed and stated, reviews are conducted weekly on

Tuesdays.in the conference room. The detention review specialist, superintendent or designee, designee from probation by telephone, commitment manager by telephone, and medical, mental health, and education representatives participated in the weekly detention reviews. Information discussed includes youth release dates, court dates, placement of youth, and youth medical or mental health issues.

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

The program has a daily activity schedule which was observed posted in various program areas. Activities such as visitation, hygiene, meals, education, bed times, groups, and recreation are outlined and provided regularly. Five interviewed youth and five staff confirmed the center has a daily schedule which is followed each day. Five staff reported the center provides restorative justice activities for youth. One of the five staff reported the center offers gender-specific programming as part of the daily schedule. Four of the five staff reported they were unsure of gender-specific programming at the center.

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

Observations of daily activity schedules were made during the annual compliance review. The youth were observed during meal times, classes, and detention reviews. Youth were observed consistently arriving fifteen-minutes to an hour late to classes in the mornings during the annual compliance review week. The center's master control operator was observed documenting all youth movement for activities within the master control logbook. Samples of previous days of logbook entries were reviewed and supported youth were arriving to school late on numerous days. Five staff interviews were conducted. Four of five staff reported, there was minimal interference with school and one staff reported there was not minimal interference. One staff stated youth are sometimes acting out in class and the minimal interference comes from youth behavior issues. Five interviewed youth confirmed the center has a daily schedule which is followed each day.

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

Youth enrolled in educational programs within the center will have the opportunity to earn course credit for completion of the education and training experience. An interview with the center's lead teacher was made to determine the number of hours youth are enrolled in school

daily. The lead teacher provided the school calendar which revealed the school allows for ten teacher workdays and nine professional development days. On these days, youth are not in school. In addition, the school calendar allows for twenty-two early release days for youth. Based on this information, the center's educational component is not providing 250 days distributed over twelve months, for a minimum of twenty-five hours of instruction weekly. In addition, on-site observations and review of the master control log book was completed during the annual compliance review. Based on documentation and observations made, students were arriving fifteen-minutes to an hour late for class each day of the annual compliance review week. Multiple samples of log book entries were also reviewed which supported the youth were getting to school late on numerous other days. The detention superintendent was interviewed and stated, the center experiences minimal interference with educational instruction. Five interviewed youth all reported the center's daily schedule is followed. All five youth stated the center provides educational classes Monday through Friday. The youth stated the classes consist of subjects such as math, science, history, english, reading, and social studies. Five staff interviews were conducted. Four of five staff reported there was minimal interference with school and one staff reported there was not minimal interference. One staff stated youth are sometimes acting out in class and the minimal interference comes from youth behavior issues.

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

The center provides requirements for Type I programming. The center utilizes MyCareerShines. The career education programming includes communication, interpersonal, and decision-making skills. Five interviewed youth stated the classes offered consist of subjects such as math, science, history, english, reading, and social studies.

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

The center's behavior management system (BMS) was observed posted in all youth living areas. The BMS is also documented in the youth orientation brochure which each youth receives as part of their admission to the center. The BMS clearly specified appropriate and inappropriate behaviors, rules, norms, and expectations for youth. A review of the center's BMS revealed it has been approved by the detention regional director. The system includes rewards for positive behavior and consequences for inappropriate behavior. Observations made during the annual compliance review found evidence of staff implementation of the center's BMS. The center has a written policy and procedures on the BMS to ensure compliance with the components of the system. The staff was observed providing point cards for youth and explained the process of the BMS. The youth are responsible for keeping their point cards with them during the daily activities. The detention superintendent was interviewed and stated, the

BMS provides all secure detention centers a uniformed BMS which offers a predictable set of rewards, privileges, and consequences for behavior. It enhances safety and security and relates to the youth's behavior while promoting the health and well-being of the youth by providing an environment which fosters social, emotional, intellectual, and physical development. Five interviewed staff all reported they felt the center's BMS was effective. All five staff reported they speak with youth to discuss the consequences of any sanctions being imposed and youth are given the opportunity to explain their behaviors. All five staff also reported, they speak with youth about alternative acceptable behaviors. The five interviewed staff reported only points and levels of youth may be taken away as a consequence for bad behavior. All five staff reported, f supervisors provide feedback to staff for their implementation of the BMS. The staff indicated feedback was given on an as needed basis. Five youth were interviewed concerning the center's BMS. One youth rated the BMS as poor, one stated it was good, one stated it was very good, and two indicated the BMS was fair. Four of five youth reported when they received consequences for behaviors, the consequences were fair. One stated they were not. The youth reported only the level was taken away as a consequence for negative behavior. All five youth stated youth are never allowed to punish other youth.

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

The center has a written policy and procedures regarding the behavior management system (BMS) utilized. Five youth were interviewed concerning the center's BMS. Four of five youth reported when they received consequences for behaviors, the consequences were fair. One youth stated they were not. The youth reported only the level was taken away as a consequence for negative behavior. All five youth stated youth are never allowed to punish other youth. Three of five youth reported they have never been sent to their room for punishment. Two reported they have been sent to their room. The two youth also indicated the room door was shut and locked. Four of five interviewed youth reported they have never witnessed mechanical restraints used on out of control youth to prevent them from hurting themselves or others. One youth stated they have witnessed this. Five interviewed staff denied consequences for youth inappropriate behavior included the loss of meals, snacks, sleep, or school. All five staff denied observing a staff encourage youth to beat up another youth.

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

The center has a written policy and procedures for youth grievances and the center's grievance process. Grievances are provided to youth in boxes located in their assigned living unit area. A drop box is provided for youth to turn in completed grievances. The grievance process is also documented in the youth orientation brochure which each youth receives as part of their admission to the center. According to the procedures, juvenile justice detention officers attempt to resolve any dispute or issue which could lead to a grievance prior to the youth actually filing the form. All grievances are entered in the Facility Management System in the Juvenile Justice Information System. Completed hard copies of grievances are maintained in a central file system. A review of the center's grievances for the previous six months found nine grievances attached. All nine grievances were resolved and within the appropriate time frame, with the exception of two. The two grievances were resolved three days late. The detention superintendent was interviewed and reported, the grievance system is divided into three phases. During phase One, the youth writes a grievance, gives it to a staff member, and the staff tries to address the grievance. During phase two, if a youth does not feel the grievance was handled appropriately, the grievance is forward to the supervisor for review. The supervisor determines if the issue is valid and what actions if any, should be taken. The youth then signs the grievance and documents whether they are satisfied with the action or not. Phase three is the administrative review of the grievance. Grievances are reviewed by the superintendent or designee within seventy-two hours. A final determination is made and the youth is notified of the decision. Five interviewed staff were all able to summarize the center's grievance process. Five interviewed youth all reported they have never filed a grievance at the center.

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

A review of the center's practice for implementing trauma-informed care found the center has a soft room which includes painted walls with soothing colors. A review of five staff training records found all five staff received trauma-informed care training as part of their annual training requirements. The detention superintendent was interviewed and stated, trauma-informed practices include utilization of the youth soft room which consists of soft colors and positive art work. All staff are trained in techniques of recognizing trauma and appropriate responses when interacting with youth. Trainings are conducted by instructor-led teachings and within the Department's Learning Management System (SkillPro).

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 identified a single licensed mental health professional who has been established as the designated mental health clinician authority (DMHCA). The center's DMHCA is a licensed mental health counselor (LMHC) under Chapter 491. The LMHC is a full-time employee and is on-site forty hours per week. The Department has a contract with Maxim Healthcare Services, Inc. to provide mental health and substance abuse services. A copy of the LMHC licensure and agreement was available while on-site during the annual compliance review.

An Interview with the DMHCA confirmed their credentials as a LMHC. The license is clear and active within the State of Florida. The DMHCA was also able to confirm they are on-site at the center five days a week for forty hours per week. The DMHCA described their role in the coordination and implementation of mental health and substances abuse services at the center by providing mental health services. The center does not offer or provide any type of specialized services per the DMHCA. Clinical services provided for according to the DMHCA are all mental health services. The communication between the DHMCA and clinical staff at the center is very good. The DMHCA meets with the psychiatrist weekly and as needed.

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

The center does not employ any other licensed clinical staff other than the designated mental health clinician authority (DMHCA); therefore, this indicator shall be rated as non-applicable.

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

The center is licensed under Chapter 397 which became effective on May 22, 2019 and will expire on April 1, 2020. The clinical supervisor assures the one non-licensed staff working under their supervision is performing services they are qualified to provide based on their education, training, and experience. The non-licensed mental health clinical staff holds a master's-level degree from an accredited university or college in the field of counseling. The non-licensed mental health clinical staff is a registered intern mental health counselor. Each of the non-

licensed clinical mental health staff is an employee of a facility licensed under Chapter 397, Florida Statutes and holds at a minimum a bachelor's degree from an accredited university or college with a major in psychology, social work, counseling, or related human services field. The non-licensed mental health clinical staff conducting Assessments of Suicide Risk (ASR)received twenty hours training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. The non-licensed clinical staff training includes administration of, at a minimum, five ASR or crisis assessments conducted on-site in the physical presence of a licensed mental health professional and documented on non-licensed mental health clinical staff person's training in ASR form. Training was completed on May 3, 2018. The non-licensed mental health and substance abuse clinical staff received on-site face-to-face direct supervision by the licensed clinical supervisor(s), at least one hour per week. These face-to-face supervisions were conducted individually. Documentation of direct supervision was recorded on the Department's form, Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log.

An on-site review of youth records revealed, the licensed mental health professional providing direct supervision is responsible for reviewing and signing Comprehensive Mental Health Evaluations, updated Comprehensive Mental Health Evaluations, Initial Mental Health Treatment Plans, and Individualized Mental Health Treatment Plans. The documents prepared by the non-licensed mental health clinical staff person, were reviewed by the licensed mental health professional within ten calendar days of administration of the instrument. In addition, the licensed mental health professional providing direct supervision conducted reviews for each ASR and Follow-Up ASR (FASR), Crisis Assessment, and Follow-Up Crisis Assessment conducted by the non-licensed mental health clinical staff within twenty-four hours of the referral for assessment. Each of the ASR, FASR, Crisis Assessment, or Follow-Up Crisis Assessment conducted by the non-licensed mental health clinical staff was also signed by the licensed mental health professional by the next scheduled on-site visit. The qualified professional providing direct supervision to the substance abuse clinical staff also reviewed and signed any Comprehensive Substance Abuse Evaluations, Updated Comprehensive Substance Abuse Evaluations, Initial Substance Abuse Treatment Plans, and Individualized Substance Abuse Treatment Plans when prepared by the non-licensed substance abuse clinical staff person within ten calendar days. The non-licensed mental health and substance abuse clinical staffing is in accordance with current contract and Florida Administrative Rule 63N-1.

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

A total of five youth records were reviewed for mental health and substance abuse admission screening. The Suicide Risk Screening Instrument (SRSI) and Massachusetts Youth Screening Instrument – Version 2 (MAYSI-2) were completed by probation staff. Each of these instruments were completed and reviewed by detention staff for each of the five youth records reviewed. Each of the five youth records contained a completed SRSI and MAYSI-2 which was completed at the youth's intake. The SRSI and MAYSI-2 was documented within the Department's Juvenile Justice Information System (JJIS). Each of the youth records reviewed had the nurse and/or

mental health staff sections of the SRSI completed, as required. There were complete entries,, including a summary and recommendations in the “screening results” sections. In four applicable records reviewed, the youth had a “yes” response on the SRSI. Each of these youth were appropriately placed on suicide precautions and a mental health referral was completed. Each of the screenings reviewed were completed by trained staff. In the four applicable records reviewed, the results of the SRSI and MAYSI-2 indicated a need for further assessment. A referral was made for each of the applicable four records. The superintendent was notified of the screening instrument findings. In the four applicable records reviewed, a MAYSI-2 assessment indicated an elevated suicide risk subscales. Subsequently, each youth was placed on suicide precautions and referred for an ASR. None of the youth required a referral for a comprehensive assessment.

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.	

Five youth records were reviewed for mental health and substance abuse evaluations. Only one was applicable. Two additional youth records were reviewed for mental health and substance abuse evaluations making a total of three applicable records reviewed for this indicator. Each of the three youth records reviewed were identified after admission of needing a mental health and substance abuse evaluation. One of the three youth was referred to the detention provider and the remaining two youth were referred to a community provider. One of the three referrals resulted in completion of an updated mental health and or substance abuse evaluation which was completed by the detention provider. The remaining two referrals resulted in completion of a new mental health and/or substance abuse evaluation which was completed by a community provider. Each of the three mental health and or substance abuse evaluations were completed within thirty days of the referral.

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

A total of five youth records were reviewed for mental health and substance abuse treatment. Four of the five reviewed youth required some form of mental health and or substance abuse treatment. All four youth requiring treatment were assigned to a mini-treatment team. Each of the mini-treatment teams consisted of a mental health clinical staff, a staff from a different service area, the youth, and when possible the youth’s parent/guardian. Each of the four youth were assessed and determined to be in need of mental health treatment were in receipt of individual, group, and or family counseling. Treatment was provided according to the frequency required by the youth’s plan. Only one youth were applicable for substance abuse treatment.

The one youth received individual, group, and or family counseling according to the frequency required by the youth's substance abuse plan. All four youth requiring mental health treatment had a proper consent for treatment, and an Authority for Evaluation and Treatment (AET). The one applicable youth requiring substance abuse treatment had a consent and information release on file related to substance abuse. Only one youth had been in treatment long enough to have treatment notes documented. Treatment notes were found documented on the Department's form Counseling/Therapy Progress Note in the youth's record. Mental health staff have adequate access to youth in order to provide treatment services. Group therapy is limited to ten or fewer youth with mental health diagnoses for mental health treatment groups. Group therapy is limited to fifteen or fewer youth with substance abuse diagnoses for substance abuse treatment groups. The designated mental health clinical authority (DMHCA) stated they provide all mental health services at the center. Five youth were interviewed on how they would rate the mental health and substance abuse services they are receiving at the center. Two youth responded fair, one youth responded good, one youth responded very good, and the remaining youth was not receiving mental health and or substance abuse services.

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

Five youth records were reviewed for treatment planning. Three of the five youth records reviewed were applicable for a treatment plan. One of the youth's initial treatment plan was in place within seven days of initiation of treatment. Two of the three initial treatment plans were late in which one was three days late and the other treatment plan was five days late. Each of the three initial treatment plans reviewed were developed on the Department's form Initial Mental Health/Substance Abuse Treatment Plan. All three youth had a documented reason of referral for treatment and an initial Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) and Diagnostic Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis. The treatment plans also included initial treatment methods and initial treatment goals. Three of the reviewed five youth records required psychiatric services. Each of the initial treatment plans included the signature of the licensed mental health and substance abuse professional. The plans also included the signatures of each youth and the mini-treatment team members involved with the development of the initial treatment plan.

One youth record was applicable for completion of an individualized treatment plan. The youth's individualized treatment plan was completed within the first thirty days of the youth's admission. The remaining three applicable youth were recently admitted to the center and a plan was not required to be developed. The one reviewed applicable individual treatment plan included the signature of the licensed mental health professional within ten days of completion. The treatment plan included an initial DSM-IV-TR or DSM-5 diagnosis. Additionally, the treatment plan included symptoms which were treatment focused, treatment goals, strengths/abilities, and preferences/needs. The individual treatment plan also included treatment recommendations for psychiatric services. The psychiatric services included psychotropic medication and frequency

of monitoring along with pharmacological interventions. A review of the one applicable youth progress notes validated the youth was in receipt of treatment services as stipulated on the treatment plan. The one applicable youth individual treatment plan was reviewed, signed, and dated by the youth, mental health and substance abuse professionals, treatment team members, and the parent/guardian when possible. There was only one individual treatment plan which required a review to be completed within a thirty-day time frame. The individual treatment plan was completed within the thirty-day time frame, as required. This plan was reviewed by the treatment team and modifications were documented on the review form. This individual treatment plan review was signed and dated by clinical staff, the youth, and the licensed mental health professional. The one youth individual treatment plan was applicable for psychiatric treatment services. The youth's individual treatment plan included treatment and services provided for by a licensed psychiatrist. None of the five youth records reviewed were an alleged victim of a Prison Rape Elimination Act (PREA) event.

A total of three youth records were reviewed for mental health and substance abuse treatment discharge summary. Each of the three youth contained a mental health and substance abuse treatment discharge summary which was completed upon each of the youth's transition or discharge from the center. Each of the mental health and substance abuse treatment discharge summaries were provided to the juvenile probation officer (JPO), parent/guardian (as allowed), and the youth.

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.	

A total of five youth records were reviewed for psychiatric services. Four of the five youth records reviewed were applicable for psychiatric treatment services. Three of the four youth entering the detention center were referred for an initial diagnostic interview and seen within fourteen days of the youth's admission. The one remaining youth did not have a referral made; however, the youth was seen within eight days of admission. Each of the four youth had an initial psychiatric interview which included the reason for the referral, history (medical, mental health and substance abuse history), mental status examination, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) or Diagnostic Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis and symptoms, treatment recommendations, prescribed medication, explanation of the need for psychotropic medication, and frequency of medication monitoring/management.

Three of the four youth reviewed were applicable for completion of an in-depth psychiatric evaluation. Each of the three in-depth psychiatric evaluations were documented on the Department's form Clinical Psychotropic Progress Note (CPPN) form which includes all the required elements. Each of the three psychiatric evaluations included identifying data, diagnosis, target symptoms for each psychotropic medication, and evaluation and description of effect of prescribed medication for target symptoms. Each of the prescribed psychotropic medication included the name, dosage, and quantity of the medication. In addition side effects, youth adherence to the medication regime, and youth vitals were included. There was documentation to support whether there was contact with the youth's parent/guardian to discuss psychotropic medications. In addition, the date and signature of the prescribing psychiatrist.

Each of the four youth in receipt of psychotropic medication had documented monitoring for Tardive Dyskinesia monthly, as required. Additionally, each youth record contained an Authority for Evaluation and Treatment (AET). In all of the four youth records reviewed, none required a new psychotropic medication, discontinuation, or dosage of medication to be significantly change. None of the youth reviewed for psychotropic medication were in foster care. Two youth reached the age of eighteen and were responsible for authorizing their individual healthcare and authorizing release of healthcare records.

The provider employs a psychiatrist who is licensed pursuant to Chapter 459, Florida Statutes. The provider does not employ a licensed and certified psychiatric advanced registered nurse practitioner (ARNP) or an advanced practice registered nurse (APRN) under Chapter 464, Florida Statutes.

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

The center has a written plan detailing suicide prevention procedures. The written suicide prevention plan includes a way for staff to identify and provide an assessment of youth at risk of suicide. The plan includes staff training which includes a minimum of six hours of training annually on suicide prevention and implementation of suicide precautions. The plan also includes mock suicide drills for all staff who come in contact with youth on each shift, quarterly. In addition, the detention center's suicide prevention plan includes suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and a review process as referenced in Department's Rule 63N-1(2)(e)3(l).

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

Five youth records were reviewed for suicide prevention services. Four were applicable and identified to be at risk during admission screening. Each of the four youth identified were placed on precautionary observation at a minimum of constant supervision. An alert was initiated for three of the four youth reviewed. The three alerts were entered into the Department's Juvenile Justice Information System (JJIS). The fourth youth had a referral but no alert was entered into JJIS for suicide precautions. All four youth had a suicide risk assessment referral. An Assessment of Suicide Risk (ASR) was documented in real time for each of the four youth. The completed ASR's indicated the level of supervision for each youth reviewed. All four youth reviewed were placed on standard supervision at time the ASR was administered.

A total of nine suicide precautionary observation logs were generated between the four youth reviewed. One of the nine precautionary observation logs were not completed in their entirety. The one log had a gap of thirty minutes missing. The staff conducting observations of the youth did not document a check having been completed between the hours of 3:00 a.m. and 4:00 a.m., as required. There were three precautionary observation logs which indicated the youth's placement on suicide risk was in the a.m.; however, the log should have reflected the youth going on alert in the p.m. There was one precautionary log which was documented with the incorrect youth's name. This particular precautionary log which was not included with the nine reviewed was also missing the mental health clinical staff signature. The remaining reviewed eight precautionary observation logs contained all necessary requirements.

None of the youth reviewed were released prior to receiving an ASR or released while on suicide precautions. In the four ASR's completed, each documented a consultation with the designated mental health clinical authority (DMHCA) or licensed mental health professional. The superintendent or designee was also notified immediately of the youth's suicide risk. An ASR for each of the youth was completed within twenty-four hours. None of the youth were identified as having been in crisis. All four youth placed on precautionary observation were placed on standard supervision at time of the assessment. None of the youth required a follow-up ASR to be completed. Two of the four completed ASR's were conducted by a non-licensed clinical staff under the supervision of a licensed mental health professional. The non-licensed licensed clinical staff was in receipt of twenty hours of ASR training. The two remaining ASR's were completed by the center's licensed mental health professional.

There was evidence within the center's logbook and on the ASR where administrative or supervisory staff provided instructions related to the suicide risk assessment findings to include beginning and ending time for any youth placed on suicide precautions. There were alerts within JJIS found for three of the four applicable youth reviewed. There were no youth requiring secure observation. The superintendent has an established review process for every serious suicide attempt or serious self-inflicted injury requiring hospitalization or medical attention and a mortality review for a completed suicide. The multidisciplinary review included circumstances surrounding the event, written facility procedures relevant to the incident, relevant training received by involved staff, pertinent medical and mental health services involving the victim, possible precipitating factors, and recommendations if any for changes in policy, training, physical plant, medical or mental health services, and/or operational procedures.

Two of the five interviewed youth stated, they have been placed on suicide watch while at this detention center. Three youth responded they have not been on suicide watch. The two youth who were on suicide watch also stated staff watched them all of the time. Five staff were interviewed and were able to identify practices they are responsible for if a youth expresses suicidal thoughts.

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

There were four of five youth records applicable for the use of suicide precautionary observation logs. A total of nine suicide precautionary observation logs were generated between the four youth reviewed. All nine precautionary observation logs where documented on the Department's

form Suicide Precaution Observation Logs which was maintained for the duration the youth is on suicide precautions. One of the nine precautionary observation logs were missing appropriate level of supervision and observations of the youth's behavior. The one log had a gap of thirty-minutes missing. The staff conducting observations of the youth did not document a check having been completed between the hours of 3:00 a.m. and 4:00 a.m., as required. The remaining eight precautionary observation logs did document the appropriate level of supervision and observations of the youth's behavior. The documentation is in real time and did not exceed thirty-minute intervals. There were no warning signs observed. Each of the precautionary observation logs were reviewed and signed by each shift supervisor. One precautionary observation log was missing the mental health clinical staff signature. Four youth were interviewed face-to-face separately if staff were with them at all times while they were on suicide precautions. Each youth replied yes.

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.	

A total of five staff training records were reviewed for completion of suicide prevention training. All five staff received a minimum of six hours annual of suicide prevention and implementation of suicide precautions training. Training consisted of two hours of SkillPro and four hours of instructor-led. Training at the center included a total of eighteen separate mock suicide drills. The drills were held no less than quarterly for each of the three shifts reviewed. The mock suicide drills included all staff who come in contact with youth which included kitchen and maintenance staff. Each of the reviewed mock suicide drills demonstrated fifty percent of staff participated in the quarterly drills. In addition, fifty percent of staff with direct contact on a day-to-day basis with youth, participated in at least one mock drill which included the use of cardiopulmonary resuscitation (CPR) annually. Staff members who are not present during a quarterly drill have the opportunity to review mock drill scenarios and procedures during shift briefings. A total of five staff were interviewed and able to identify locations within the center where the knife for life, wire cutters, and needle nose pliers are stored.

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

The center has a written mental health crisis intervention plan which details crisis intervention procedures. The written crisis intervention plan includes notification and alert system, means of referral including youth self-referral, communication, supervision, documentation, and review process.

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

The center has a written emergency care plan which included immediate staff response, notifications, communication, and supervision. In addition, the emergency care plan included process for authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment under Chapter 394, Florida Statutes (Baker Act), transport for emergency substance abuse assessment and treatment under Chapter 397, Florida Statutes (Marchman Act). The emergency care plan also included procedures for documentation, training, and a review process. The center's written emergency care plan was last updated and approved on August 8, 2018. The written emergency care plan is located within the center's training room, master control, and on the centers K Drive electronically. The written emergency care plan is accessible to all staff.

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

The center has not had any youth requiring a crisis assessment during the annual compliance review period. An informal interview was conducted with the center's designated mental health clinician authority (DMHCA). The DMHCA reported, there were no youth requiring a Crisis Assessment since the last annual compliance review. Should a Crisis Assessment is necessary, the center would use the Department's form Crisis Assessment. This form is located within the Office of Health Services (OHS) electronic medical records system.

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 had one example of a youth requiring a Baker Act and there were no youth requiring a Marchman Act for the annual compliance review period. The youth was placed on suicide precautions upon readmission from the Baker Act. A mental health referral was generated for completion of mental status examination (MSE). The MSE was completed by the center's licensed mental health professional. The youth was maintained on a minimum of constant

supervision until properly transitioned to a lower level of supervision. Subsequently, the youth was placed on standard supervision upon completion of the Assessment of Suicide Risk (ASR). Reviewed documentation supported the mental health staff conferred with the superintendent. A suicide alert was entered within the Department's Juvenile Justice Information System (JJIS) for the one youth reviewed.

Standard 4: Health Services

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

The center has a contract with Maxim Healthcare Services, Inc. to provide comprehensive medical services at the detention center. The center has a board-certified physician who has a clear an active license and meets all the requirements to serve as the designated health authority (DHA). During an interview with the DHA, it was confirmed the DHA is responsible for signing orders, conducting periodic evaluations, physicals, and sick calls. A review of the sign-in logs for the six months prior to the annual compliance review confirmed the DHA is on-site weekly for at least one hour on Monday's. The DHA is also available twenty-four hours a day, seven days a week by telephone to address the center concerns.

The center also employs an advanced registered nurse practitioner (ARNP) who holds an unrestricted license to practice in Florida. The ARNP provide services on-site, a minimum of twenty-four hours a week. The ARNP works in collaboration with the DHA, who signed the nurse practitioner protocol/collaborative practice agreement on August 31, 2018. A check of all licensed medical staff confirmed all had current State of Florida medical licenses which was verified by the Department of Health.

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

The center has facility operating procedures (FOPs) and treatment protocols for all health-related concerns. The FOP's were found to be well organized in a three-ring binder. All FOPs and treatment protocols contained the signature of the designated health authority (DHA) and the superintendent. There was documentation of all newly employed healthcare personnel receiving a comprehensive clinical orientation to the Department's healthcare policies and procedures which was provided by the registered nurse. Documentation confirmed nursing staff completed the annual review of FOPs and signed the cover page.

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.	

A review of five youth individual healthcare records revealed four had an original signed Authority for Evaluation and Treatment (AET) filed in their record. The remaining youth is eighteen years of age and is not required to have an AET.

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

A review of five youth individual healthcare records (IHCRs) found three were applicable for a parent/guardian notification. Two of the three youth required parental notification for over-the-counter medications not covered by Authority for Evaluation and Treatment form. All three youth required parental notification for new medication. For each parental notification there was documentation of telephone calls, attempts, and verbal approvals which were witnessed.

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

A review of five youth individual healthcare records each youth received a medical and mental health admission screening for their most recent visit. The screenings were completed on the day of admission by a juvenile justice detention officer (JJDO). There was documentation of each screening was reviewed with youth by a licensed practical nurse or higher within twenty-four hours. None of the youth had a change in their physical custody since their arrival to the facility requiring a healthcare admission rescreening. The superintendent interview revealed staff completes healthcare admission screenings.

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

A review of five youth individual healthcare records revealed each youth received a general orientation within twenty-four hours of admission to the center. The healthcare topics included access to medical, sick call (use, how to access), what constitutes an "emergency" and when to notify staff, medication process and side effect monitoring, the right to refuse care and how it is documented, what to do in the case of a sexual assault or attempted sexual assault, and the non-disciplinary role of the healthcare providers.

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

A review of five youth individual healthcare records (IHCRs) found one youth were applicable for this indicator. Additional youth records were requested and one was provided. The designated health authority received an immediate notification when youth were identified as in need of emergency care. The notifications were documented in the youth IHCR.

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

A review of five youth individual healthcare records (IHCRs) found each youth had a Health-Related History (HRH) completed within seven days of admission. Each HRH was completed by a licensed nurse or practitioner and reviewed by a physician or an advanced registered nurse practitioner (ARNP). Each of the HRHs were completed before or at the same time of the Comprehensive Physical Assessment.

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

A review of five youth individual healthcare records (IHCRs) found each contained a current Comprehensive Physical Assessment (CPA). Each of the CPA were reviewed, initialed, and dated by the designated health authority. Four of the five CPAs were completed within seven days of admission. The remaining CPA was completed four days late. There was documentation of when any part of the exam was refused the clinician wrote, “Youth Refused”. There was documentation of the youth signing a refusal form which reflected the refused portion on the CPA exam and matched the date of the exam. Each of the youth had at least on verified tuberculosis skin test (TST) test documented in the IHCR on the Infectious and Communicable Diseases Form. The Tier 1 TB screening was completed within seventy-two hours. None of the youth had a positive TST or symptoms of TB requiring them to be transported to the nearest hospital for further evaluation.

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

A review of five youth individual healthcare records (IHCRs) found each youth have the opportunity to be screened and evaluated for sexually transmitted infections (STIs). All five youth were offered human immunodeficiency viruses (HIV) testing. Three of the youth consented to HIV testing. There was documentation of each youth being offered counseling, testing, and treatment for HIV. The test results of the youth were not in the youth’s IHCR due to the results were not available during the annual compliance review. The nurse stated youth are offered HIV testing at the time of intake and if consent is given the youth is provided with pre-counseling and post-counseling by Oasis and have their blood drawn by the contracted company. Five interviewed youth stated they could request an HIV/AIDS test.

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

The center has a policy and procedures in place to request and conduct sick calls at the center. A review of five youth individual healthcare records (IHCRs) found three youth requested sick calls. All sick call request forms and narrative progress notes conformed to the professional standard to include all elements of the subjective, objective, assessment, and plan (SOAP) format. None of the youth presented a similar sick call complaint three or more times within a two-week period. The center has approved treatment protocols appropriate to the level of the provider conducting sick call. Sick calls are conducted in the medical clinic by licensed medical staff at the center. When a licensed nurse is not on-site, the center has procedures in place for the shift supervisors to review all sick call requests no longer than four hours after a request is submitted. Sick calls are scheduled Monday through Friday at 10:00 a.m. and 5:00 p.m., Saturday and Sunday at 10:00 a.m. and 3:00 p.m., and as needed. There were no youth complaints of severe pain with which medical staff was unfamiliar with. Two of the five interviewed youth revealed they never requested a sick call. Additionally, four youth stated they could be seen immediately once they make a sick call, within one day, or within two days. The five youth responded the nurse and staff conduct sick calls. The medical department was rated good by each of the five interviewed youth. Five interviewed staff revealed nurses conduct sick calls for youth.

During the annual compliance review, two sick calls were observed with the youth's permission. The youth was escorted to the medical clinic by a Protective Action Response (PAR) trained supervisor. The youth was examined by a licensed medical staff. The youth was seen in a private area with no other youth present to hear or see the examination.

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

The center has an established policy and procedures for the provision of episodic care, first aid, and emergency care. A review of five youth individual healthcare records found none of the youth received episodic/first aid care by a non-healthcare staff. Three of the five youth were seen by medical staff for episodic/first aid. There was evidence of the center maintaining an Episodic Care Log to document the provision of episodic care and first aid treatment. Each youth was seen by medical staff. The center maintained an Episodic Care Log to document the provision of episodic care and first aid treatment. A review Episodic Care documentation found the subjective, objective assessment, and plan (SOAP) elements. A review of the logs indicated episodic care was administered by the nursing staff. The center has a total of thirteen first aid kits which are monitored monthly. The first aid kits are replenished as need. The program has one automated external defibrillator (AED) which the center recently received and is located outside of master control. The AED was tested and functional during the annual compliance review. There was documentation of the AED being checked monthly by medical staff. The pads expire on March 28, 2021. The expiration date was not found for the batteries. The center; however, has a backup battery just in case. The pads and batteries were installed on August 20, 2018 and expire on March 28, 2021. Documentation and interviews confirmed the nursing staff

reviews inventory and restock all first aid kits monthly which are maintained on a log located on each first aid kit. First aid kits were found located throughout the center. A review of the center's medical drills confirmed, the center conducts mock emergency medical drills at least quarterly on each shift. The mock emergency drills includes CPR/AED demonstration once per quarter. Five interviewed staff reported they are able to call 9-1-1 if they feel necessary. Each of the licensed health care staff have a current CPR/AED certification. A review of pre-service and in-service training found all staff had current CPR/AED First Aid certification.

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

The center has a policy and procedures in place in reference to off-site care for youth. A review of five youth individual healthcare records (IHCRs) found one youth was applicable. Additional records were requested and one additional record was provided. The Summary of Off-Site form was filed in the IHCR. There was documentation of the designated health authority being notified of the event. One youth was sent off-site during the annual compliance review and the doctor has not been back to the center to review the paperwork. Information was documented on the episodic care log. The IHCRs contained a summary of off-site care form and discharge instruction documents when applicable.

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

The center has a written policy and procedures for the delivery of treatment to youth identified as having a chronic medical condition. A review of five youth individual healthcare records (IHCRs) found one youth was identified with a chronic medical condition and/or taking prescribed medications. Additional records were requested and one additional record was provided. Both youth were found to have a chronic condition and were currently taking prescribed medication. Both youth were classified with medical grade two through five. An interview with the nurse revealed the facility monitors youth with chronic conditions. The nurse revealed the youth either obtains a complete physical assessment at the time of intake and are reevaluated by the practitioner every thirty days while the youth are in the facility.

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

The center has a written policy and procedures to ensure medication is received, stored, inventoried, and provided in a safe and effective manner. A review of five youth individual healthcare records (IHCRs) found four youth was prescribed medication prior to their admission to the center. In each of the three IHCRs, the medication was from a licensed pharmacy with a current, patient-specific label intact on the original medication which was brought to the facility by the parent/guardian, verified by medical staff, and the youth was continued on medications. The center used the standard Department Medication Administration Record (MAR)/Electronic

Medical Record (EMR) to document consumption and refusal of medications. The MAR documented all of the required information including demographic information of youth, medication start and stop dates, and staff and youth initials of medication received. There were no lapses or errors in medication administration. The medical staff documented weekly side effect monitoring on the MARs. There were no refusals documented; however, the program practice is to clearly document refusals on the MAR and Refusal Form, when applicable. None of the youth required parenteral medication. Three of the four youth were prescribed psychotropic medication upon admission. There was documentation of the designated health authority, designated mental health clinical authority, and psychiatrist were notified upon admission. The initial diagnostic psychiatric interview was conducted with fourteen days of the youth's admission. There was documentation of the youth receiving medication monitoring/review every thirty days by the psychiatrist. A medication pass was observed during the annual compliance review, after the youth gave verbal consent for the Monitoring and Quality Improvement staff to observe. The registered nurse (RN) verified the six rights of medication administration (right youth, right med, right dose, right route, right time, and right documentation). After the RN gave the youth the medication, the RN verified the youth consumed the medication by checking the youth's mouth. The center has a total of fifteen trained non-healthcare staff to assist in the delivery of medications when licensed staff are not on-site. Four of five interviewed staff reported they do not give medications to youth. Five youth were interviewed and reported the nurse provides their medication.

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

The center has a written policy and procedures ensuring medications and sharps are secured and inventoried by using a routine perpetual inventory. The medication and sharps were found stored and locked in designated areas inaccessible to youth. Medications are stored in a locked medication cart, cabinets, and in the locked refrigerator all of which are situated in the medical clinic. All controlled medications were found stored behind two locks. A shift-to-shift inventory count of all controlled substances was documented on the youth's individualized Controlled Medication Inventory Record.

A random inventory of three different sharps, three prescribed medications, three over-the-counter (OTC) medications, and two controlled medications revealed each count was accurate and documented by licensed nursing staff correctly. A review of the past six months medications revealed all counts and inventories matched medications on available.

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

The center has a written policy ensuring all staff and youth receive education on infection control. A review of the center's Exposure Control plan was conducted and confirmed the plan included all required elements outlined in the Department's standards. The plan was reviewed and signed by the superintendent. A review of five youth individual healthcare records (IHCRs) confirmed each received infection control training within seven days of admission. Training included guidelines for hand-washing techniques, universal/precautions, prevention/transmission of communicable diseases, prevention of blood borne pathogens, and guidelines for infection control. A copy of the Health Education Record form was maintained in each reviewed IHCR. All training and education were provided in accordance with the Center for Disease Control and Prevention guidelines. A review of ten staff training records confirmed staff received pre-service and in-service infection control training.

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

The center has a written policy and procedures in place with discuss prenatal care for all pregnant youth. Health education is provided to both youth and staff. A review of staff training records verified the center's registered nurse provided training/education to staff involved in the supervision or treatment of pregnant youth. The training/education addressed the monitoring, observation, and care of pregnant youth. The center did not have any youth records applicable to this indicator.

Standard 5: Safety and Security

5.01 Active Supervision of Youth (Critical)	Satisfactory Compliance

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

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

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

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

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

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

An observation of staff during daily activities was conducted during the review period. Activities included youth in their assigned living units, line movements, lunch, and education. There was always a minimum of two staff supervising the youth. Notification was sent to all staff including staff assigned to master control through two-way radio, when a youth left a group or a program area where staff were assigned to supervise the youth. Observations determined master control approved all movement. All movement was in accordance with the Florida Administrative Code. At no time was staff observed allowing youth to exercise control over or provide discipline or care of any type to another youth. A review of the logbooks determined the counts were conducted at the beginning and end of each shift. A census sheet is utilized as the method for tracking the youth and the center's logbook. A random sample of five staff were interviewed and each reported staffing was adequate. One staff reported the center experience high turnover rates.

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

The center utilizes a wand to conduct ten-minute observations. The wan records a digital record of each ten-minute check conducted by staff. An observation of ten-minute visual observations of youth by the center's staff determined staff conducted the required visual observations within the required time frame. Observations included staff visual observations during sleep time and confinement. Staff were observed conducting visual observations of the youth in a manner ensuring the safety and security of each youth as staff paused to look inside the secured room. Staff were in the direct line of sight as needed. While reviewing video of ten-minute checks for September 7, 2019, one youth was observed to be on precautionary observation and located outside the room. As the juvenile justice detention officer (JJDO) walked down the hall to complete ten-minute checks; constant sight and sound was not maintained during the brief time the officer conducted checks. The Precautionary Observation Log for the youth was observed and it was completed appropriately. Interviews with staff revealed the youth was in the hall as there was only one staff on the dorm at the time. The youth was always within the view of the master control camera. An observation of the center's cameras was conducted. An observation of three different shifts on six different days and times from a sample of videos determined compliance. Visual Observation sheets are utilized by JJDOs when conducting checks as the checks were being conducted within the required frequency. A random sample of five staff were interviewed and reported checks are conducted every ten minutes. The detention superintendent was interviewed and stated, staff utilize an electronic wand to do rounds on the mods approximately ten minutes apart. Staff observe each youth while they are sleeping to ensure they are safe and secure. Supervisors download the data of the wand daily. If the wand is not working, paper visual observation reports are then used.

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).

Daily observations determine census counts of the youth were taken. The juvenile justice detention officers (JJDOs) in collaboration with master control document the head counts at the beginning and end of each shift, emergencies, routine group movement, population change, and random head counts. This is accomplished by the JJDOs utilizing two-way radios. Observations of the center's logbooks determined headcounts, youth movements, and daily census are documented as required. A random sample of five staff were interviewed and reported emergency counts are conducted when a youth is missing, not visible, or after a major disturbance. Documentation did not include youth not physically present. A random sample of five staff were interviewed and reported counts are conducted at the beginning and end of each shift. If the count is inaccurate; all movement is stop and a recount count is conducted or repeated. Three staff reported recounts are conducted if a youth is missing and two staff reported when visibility is hindered.

5.04 Logbook Maintenance	Satisfactory Compliance

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

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

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

Logbooks are utilized in each living unit and master control. There is a total of three living units which only two were currently being occupied by youth as remodeling was occurring for one of the two male youth living units. The logbooks included a chronological record of events, incidents, and activities. The logbooks are bound with number pages. Each entry included

dates, times, names of staff, youth involvement, brief descriptions of events, and the name of the person making the entry. Medical, special needs, and mental health alerts or issues were highlighted. Logbook entries were reviewed for each living unit for the past six months. Entries were made in black or blue ink and the logbooks were bound with sequential pages. The master control logbook documented all the required entries.

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

Logbook entries were reviewed for each living unit for the past six months. The center utilizes two living areas B two and G one. The males utilize B two and the females utilize G one. Documentation included the captains or the superintendent reviews the logbooks weekly. The juvenile justice detention officer supervisor (JJDOS) reviewed each logbook at the end and beginning of each shift daily. The detention superintendent was interviewed and stated, supervisors are to review logbooks daily on their shift. Administrators are responsible for reviewing the logbooks weekly.

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

An observation of the center's key control was conducted. Each key was placed on a tamper-resistant king ring. The center's emergency, medical, and mental health keys were maintained in master control. During an interview with the superintendent and observations confirmed the juvenile justice detention officers (JJDOs) keys are maintained in the supervisor's office. Observations conducted during the annual compliance review, determined emergency keys provide the action of exiting though the facility exteriors doors providing access to evacuation areas. The center supervisors maintains the inventory for all keys. The center utilizes key logs

to document the shift, the ring number, the number of keys on each ring, capability of each key, to whom each key is issued to,, and the date and time the key was issued and returned. Five staff records were reviewed and each had key control training. An observation of staff during daily activities was conducted. Observations confirmed JJDOs were responsible for the security of their issued keys and are accountable for their issued keys at all times during their shift. The key identified also matched the key staffed signed out for. The issued keys were on the JJDOs at all times. Youth were not observed to have control of the keys at any time during the annual compliance review. There were no accounts of the facility's keys leaving the grounds during the scope of the review. Personal keys were observed as being secured in master control prior to entering the facility. The center's policy delineates the proper key control requirements and training for staff. The policy requires for staff to report all missing or lost keys immediately upon gaining knowledge. Five staff reported the center's daily process for keys include tracking keys, denying youth from accessing keys, reporting missing keys, replacing damage keys, and utilizing master control to properly secure and store personal keys. Staff also reported the center's practice is to maintain inventory of keys and searching the facility and youth for any missing keys. The superintendent reported permanent keys are issued to the superintendent, assistant superintendent, staff assistant, facility training coordinator, and the maintenance mechanic.

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

The center has a total of six vehicles to transport youth. Interviews with the maintenance staff revealed the vehicles are inspected prior to use by the juvenile justice detention officers (JJDOs) and when items are found or suspected to be out of compliance. Staff must have approval of transportation. The center did not have instances of a vehicle being out of compliance. Documentation included each of the six vehicles being searched before and after each transportation as a record was maintained in the center's master control's logbook. Observations revealed JJDOs completed vehicle searches prior to each transport. Documentation reviewed for the past six months included the maintenance staff conducting weekly visual checks and monthly vehicle checks to include all appropriate requirements. An observation of staff before and after transportation was completed during the annual compliance review as the JJDO utilized a first aid kit, window puncher, and knife of life. These items accompanied each JJDO as they were in a bookbag during all transports. Documentation determined a copy of the current transportation procedures were in each of the vehicles. Each of the vehicles were observed to be free of contraband, a secure screen, sufficient gasoline, vehicle logs, gas credit card, and vehicle registration. After transports, documentation determined the staff documented a search of the vehicle for contrabands and remaining youth. Invoices included annual safety inspections and any deficiencies corrected prior to use.

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

The center utilizes a locked storage room located inside the center's main hallway leading to the master control to store the center's tools. The kitchen also maintains sharp tools in a locked cabinet attached to the wall inside the kitchen supervisor's room. Each tool was inspected monthly. The results of these inspections are reviewed by the superintendent. There was no evidence of broken tools upon observations.

The center maintains a perpetual inventory of all tools and the superintendent reviewed each tool. Kitchen staff inventoried each tool daily during shift change. There was no evidence of discrepancies upon observations. There were no documented instances of lost tools by the center. Tools and equipment with the potential to cause death or serious injury are stored with strict control in locked secure areas inaccessible to youth. The maintenance tools are marked with an identification code. The issuance and return of tools were documented. Interviews with the maintenance staff and superintendent determined it is the program's practice to allow the superintendent and captains to have access to maintenance tools. Maintenance staff reported missing tools are documented and reported to the superintendent. The kitchen tools are separate and stored securely. The issuance of kitchen tools and returns of tools are documented daily. A review of the center's policy on maintenance and kitchen tools determined staff adhere to the required procedures for tool inventory and management. Each tool room was secure and inaccessible to youth. All tools were accounted for by the maintenance staff. Maintenance and kitchen staff provided appropriate documentations for the issuance and return of tools.

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

The center utilizes two living areas for both male and female youth. Each mod was clean and identified as B two for male youth and G one for female youth. Five youth and five staff were interviewed. Each youth and staff reported youth use mops, brooms, and scrub brushes. Youth were forbidden to use any other tool. Youth are under strict supervision while handling mops and brooms.

5.10 Inventory of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory Compliance

The Superintendent is responsible for the implementation of a safety plan addressing proper use, storage, and disposal of chemicals, including flammable, toxic, caustic, and poisonous items.

All flammable, toxic, caustic, and poisonous items shall be inventoried and secured when not in use. The use of hazardous material shall be consistent with the manufacturers' instruction and all safety precautions shall be followed.

All flammable, toxic, caustic, and poisonous items shall have the Material Safety Data Sheets (MSDS) on hand in the facility. Toxic or caustic materials shall not be allowed to enter into the facility unless an MSDS is on file in an MSDS logbook and posted near items. A master copy of the MSDS logbook shall be maintained in an accessible binder for all personnel to review at all times.

No hazardous chemicals should be mixed, as this could result in an explosion or emission of toxic gas.

The center utilizes three storage units for flammable, toxic, caustic, and poisonous items located outside on the facility grounds inaccessible to youth. A key lock is used to secure the storage closets. Maintenance, the superintendent, assistant superintendent, and the captains have access to the storage units outside. The kitchen staff have a separate storage closet which only kitchen staff, maintenance, the superintendent, assistant superintendent, and the captains have access to. The center's safety plan addresses the facilities process for inventory and secure storage. All flammable, toxic, caustic, and poisonous items were stored in the secure area inaccessible to youth located within the facility. The flammable, toxic, caustic, and poisonous items stored in the three shreds were identified on an inventory sheet but the quantity of each item was not recorded. The quantity was not identified as the maintenance staff revealed during an interview, the center recently implemented a system to address the missing quantity of flammable, toxic, caustic, and poisonous items. The documentation provided to the annual compliance review team included all inventoried items actual on-site. This was implemented prior to the review team arrival and in place for a month as interviews revealed. Evident of this occurrence was dated on the items inventoried. Furthermore, the Safety Data Sheets (SDS) to the flammable, toxic, caustic, and poisonous materials and items determined there is an SDS for all materials. A review of the center's safety plan determined procedures to address a chemical spill or injury while handling dangerous materials. A key lock is used to secure the storage closets. Maintenance, kitchen staff, and captains have access to the storage units. The center's safety plan covers inventory and secure storage. Each inventoried item matched the on-site inventory. All flammable, toxic, caustic, and poisonous items were stored in the secure area inaccessible to youth. A review of the center's safety plan determined procedures to address a chemical spill or injury while handling dangerous materials. There were SDS for all the flammable, toxic, caustic, and poisonous materials and items.

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

Flammable, toxic, caustic, and poisonous fluids and other dangerous substances were stored in secure areas inaccessible to youth. The center utilizes three storage units for flammable, toxic, caustic, and poisonous located within the center and in the kitchen's storage inaccessible to youth. Five staff and five youth each reported youth are not allowed to clean with flammable, toxic, caustic, and poisonous fluids and other dangerous substances.

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

Observations determined flammable, toxic, caustic, and poisonous fluids and other dangerous substances are stored in secure areas inaccessible to youth located outside in three storage units in front of the sally port entrance and in the kitchen's designated storage area. A review of the center's facility operating procedures determined all hazardous items and toxic materials are disposed of in accordance with Occupational Safety and Health Administration (OSHA) Standard. There were no signs of kitchen waste being disposed of inappropriately as observations revealed. An interview with maintenance personnel determined, it is the center's practice of the facility to dispose of flammable, toxic, caustic, and poisonous items and materials in accordance of OSHA. Okaloosa County Waste Pro was identified to address the disposal of waste. The center does not use grease.

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

The center utilizes two living areas for confinement. B two for male youth and G one for female youth. The rooms on each mod were free of obstruction. Five confinements under twenty-four hours were reviewed. Each room utilized did not have any safety hazards. Each youth had the appropriate amount of meals. Each youth reviewed had access to medical care and mental health care, as needed. Each youth was placed on confinement after their shower, having clean clothing, hygiene items, bedding, and educational materials was provided as applicable or appropriate to behavior. Prior to placing each youth on confinement, each of the five youth confinements was approved by the juvenile justice detention officer supervisor. One youth was placed in a confinement room. The room was searched by a JJDO and each room was free of potential safety hazards. The confinement report was completed in the facility management system (FMS). The JJDOS documented any special needs for each youth reviewed. The

confinement report was evaluated and the JJDOS documented the youth's status every three hours for each of the five youth. The superintendent reviewed each of the confinement reports within twenty-four hours. The JJDOS reviewed each confinement within two hours and continued to counsel the youth. All instance of continued confinement was stated clearly in the confinement report. None of the confinements interfered with visitation. Five staff reported they search the room, document ten-minute checks, and complete a confinement report when a youth is placed in confinement.

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

Five confinements over twenty-four hours for the last six months were reviewed. The confinement review was conducted by the center with permission granted to continue each of youth confinements to beyond twenty-four hours by the regional director. A copy of the confinement report, documents, and interviews were provided. The facility management system (FMS) had documentation to include the center's mental health team meeting with the youth. Documentation on the confinement report captured the superintendent's approval for confinements extended beyond twenty-four hours. Documentation on the confinement report captured the juvenile justice detention officer supervisors (JJDOS) continued to evaluate and document the youth's status every three hours. The JJDOS's documentation captured the current youth's behaviors. None of the reviewed confinements extended beyond three days. The superintendent was interviewed and stated, all incidents of Protective Action Response (PAR) and confinements are documented in FMS and are reviewed by the superintendent or designee. The PAR reports are tracked through FMS and Tableau for review by the regional office.

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

The center utilizes a binder to maintain the Continuity of Operations Planning (COOP) drills. The center had documentation of completing a COOP drill prior to June 1, 2019. The center completed all required COOP drills within the last year. Drills were also located in the center's logbooks. Five staff were interviewed and reported participation in a severe weather drill, major disturbances drill, chemical spills drill, terrorism drill, escape drill, fire drill, and flooding drill.

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

A review of the center's escape prevention plan determined the center has a process to maintain safety & security in the event the center needs to respond quickly and appropriately. The plan delineated appropriate levels of supervision, staff vigilance, and proper building maintenance in escape drills. The center utilizes a binder to maintain the escape drills. The center has a total of three shifts. The center conducted and documented quarterly mock escape drills for each shift each quarter. Five staff were interviewed and each reported they are trained annually on escape prevention. Drills were also located in the center's logbooks. Five staff were interviewed and each reported participation in drills. The superintendent reported the center has a written policy and procedures which deals with the escape prevention plan. Escape drills are completed and documented for each shift on a quarterly basis.

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

A review of the center's fire prevention plan determined the center has implemented a disaster preparedness plan. The center utilizes a binder to maintain fire drills. Drills were found to be conducted monthly, facility wide, and on each shift. The center provided documentation of conducting monthly fire drills. Dills were also located in the center's logbooks. Five staff were interviewed and each reported participation in monthly fire drills.