STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

PROGRAM REPORT FOR

Palm Beach Regional Juvenile Detention Center

Department of Juvenile Justice

(State-Operated)
1100 45th Street
West Palm Beach, Florida 33407

Review Date(s): May 14 - 17, 2019

PROMOTING CONTINUOUS IMPROVEMENT AND ACCOUNTABILITY IN JUVENILE JUSTICE PROGRAMS AND SERVICES

Rating Definitions

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

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

Review Team

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

Shakela Minns, Office of Program Accountability, Lead Reviewer (Standard 1, Interviews)
Christina Calvert, Office of Progran Accountability, Regional Monitor (Standard 3)
Peter Keelan, DJJ Office of Education, Education Coordinator (Standard 2)
Gabriel Medina, Office of Progran Accountability, Regional Monitor (Standard 2)
Patrick Morse, Office of Program Accountability, Regional Monitor Supervisor (Standard 5)
Marissa Stress, Office of Progran Accountability, Regional Monitor (Standard 4)

Program Name: Palm Beach Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: Palm Beach County / Circuit 15
Review Date(s): May 14 - 17, 2019

MQI Program Code: 207
Contract Number: N/A
Number of Beds: 65
Lead Reviewer Code: 159

Methodology

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

Persons Interviewed

☒ Program Director
☒ DJJ Monitor
☒ DHA or designee
☒ DMHCA or designee
1 # Case Managers
1 # Clinical Staff
2 # Food Service Personnel
2 # Healthcare Staff
1 # Maintenance Personnel
2 # Program Supervisors
7 # Youth
7 # Direct Care Staff
_____ # Other (listed by title): _____

Documents Reviewed

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

Observations During Review

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

Comments

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

Standard 1: Management Accountability
Detention Rating Profile

Indicator Ratings

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

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

Standard 2: Youth Management
Detention Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Detention Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Detention Rating Profile

Indicator Ratings

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

* 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 Palm Beach Regional Juvenile Detention Center is a state-owned detention facility, operated by the Department, located in West Palm Beach, Florida. The center serves youth in Delray, Boynton, Boca Raton, Belle Glades, and Palm Beach Gardens within Circuit 15 and Palm Beach County. The youth are processed through the Juvenile Assessment Center (JAC), which is located at the detention center. Male and female youth who are detained pending adjudication, disposition, or placement in a residential commitment program are housed in the sixty-bed center. Youth are provided services which include youth orientation, behavior management, safety and emergency procedures, transportation, mental health, and healthcare services. The center's educational services are provided by the Palm Beach County School Board. The center's management team includes the superintendent, two assistant superintendents, one administrative assistant, one staff assistant, eight juvenile justice detention officer (JJDO) supervisors, and forty-six JJDOs. The center maintains a contract with Maxim Healthcare Services, Inc. to provide mental health and substance abuse services. Maxim Healthcare Services, Inc. subcontracts with Camelot Community Care, Inc., to provide comprehensive mental health and substance abuse services and psychiatric services. Camelot Community Care, Inc. subcontracts with Heartwork of Orlando, Inc., to provide a State of Florida licensed psychiatrist.. Mental health services are provided by a licensed mental health counselor who serves and the designated mental health clinician authority (DMHCA), as well as two non-licensed, master's-level mental health therapists. Clinical services provided by the center include mental health and substance abuse evaluations, mental health treatment planning, individual, group, and family therapy, mental health crisis intervention services, on-site psychiatric services, and availability for substance abuse services for youth with co-occurring disorders. The center has a current contract with Maxim Healthcare Services, Inc. to assume the responsibility for the provision of medical services to all youth. All healthcare staff are employed by Maxim Healthcare Services, Inc. At the time of the annual compliance review, the medical healthcare staff consisted of a medical doctor (MD) serving as the designated health authority (DHA), one advanced registered nurse practitioner (ARNP), one registered nurse (RN), and two licensed practical nurses (LPNs). The medical clinic maintains nursing coverage seven days a week, from 8:30 a.m. to 8:30 p.m. Monday through Friday, and 8:30 a.m. 4:30 p.m. on weekends. 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 which are divided by two males and one female module. There are eighty-one security cameras at the center, all of which were operational. At the time of the annual compliance review, the center had four vacancies, which included three JJDOs and one food service position.

Standard 1: Management Accountability

1.01 Initial Background Screening (Critical)	Satisfactory Compliance

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

The center maintains a written policy and procedures addressing the completion of a background screening prior to hiring an employee or utilizing the services of a volunteer, mentor, or intern. A review of the staff and volunteer roster found nineteen staff, thirty volunteers, and two contracted staff all required an initial background screening. Each applicable employee had an initial background screening completed prior to their date of hire. The criminal history report was reviewed for each employee and all staff were found eligible for hire. Nineteen staff were applicable for the pre-employment assessment tool administered to direct care staff. Sixteen staff records documented a passing score. Three records documented a failed score and had supporting documentation indicating the Department provided consent for the center to hire the staff. None of the applicants were identified for an exemption by the Department's Office of Inspector General (OIG), Background Screening Unit (BSU) prior to employment. The Annual Affidavit of Compliance with Level Two Screening Standards was completed and submitted to the Department's Background Screening Unit (BSU) on January 24, 2019, meeting the annual requirement. The Annual Affidavit of Compliance with Level Two Screening Standards for school board teachers was completed and submitted to the Department's BSU on January 29, 2019, meeting the annual requirement.

1.02 Five-Year Rescreening	Satisfactory Compliance

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

The center maintains a written policy and procedures requiring the completion of a five-year background rescreening for all applicable staff. A review of employee records found five staff were applicable for a five-year background rescreening since the last annual compliance review. Reviewed documentation reflected all applicable staff received a five-year rescreening within the required time frame. Four of five staff rescreens were submitted at least ten business days prior to the staff's five-year anniversary date. One staff five-year rescreening was not submitted at least ten business days prior to the staff's five-year anniversary. The staff was hired on February 6, 2009 and the rescreening was completed on February 7, 2019. There were no contracted providers, interns, educational, medical, or mental health staff requiring a five-year background rescreening during this annual compliance review period.

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

The center maintains a written policy and procedures regarding staff code of conduct. Staff are required to adhere to the code of conduct which prohibits any type of abuse, profanity, threats, harassment, intimidation, horseplay, or personal relationships with youth. Seven staff personnel records were reviewed, and each contained the signed acknowledgement, receipt, and review of the Department's code of conduct. There were no incident reports for substantiated allegations of improper conduct by staff during the past six months. There were no applicable staff found to have disciplinary actions or code of conduct violations within the past six months. An interview with the superintendent indicated there were no formal violations for code of conduct since the last annual compliance review. Seven staff were interviewed, and five staff stated they have never observed their co-worker using profanity when speaking to youth. Two staff stated they observed staff use profanity once. It was further explained when a staff is trying to gain control, profanity may slip out of their mouth. However, the staff was addressed immediately by administration. Seven interviewed staff reported they have never witnessed staff using threats, intimidation, or humiliation. Seven staff were interviewed regarding the center's working conditions. Three staff reported the working conditions are good at the center and four staff stated the working conditions are very good. Seven youth were interviewed regarding the staff using profanity. Five youth stated they have never heard staff use curse words when speaking with youth, one youth stated staff uses profanity at other youth often, and one youth reported staff uses profanity occasionally. This information was relayed to the superintendent during the annual compliance review. All seven youth also stated they have never heard staff threaten youth. All seven staff reported staff are respectful when talking with them.

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

The center maintains a written policy and procedures to ensure when a reportable incident occurs; the center notifies the Department's Central Communications Center (CCC) within two hours of becoming aware of the incident. The center had a total of twenty-three reportable incidents during the past six months. A review of five incidents documented in the center's logbook indicated the incident dates, times, incident types, and persons involved. A review of internal incidents for the past six months found there were no additional incidents which should have been reported to the CCC. An interview with the superintendent indicated there has not been an increase in the number of reportable incidents to the CCC.

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

The center has a policy and procedures pertaining to the use of Protective Action Response (PAR). A review of seven pre-service and seven in-service staff training records found each staff received PAR training approved by the Department's Office of Staff Development and Training. A review of five PAR incidents reports found each report was completed by the end of the shift, inclusive of statements from all staff involved, and contained a post-PAR interview conducted within thirty minutes after the incident. None of the youth involved in the reports sustained injuries which required medical attention, or a call to the Florida Abuse Hotline. Four of five reviewed PAR reports contained a review of the PAR incident report by the superintendent or designee within seventy-two hours of the incident. One was not reviewed within the required time frame. The superintendent was made aware of this issue during the annual compliance review. The center's PAR rate during the annual compliance review period was 6.54, which is below the statewide Detention PAR rate of 11.61. An interview with seven staff indicated staff attempt verbal interventions prior to applying any touch control techniques and/or physical restraint. An interview with the superintendent indicated there has been a decrease in the use of PARs since the last annual compliance review.

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

The center maintains a written policy and procedures regarding pre-service training. A review of seven staff training records for pre-service training indicated four staff completed all required trainings within 180-days of hire. One staff was still within a 180-days of completing training. Two staff were not certified within a 180-days of being hired. One staff was hired July 6, 2018 and did not complete the Department's academy until February 8, 2019. Another staff was hired

September 14, 2018 and did not complete the Department's academy until February 8, 2019. Each record included Protective Action Response (PAR) training, cardiopulmonary resuscitation (CPR), first aid, mental health services, substance abuse services, suicide recognition and intervention, emergency safety and security, Prison Rape Elimination Act (PREA), human trafficking, and detention operations.

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

The center maintains a written policy and procedures which requires staff to complete twenty-four hours of in-service training each calendar year after completion of pre-service certification training. The policy requires supervisors to complete eight hours of supervisory training annually. A review of seven staff training records found all staff received in-service training in the Department's required topics including epinephrine auto injector training. Each reviewed staff record reflected staff met the minimum hourly requirements for training to include Protective Action Response (PAR) update, cardiopulmonary resuscitation (CPR), first aid, suicide prevention, and professionalism and ethics. Reviewed documentation of the two supervisory staff's training records reflected each completed the eight-hour requirement of supervisory training for the year. All training was documented in the Department's Learning Management System (SkillPro). The center maintains an annual training plan, which is updated as needed to reflect any changes. The training plan was approved by the Department's Office of Staff Development and Training on January 14, 2019.

1.08 Entering Alerts (JJIS) and Sharing of Alert Information (Critical)	Satisfactory Compliance
Superintendents shall ensure Critical and Special Alerts are reviewed and responded to appropriately. *Upon completion of the Admission Wizard, the officer shall ensure all Critical and Special Alerts are listed in JJIS.* *The JJIS alert report shall be reviewed daily by supervisors and administrators to ensure it correctly reflects the status of youth.* *If the electronic system is inoperable, for any reason, the JJDO Supervisor shall ensure the last hard copy of the alerts shall have a written notification or update of the recent admissions or changes to existing alerts on the alert sheet and distribute to all staff within the facility immediately.* *Medical and mental health staff shall review alerts to ensure each alert is correctly tracked and managed.* *The responses and updates by medical, mental health and other staff should be documented in JJIS alerts as they pertain to that critical alert.* *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 maintains a written policy and procedures regarding entering alerts in the Department's Juvenile Justice Information System (JJIS) and the use of an internal alert system. Alerts were appropriately entered and downgraded or discontinued in JJIS by the appropriate staff member on the date each was identified and no longer applicable. Medical and mental health staff track and manages the youth alerts daily. Seven youth records were reviewed for alerts in JJIS and reflected alerts were appropriately entered in JJIS on the date each was identified. A review of JJIS reflected alerts included the name and title of person entering the alert, along with the alert type. A review of supporting documentation in comparison with staff interviews confirmed internal alerts were discussed during each shift briefing and printed daily by each shift supervisor. Alert copies are provided to each staff during shift briefings. Observations of a shift briefing validated the youth, applicable alerts, and youth in confinement were discussed. Alerts were also documented in the master control and module logbooks. Seven staff were interviewed regarding alert notifications. All seven staff reported they are informed of alerts through the center's logbooks, shift briefings, alert forms, JJIS, and the alert board maintained in master control.

Standard 2: Assessment and Performance Plan

2.01 Admission	Satisfactory Compliance

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

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

The center has a written policy and procedures addressing the admissions process for each youth admitted into the center. A review of seven youth case management records reflected the juvenile justice detention officer (JJDO) intake screeners completed the Admission Wizard in the Department's Juvenile Justice Information System (JJIS). Each reviewed youth case management record revealed the records contained an arrest affidavit, Detention Risk Assessment Instrument (DRAI), and Suicide Risk Screening Instrument (SRSI). Each applicable record indicated an electronic, frisk, and strip searches were completed for each youth by an officer of the same gender. Each record had a telephone call by the youth documented in the record, and it was also documented a meal was provided to each youth upon intake. In addition, all seven youth records contained assessments for medical concerns, substance abuse, and mental health issues. The center did not have any new admissions to observe during the annual compliance review week.

2.02 Orientation	Satisfactory Compliance

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

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

The center has a written policy and procedures to ensure admitted youth are provided with an orientation within twenty-four hours of admission. A review of seven youth case management records found each contained a signed orientation acknowledgment form signed by the youth,

confirming orientation took place within twenty-four hours of the youth's admission into the center. Each reviewed record revealed all youth were advised both verbally and in writing of the orientation process. All seven records provided documentation of the rules and regulations, grievance procedures, visitation, telephone calls, youth rights, the behavior modification system and related consequences, and how to access the Florida Abuse Hotline and the Department's Central Communications Center (CCC), including medical, mental health and substance abuse concerns and how to access the services. Seven youth were interviewed, and all indicated they received an orientation to the rules and regulations of the detention center during admission. The center did not have any new admissions to observe during the annual compliance review week.

2.03 Classification	Satisfactory Compliance

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

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

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

The center has a written policy and procedures regarding classification and orientation to ensure each youth is protected from harm, violence, and/or victimization. The policy takes into consideration the youth's gender, age, weight, level of aggression, special medical or mental health needs, criminal behavior, history of violent behavior, gang affiliation, history of sexual offenses, and security and escape risk. Seven youth records were reviewed and all included documentation of consideration of potential safety and security concerns prior to being assigned to a room. However, five of the seven youth records reviewed did not document the youth's gender as one of the reasons for room assignment. All youth were assessed using the Vulnerability to Victimization Sexually Aggressive Behavior (VSAB) assessment, Secure Detention Admission Wizard, juvenile offense history, active alerts, and the Suicide Risk Screening Instrument (SRSI). All information was documented in the Department's Juvenile Justice Information System (JJIS) Admission Wizard prior to making a room assignment.

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

The center has a screening process for youth newly admitted into the center to determine if the youth is a gang member or gang affiliated. The center's assistant superintendent serves as the gang representative who reviews identified youth for suspected gang involvement. A review of seven case management records found none were applicable for youth identified as gang members. Three additional records were requested and reviewed. Each of the three applicable reviewed records showed an alert was entered into the Department's Juvenile Justice Information System (JJIS). The center also maintains a gang unit tracking log, which was reviewed and confirmed the center's practice of documenting identified gang members.

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

The center has a screening process for youth newly admitted into the center to determine if the youth is a gang member or gang affiliated. The center's assistant superintendent serves as the gang representative who reviews identified youth for suspected gang involvement. Once a youth is admitted, the gang representative notifies the juvenile probation officer (JPO) and law enforcement officer (LEO) by e-mail when a suspected gang member is identified. Additionally, gang information is shared with all other pertinent parties through e-mail, telephone, and during the weekly detention review meetings. None of the seven reviewed records were applicable for youth affiliated with a gang. Three additional applicable records were requested and reviewed. Each included a gang identification form and a corresponding e-mail message to the gang liaison. During the week of the annual compliance review, an informal interview was conducted with the gang representative which confirmed the center's practice.

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

The center has a written policy and procedures for securing, storing, and returning each youth's property and valuables. Seven reviewed records contained a property receipt. Each receipt

documented the youth and staff names and signatures, letter of acknowledgement of unclaimed property form, and a property receipt for the youth's personal property. Personal property was inventoried and documented upon each youth's admission. Personal property was maintained in a secure room under video surveillance. All valuables were placed in a clear and tamper-resistant sealed bag and placed in the center's drop safe. A drop safe logbook was observed on top of the secured drop box which documented each youth's name and property number. All seven youth records had documentation showing the youth was assigned a specific locker number assigned on the property receipt. Observations of a youth admission was not conducted the week of the annual compliance review due to the center not having any new admissions. Seven interviewed youth reported staff checked their personal property at the time of admission and had them sign a receipt acknowledging the form.

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

The center has a written policy and procedures for storage of youth personal property. Observations made during the week of the annual compliance review found the center utilized two safes for the storage of youth valuable personal property. One safe was located in master control, the other was in the detention review specialist's office, and both were under video surveillance. Seven youth records were reviewed for the storage of youth personal property. The records, in comparison with an observation of the property room, displayed safe guards were in place for each youth's personal property until the property was returned to the youth and/or parent/guardian. All youth property was inventoried by the booking officer in the presence of the youth and signed by both parties. The shift supervisor logs it into the safe logbook and secures the youth's property. All property remains under constant video surveillance. A review of reports to the Department's Central Communications Center (CCC) for the past six months did not indicate any incidents were reported regarding youth property. An interview with the center's superintendent validated the center's property storage practice. The superintendent also advised access to the property room is limited and only administration has access to remove valuables.

2.08 Release	Satisfactory Compliance

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

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

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

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

The releasing officer shall verify the identification of the youth.

The center has a written policy and procedures to ensure all releases from the center occur promptly and accurately. Three closed youth records were reviewed for release procedures. All three records documented the on-duty supervisor reviewed all release paper-work prior to the youth's release. Each record contained a copy of the identification of the person taking custody of the youth, a copy of the release wizard checklist, and a signed property receipt acknowledging the youth's property was returned. The release date documented in the Department's Juvenile Justice Information System (JJIS) reflected the youth's correct release date, consistent with the actual date of release. Reviewed documentation in each of the three closed records indicated the youth and the youth's parent/guardian were informed of future court dates and appointments. The center did not have any releases the week of the annual compliance review. A review of the Department's Central Communications Center (CCC) incident reports for the past six months found there were not any unauthorized releases from the center during this annual compliance review period.

2.09 Release of Youth Personal Property	Satisfactory Compliance

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

The center has a written policy and procedures to ensure youth's personal property is maintained securely and returned to them in a timely manner upon their release. Once a youth is released from the detention center, the personal property, the releasing officer, the youth, and the parent/guardian shall review and sign the property receipt form to claim all of the youth's personal property. All personal property not claimed within thirty days of a youth's release is considered abandoned and a letter is forwarded to the youth and parent/guardian advising them of the property status. The center donates the property if it remains unclaimed for over thirty days. Unclaimed valuables such as money is forward to the regional fiscal manager in the form of a money order. Three closed youth case management records were reviewed and confirmed each youth, parent/guardian, and staff signed the receipt of property form upon release. An observation of a youth being released could not be observed during the week of the annual

compliance review. An interview with the superintendent and the assistant superintendent confirmed the center's practices for the release of a youth's personal property.

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

The center has a written policy and procedures regarding the release of medication aftercare instructions. Three closed records were reviewed. Each record contained an identification and the Office of Health Services Medication Receipt, Transfer, and Disposition form and a youth medication receipt signed by the parent/guardian. Documentation verified the youth were released to an appropriate person with a copy of their identification. A release of medication was not observed due to the center not having any releases the week of the annual compliance review.

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

The center has a written policy and procedures for review of youth in secure and home detention. The center conducts detention reviews weekly, every Wednesday. The participants for detention review include center staff, probation staff, the commitment manager, education, mental health, medical, and administration, as well as a Department of Children and Family (DCF) representative, when applicable. An observation of a weekly detention review and a review of minutes from detention reviews during the previous six months indicated youth information was shared with the participants and captured in the meeting minutes, signed, dated, and collected from all the parties attending the meetings. During the detention review, the superintendent covered youth in secure detention, non-secure home detention, and youth on electronic monitoring. Reviewed documentation also confirmed the center consistently conducted weekly detention reviews to ensure the screening of all youth who may be able to transfer to a less restrictive placement or to their designated commitment placement expeditiously. An interview with the superintendent confirmed the weekly detention review takes place at the center every Wednesday in the conference room.

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

The center has a written policy and procedures regarding daily activities. Youth are provided the opportunity to participate in constructive activities benefiting the youth and the center. The activities of youth in the center are related to protection and rights afforded to them by statute and the expectations of the center programming. The master program schedule includes hygiene times, meal times, visitation dates, phone calls, education, and center activities to include recreation, volunteer activities, programming such as restorative justice, gender-specific, and life skills. Observations made during the annual compliance review, coupled with reviewed documentation found life skills and restorative justice sessions are led by mental health staff,

volunteers, and center staff. A review of the center's daily activity schedule found all required elements were included. A tour of the center revealed the schedule was individualized by module, posted in each living area, and outlined the days and times for each youth activity. Seven interviewed staff reported the center follows the daily activity schedule. All seven staff indicated the center offers gender-specific programming as a part of the daily schedule. Seven youth interviews were completed, and all seven youth reported the center posted a daily schedule.

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

The center has a written policy and procedures regarding adherence to daily activities. Youth were observed following the daily activity schedule during the annual compliance review week. The center logbooks and movements were also observed during the annual compliance review. Seven youth were interviewed. Each youth confirmed the center follows the daily schedule. Seven staff were interviewed and confirmed the center follows the daily schedule. However, the schedule can change due to inclement weather. Changes to the schedule are relayed to staff by the supervisor and require approval from administration. Any cancellation of visitation must be approved by the superintendent.

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

The center has a written policy and procedures regarding educational access. The center's educational program managed by the Palm Beach County School Board operates on a year-round basis, providing the youth within the facility 300 days of instruction, which is distributed over twelve months with a minimum of twenty-five hours weekly. School may be canceled due to natural and/or climatic emergencies such as hurricanes and other severe weather conditions. Upon review of the school's schedule, in comparison with the school's lead educator's interview, education staff are afforded ten days of planning. Observations of the center, coupled with a review of the center's logbooks, found youth were involved in classroom activity, as designated by the daily activity calendar with minimal interference. This was verified during an informal interview with the lead educator during the week of the annual compliance review. The lead educator also reported the youth enrolled in the education program have the opportunity to earn course credits through the Palm Beach County School District. Seven youth interviews indicated the school schedule is followed and they attend school Monday through Friday. Each youth was aware of the courses they are enrolled in at the center.

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

The center has a policy and procedures regarding career education.The career education component offered is categorized as a Type 1 Career and Vocational curriculum. The Type 1 program integrates personal accountability skills and behaviors leading to the development of work habits to help maintain employment and living standards. Career education is inclusive of communication, interpersonal, and decision-making skills. An interview with the lead education counselor indicated the youth are provided employment and life skills guidance through an on-site job coach who provides the youth with various exercises dealing directly to exploring career choices, corrective résumé writing, and interviewing skills. Seven youth interviews validated educational career/vocational classes are offered Monday through Friday.

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

The center has a written policy and procedures outlining the behavior management system (BMS). The center's BMS consists of three levels and includes rewards for positive behavior and consequences for inappropriate behavior. The center's BMS prohibits corporal punishment, use of drugs to control youth behavior, and group punishment. The center's BMS meets the needs of the youth along with the safety and security of the youth and staff. The behavioral norms and expectation for the youth is posted in all living areas and clearly specifies appropriate and inappropriate behaviors. An observation of the center in comparison with reviewed documentation revealed the BMS was explained to each youth during the admission process and orientation, as well as included in the youth's orientation brochure. During an informal interview, the superintendent indicated the center uses a three-level system. When the youth is admitted into the center, he/she is entered as a level two and after three days of good behavior, the youth level can be upgraded. If the youth is misbehaving, the youth's level will drop or be frozen by the supervisor. All youth placed on level three attends a level three party on every Friday. Seven youth were interviewed to rate the effectiveness of the center's BMS. Seven interviewed youth reported only levels and points were taken away for negative behavior. One youth rated the system as very good, two rated the BMS as good, while four considered the practice to be fair. Five youth reported the consequences they received were fair, one youth indicated the consequences were not fair, and one never received consequences. Seven interviewed staff reported the youth are spoken to about their behavior and the level of consequences. Also, staff reported discussing alternative acceptable behavior with the youth. Interviewed staff confirmed they receive feedback on the implementation of the BMS through their supervisors and administrative staff.

2.17 Unauthorized Use of Punishment (Critical)	Satisfactory Compliance

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

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

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

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

The center has a written policy and procedures in place to address the unauthorized use of punishment in the behavior management system (BMS) which restricts certain types of penalties for youth who demonstrate negative behaviors. Postings are located on the housing units, which includes the telephone numbers for the Florida Abuse Hotline and the Department's Central Communications Center (CCC). A review of the center's internal incidents, CCC reports, and the center's logbooks confirmed there were no instances of unauthorized use of punishment. Seven youth were interviewed, and each reported youth are not allowed to discipline other youth, nor have they observed staff tell other youth to discipline other youth. All youth responded they never witnessed a youth having iron restraints used for out of control youth. Three of the seven youth revealed they were sent to their room for punishment and the other four youth indicated they never break the center rules. Seven interviewed staff indicated they have never witnessed intimidation, humiliation, or unauthorized use of punishment at the center. All seven staff responded at no time would a consequence for negative behavior result in the loss of a meal, snack, sleep, or school. Further, none of the staff have ever witnessed another staff encouraging one youth to fight another.

2.18 Grievances	Satisfactory Compliance

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

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

The center has a written policy and procedures in place related to youth grievances to ensure each youth has the right to grieve and ensure all youth are treated fairly, respectfully, without discrimination, and their rights are protected. The youth can request a grievance form from staff, who will then input the grievance into the Facility Management System (FMS) in the Department's Juvenile Justice Information System. The process includes an informal phase, formal phase, and the appeal phase. The informal phase, which is completed by detention staff

where by the youth and staff attempts to resolve the youth's complaint. If the staff is unable to resolve the issue, the written grievance will be submitted to the supervisor, beginning the formal grievance process. The written grievance requires a response from the juvenile justice detention officer supervisor (JJDOS) by the end of the shift if possible or within twenty-four hours. Next, the appeal phase requires a response from the superintendent or designee. The superintendent will have seventy-two hours within receipt to take the corrective action deemed as necessary. During the annual compliance review, the assistant superintendent provided documentation to validate there have been no grievances submitted since May 31, 2018 to the present day. An interview with the superintendent indicated she is aware of the process and three phases of the grievance procedures. Seven youth were interviewed and none of the youth reported filing a grievance while at the center. Seven staff were interviewed and able to explain the center's grievance process.

2.19 Trauma-Informed Care	**Satisfactory Compliance**

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

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

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

The center has a written policy and procedures which addresses trauma-informed care. Seven staff training records confirmed the center is incorporating trauma-informed practices into current operations to deliver services and to provide care to youth in custody, acknowledging the role which violence and victimization play in the lives of most youth entering the center. A tour of the center confirmed the center has a soft room and other areas throughout the center which are painted in soothing colors. The center also created a butterfly garden to help aid youth who have experienced trauma. Mental health staff utilize the room to meet with youth and for special visitations for youth who have children and younger siblings. During an informal interview, the superintendent revealed the center has taken a softer approach by painting the modules in softer colors, creating a soft room, game room, and butterfly garden for youth to utilize. The superintendent also confirmed all staff are trained in trauma-informed care.

Standard 3: Mental Health and Substance Abuse Services

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

The center maintains a written policy and procedures to ensure there is a single licensed mental health professional identified as the designated mental health clinician authority (DMHCA), who is responsible for the coordination and implementation of mental health and substance abuse services. The center's DMHCA is a licensed mental health counselor. The reviewed license is free and clear in the State of Florida and expires March 31, 2021. An interview with the DMHCA confirmed the responsibility for the administrative oversight and management of mental health and substance abuse services at the center. The DMHCA is scheduled to be on-site forty hours a week, Monday through Friday, and provides on-call services twenty-four hours a day, seven-days a week.

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

The center maintains a written policy and procedures to ensure mental health services and substance abuse services are provided by individuals with appropriate qualifications. The center's staffing is in accordance with the contract and Department rule. The center's contract with Maxim Healthcare Services, Inc. provides for a regional mental health and substance abuse clinical director for the south region, one full-time designated mental health clinician authority (DMHCA), and a psychiatrist for approximately two hours each week. The DMHCA is employed with Camelot Community Care, Incorporated, and the psychiatrist is subcontracted with Heartwork of Orlando, Incorporated. The center's DMHCA is a licensed mental health counselor (LMHC). The reviewed LMHC license was free and clear in the State of Florida and expires March 31, 2021. A review of the psychiatrist's license confirmed a licensed medical doctor status with a specialty in child and adolescent psychiatry. The psychiatrist's license was free and clear in the State of Florida with an expiration date of January 31, 2020.

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

The center maintains a written policy and procedures to ensure mental health services and substance abuse services are provided by individuals with appropriate qualifications. The

designated mental health clinician authority (DMHCA) ensures the center's clinical staff are working under direct supervision and are providing services they are qualified based on education, training, and experience. The center has a Chapter 397 license through the State of Florida Department of Children and Families authorizing the center to provide outpatient substance abuse services. The license was issued April 3, 2019 and expires April 1, 2020. The center employs a licensed DMHCA providing direct supervision to the center's two non-licensed master's-level registered mental health counselor interns. A review of training records supported both non-licensed therapists completing the center's Assessment of Suicide Risk form completed twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. A review of the past six months of weekly direct supervision logs documented both non-licensed staff received weekly supervision. One therapist was on vacation for one week and the direct supervision was not applicable. A review of direct supervision logs showed the details of supervision session portion of the form often contained non-specific documentation. Many separate supervision logs documented the same statements including "discussed status of youths with referrals", "discussed youth participating in mental health treatment." Each reviewed direct supervision note was documented on the Department's Licensed Mental Health Professionals and Licensed/Certified Substance Professionals Direct Supervision Log form and contained all required elements.

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

The center maintains a written policy and procedures ensuring the mental health and substance abuse needs of the youth are identified through a comprehensive screening process. Six of seven reviewed records were applicable for the completion of admission screenings. One youth was a transfer and not applicable for admission screenings. Each of the six reviewed records documented the completion of a Positive Achievement Change Tool (PACT), Suicide Risk Screening Instrument (SRSI), and Massachusetts Youth Screening Inventory – Second Version (MAYSI-2), completed by the probation screening staff. Additionally, five of the six reviewed SRSIs documented completion by the center's detention staff and mental health staff as required. One reviewed record documented the youth was admitted while the Department's Juvenile Justice Information System (JJIS) was not working. Some information was entered into JJIS after the system was restored. The reviewed SRSI paper and computer versions were incomplete and there was no observed completion of the detention center's staff on the paper or electronic version. Additionally, the electronic version had only juvenile probation officer (JPO) information and the paper version had only mental health staff information. Each of the reviewed six records documented screenings were completed by trained staff. Three reviewed records documented a risk for suicide was identified on the PACT and each was placed on suicide precautions, as required. An interview with the center's superintendent reported the intake staff and the supervisor ensure the SRSI and Victimization and Sexually Aggressive Behavior (VSAB) are completed during admission. Six of the seven reviewed records documented the PACT indicated a need for a comprehensive assessment. Each of the six applicable records

contained a referral and documented the mental health staff was notified by the center staff completing the screening.

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

The center maintains a written policy and procedures ensuring youth who are identified through preliminary screening, during intake and admission, as having mental health and/or substance abuse issues or needs are referred for a further in-depth mental health and/or substance abuse evaluation. All youth referred for further assessment upon admission screening are referred to the Drug Abuse Treatment Association (DATA). DATA is responsible for conducting the Treatment Accountability for Safer Communities (TASC) assessment and case management model. The model is designed to decrease juvenile delinquency by identifying individuals with substance use and mental health problems and placing them in appropriate services. Any youth who are identified through the center's screening process as having a potential substance use and/or mental health problem is referred to the TASC program for further assessment. The TASC staff complete the Substance Abuse and Mental Health (SAMH) assessment and generate a comprehensive report and recommendations. An interview with the center's designated mental health clinician authority (DMHCA) also reported all youth receiving mental health services receive an on-site assessment. Additionally, the center works with each youth's juvenile probation officer (JPO) to obtain any ordered comprehensive evaluations. Seven reviewed youth records showed each was referred to the community provider for an additional assessment upon admission. Five records showed a SAMH assessment, and/or a comprehensive evaluation was completed within thirty days, as required. Two records documented a referral was made; however, the assessments were not yet due. Each reviewed assessment was completed by the community provider. An interview with the center's DMHCA reported center practice is to have the therapist's search the Department's Juvenile Justice Information system (JJIS) to see if a comprehensive evaluation has been uploaded by the JPO. If no assessment is uploaded, the mental health practitioner e-mails the JPO asking for the status of the assessment. Additionally, the DMHCA reported for youth with no assessment uploaded, or in cases where the JPO doesn't respond, the center's mental health staff will complete a SAMH assessment by the thirty-first day after admission.

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

The center maintains a written policy and procedures ensuring mental health and substance abuse treatment planning focuses on providing mental health treatment and/or substance abuse

treatment, which will reduce or alleviate the youth's symptoms of mental disorder or substance abuse impairment and enable the youth to function adequately. Seven records were reviewed and two were applicable for the youth receiving mental health treatment at the center. An additional record was requested and reviewed for a sample size of three. Each of the three reviewed records were applicable for the youth receiving individual, group, or family mental health and/or substance abuse counseling. Each record showed the youth participated in treatment planning and treatment team meetings. Each of the reviewed records documented the service to be received and one outlined the frequency of counseling services. Each of the three records contained a properly executed Authority for Evaluation and Treatment (AET) form and an additional consent for mental health, substance abuse, and/or psychiatric medications as required. A review of treatment notes showed all were documented on the Department's Counseling/Therapy Progress Notes form and maintained within the youth's electronic medical record. A review of the center's group therapy sign-in sheets for the past six months showed groups were being held at least bi-weekly. Sign-in sheets reflected the center was holding both mental health and substance abuse groups. Sign-in sheets supported all groups were limited to ten or fewer youth with mental health diagnoses for mental health treatment groups and fifteen or fewer youth with substance abuse diagnoses for substance abuse treatment groups. Youth interviews confirmed youth participation in mental health groups at the center. An interview with the designated mental health clinician authority (DMHCA) confirmed psychiatric medication management, screenings, crisis interventions, assessments of suicide risk, group therapy, family therapy, individual therapy, and supportive counseling is provided at the center for any youth identified with mental health and/or substance abuse needs. Seven youth were interviewed and asked to rate the mental health and substance abuse services at the center. One youth rated services as fair, three rated services as good, and three youth reported not receiving services at the center. An interview with the DMHCA reported youth admitted on medication and youth who are at the center for more than thirty days receive mental health treatment. It was also reported once a youth is receiving treatment, the DMHCA tracks services to ensure services are provided as prescribed. The center hold's mental health mini treatment teams on Thursday of each week. Participants include the DMHCA, center nurse, a representative from administration, the assigned therapist, the youth, and written input from the education staff. Observations of a treatment team meeting held during the annual compliance review week showed interactions were encouraging and all necessary center staff were in attendance. Observations and a review of the treatment team sign-in sheets did not support the parent/guardian was included, when possible, as outlined in Department rule. An interview with the DMHCA explained the parent/guardian is contacted by telephone during treatment planning and treatment planning reviews. All treatment services at the center are provided by the licensed mental health staff or the non-licensed master's-level mental health staff working under the direct supervision of the licensed mental health professional. Additionally, the provider has an active Chapter 397 license through the State of Florida Department of Children and Families authorizing the center to provide outpatient 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 facility. *All youth who receive mental health and/or substance abuse treatment while in a detention facility shall have a discharge summary completed documenting the focus and course of the youth's treatment and recommendations for mental health and/or substance abuse services upon youth's release from the facility.*	

The center maintains a written policy and procedures ensuring mental health and substance abuse treatment planning focuses on providing mental health treatment and/or substance abuse treatment which will reduce or alleviate the youth's symptoms of mental disorder or substance abuse impairment and enable the youth to function adequately. Seven records were reviewed and two showed the youth were applicable for an initial treatment plan. An additional record was requested and reviewed for a sample size of three. Each of the three reviewed initial treatment plans was in place within seven days of the initiation of treatment as required. Each reviewed initial treatment plan was documented on the Department's Initial Mental Health/Substance Abuse Treatment Plan form. Each reviewed initial plan documented the reason for treatment, the Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition (DSM-IV) diagnosis, initial treatment methods, initial treatment goals, and psychiatric services. Each of the three-reviewed initial treatment plans documented signature by the mental health staff, youth, and team members involved in the development of the plan. Seven records were reviewed and two showed the youth were applicable for an individual treatment plan and an additional record was requested and reviewed for a sample size of three. Each reviewed individualized treatment plans documented the plan was developed by the thirty first day of the youth's admission. Each of the reviewed plans were developed by the licensed mental health professional. Each of the three reviewed individual treatment plans included a DSM-IV diagnosis, symptoms, treatment goals, strengths/abilities, preferences/needs, psychiatric services, and pharmacological interventions. A review of progress notes supported each youth was receiving treatment services as stipulated in the treatment plan. Each reviewed individual treatment plan was signed and dated by the youth, mental health professional, and treatment team members.

None of the seven reviewed records were applicable for documenting an individualized treatment plan review. Three additional records were requested and reviewed for a sample size of three. Each reviewed record documented a single treatment plan review was completed during the youth's stay at the center. Each record documented a review was completed within thirty days by the treatment team, as required. None of the three reviewed records were applicable for and/or documented a modification to the plan as a result of the review. Each reviewed individualized treatment plan review was signed and dated by the clinical staff, youth, and the licensed mental health professional. Two reviewed treatment plan reviews documented the prescribed psychiatric treatment services and the third documented "youth is not receiving psychiatric services." None of the seven reviewed records were applicable for a mental health/substance abuse treatment discharge summary. Three additional records were requested and reviewed. Each of the three records documented a discharge summary was completed on the Department's Mental Health/Substance Abuse Treatment Discharge Summary form and was provided to the youth and parent/guardian upon release. Documentation supported each discharge summary was also e-mailed to the youth's assigned juvenile probation officer (JPO).

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

The center maintains a written policy and procedures ensuring psychiatric services are provided to youth in need. Psychiatric services at the center include psychiatric evaluation, psychiatric consultation, medication management, and medical supportive counseling. The center maintains a contract with Maxim Healthcare Services, Inc., signed on April 28, 2017, and executed on May 1, 2017, to provide mental health and substance abuse services. Maxim Healthcare Services, Inc., subcontracts with Camelot Community Care, Inc., who subcontracts with Heartwork of Orlando, Inc., to provide a State of Florida licensed psychiatrist. Maxim Healthcare Services, Inc. subcontracts with Camelot Community Care, Inc., to provide comprehensive mental health and substance abuse services and psychiatric services. Camelot Community Care, Inc. subcontracts with Heartwork of Orlando, Inc., to provide a State of Florida licensed psychiatrist. Psychiatric services are provided to youth with a Diagnostic and Statistical Manual of Mental Disorders-Fourth edition (DSM-IV) mental disorder and each youth receiving psychotropic medication as set forth in Rule 63N-1, Florida Administrative Code. The center's psychiatrist is a licensed medical doctor with a specialty in child and adolescent psychiatry. The psychiatrist's license was free and clear in the State of Florida with an expiration date of January 31, 2020. An interview with the center's registered nurse and the psychiatrist confirmed the psychiatrist is scheduled on-site two hours a week on Thursdays. A review of sign-in sheets supported the psychiatrist was at the center weekly for the past six months. Seven records were reviewed, and one was applicable for psychiatric services. Two additional records were requested and reviewed for a sample size of three. Each of the three reviewed records were applicable for arriving with psychotropic medication prescribed and received a psychiatric evaluation within fourteen days of admission as required. The center completed an in-depth psychiatric evaluation for all youth. Each reviewed psychiatric interview documented the reason for referral, history, mental status examination, the DSM-IV diagnosis, treatment recommendations, applicable prescribed medication, psychotropic medication need, and frequency of medication monitoring. Each reviewed psychiatric evaluation also included developmental history, psychiatric history, individual, contributing family or environmental factors, and the signature of the practitioner. None of the youth were applicable for a newly prescribed or change to an existing prescription; however, the third page of the Clinical Psychotropic Progress Note (CPPN) form was completed for all of the youth. Each of the three records was applicable for the continuation of a prescription of psychotropic medication and documented the medication's identifying data, medication target symptoms, evaluation and description of effect of prescribed medication on target symptoms, prescribed medication, side effects, youth's adherence to the medication regime, applicable parent/guardian contact, and the signature and date of the psychiatrist. None of the reviewed records were applicable for the completion and/or review of completed labs. Each of the three records were applicable for the monthly monitoring of Tardive Dyskinesia.

Each reviewed record contained an active Authority for Evaluation and Treatment form (AET) in addition to the consent for psychotropic medications signed by the youth's parent/guardian. None of the reviewed records were applicable for youth in foster care or reaching eighteen while at the center and requiring additional consents. The center had no applicable youth for significant changes in dosage of the prescription of medications subsequent to admission. An

interview with the center's registered nurse and psychiatrist explained the conservative practices were due to the extremely short-term care of the youth at the center, in addition to the psychiatrist's recommendation of intensive therapy services for youth with behavior related diagnoses. An interview with the center's psychiatrist during the annual compliance review confirmed twenty-four hour a day on-call availability, active communication with the center's mental health and medical staff, as well as fulfilling the role and responsibilities for the oversight of psychiatric care at the center. The center's designated mental health clinician authority (DMHCA) also reported the psychiatrist sees all youth admitted on psychotropic medication within two weeks of admission, and is responsible for monitoring concerns, side effects, and medication management.

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

The center follows a suicide prevention plan to safely assess and protect youth with elevated risks of suicide in the least restrictive means possible, in accordance with Rule 63N-1, Florida Administrative Code. The center's suicide prevention plan includes identification and assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and review process. The plan was revised and approved by the center's superintendent and designated mental health clinician authority (DMHCA) on January 2, 2019.

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

The center 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. A review of seven youth records showed three were applicable for a youth being placed on suicide precaution status upon admission as a result of the completed admission screenings. Each of the three records documented the completion of an Assessment of Suicide Risk (ASR) by the non-licensed master's-level clinician. Reviewed training records supported both non-licensed mental health staff completed the required twenty hours of training and five ASRs under the direct supervision and within the physical presence of a license mental health professional. Each record documented the immediate notification to the center's superintendent and/or designee and the completion of a suicide precaution observation log. No records were applicable for the youth being released from the center on precautionary observation (PO) status. Each record documented a referral was made to a mental health professional, an alert was entered into the Department's Juvenile Justice Information System

(JJIS) and the youth was maintained on precautionary observation until assessed. Each of the three records documented the youth was transitioned to standard supervision after the completion of an ASR, consultation with the designated mental health clinician authority (DMHCA), and the consultation with the center's superintendent and/or designee as outlined in the center's suicide prevention plan. A review of the center's master control logbook showed beginning and end times were documented for youth placed on precautions. The center did not have any instances of a youth attempting suicide or self-inflicting injury since the last annual compliance review; however, there is an established review process in place. Seven staff were interviewed regarding responsibilities to be completed when a youth expresses suicidal thoughts. Each of the seven-staff stated they would contact mental health staff, six staff reported they would document supervision, four staff reported they would maintain constant sight and sound supervision, and one staff also reported they would search the youth and the youth's room for sharp objects. Seven interviewed youth reported never being placed on suicide precautions while at the center. Three additional youth whose records reflected the youth was on suicide precautions while at the center were interviewed. Each of the three youth reported never being left alone while on PO status. An interview with the center's superintendent reported the center only utilizes secure observation for potentially suicidal youth showing active aggression towards staff. The superintendent added the center's practice is to have staff stand at the door maintaining constant monitoring of youth placed in secure observation. None of the reviewed records were applicable for youth being placed on secure observation status. An interview with the center's DMHCA explained the reporting procedures for youth placed on PO at the center. The DMHCA explained assigned juvenile probation officers and parents/guardians are notified of PO status and the mental health practitioner notes the contact in the chronological log. Additionally, it was reported the superintendent and/or designee are notified of any youth requiring PO status through face to face contact or by e-mail.

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

The center maintains a written policy and procedures ensuring the staff assigned to monitor each youth on suicide precautions must maintain one-to-one supervision or constant supervision and document their observations of the youth's behavior on the Department's Suicide Precautions Observation Log. Seven records were reviewed and three were applicable for a youth being placed on suicide precaution status upon admission. Each reviewed record contained a precautionary observation log documented on the Department's Suicide Precautions Observation Log form. Each reviewed record contained documentation of the youth's behavioral observations documented in real time. Two of the three reviewed logs documented all observations at or below thirty-minute intervals. One log noted one observation was nine minutes late. None of the reviewed records were applicable for observed warning signs requiring supervisory and/or mental health notification and/or consultation. Each reviewed record documented the signatures of each shift supervisor, the center's mental health clinical staff, and documented safe housing requirements. Three interviewed youth reported staff were with them at all times while they were on suicide precaution status.

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

The center maintains a written policy and procedures ensuring all staff will receive at least six hours of suicide prevention and implementation of suicide precautions training annually. A review of seven staff training records supported each staff received two hours of training in the Department's Le and four hours of face to face suicide prevention and suicide precaution training. A review of suicide drills since the last annual compliance review showed the center completed twenty-seven mental health drills in the last eleven months. Documentation supported all staff participated in at least one drill and the center has additional drills scheduled for the fourth quarter. Each reviewed drill documented needed action by staff, provisions of contacting center staff and 9-1-1 when applicable, and provisions for life saving measures. The center's practice is to review all completed drills during the mandatory monthly all staff meeting, and display completed drills on the wall outside of the staff break room, accessible to all staff for review. An interview with the center's designated mental health clinician authority (DMHCA) reported the mental staff participates in mock drills conducted at the center when available, and the center's administration staff coordinates all drills. An interview with the center's registered nurse reported the center maintains five suicide response kits. Each kit was observed to be fully stocked and contents included pliers and wire cutters. Seven staff were interviewed regarding the location of the center's suicide response kits. Each of the seven staff reported the kits were located in master control and the three sub-controls. Four staff reported there was also a kit located in the medical clinic.

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

The center maintains a written policy and procedures ensuring the center responds 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 center. The center's combined emergency services plan was reviewed and signed by the designated mental health clinician authority (DMHCA) and superintendent on January 2, 2019 and included all required elements.

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

The center maintains a written emergency care plan outlining mental health and substance abuse emergency procedures and ensure youth who are believed to be an imminent danger to themselves or others, due to mental illness or substance abuse impairment, receive emergency

mental health or substance abuse services. The center maintains a combined suicide prevention, mental health crisis intervention services, emergency care, and emergency mental health and substance abuse plan. The plan was revised and approved by the center's superintendent and designated mental health clinician authority (DMHCA) on January 2, 2019. The plan detailed emergency procedures to include immediate staff response, notification, communication, supervision, authorization to transport, and transporting for Baker Act and Marchman Act. The plan detailed procedures for documentation, training requirements, and a review process. The center utilizes John F. Kennedy North Hospital in West Palm Beach, Florida, for Baker Act crisis stabilization and for Marchman Act.

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

The center maintains a written policy and procedures ensuring the center responds 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 center. The center maintains a combined suicide prevention, mental health crisis intervention services, emergency care, and emergency mental health and substance abuse plan. The plan was revised and approved by the center's superintendent and designated mental health clinician authority (DMHCA) on January 2, 2019. An interview conducted with the DMHCA, as well as the superintendent confirmed the center has not had any applicable youth requiring a crisis assessment since the last annual compliance review. Seven staff training records were reviewed and confirmed staff received mental health training relating to youth in crisis. The center's policy and DMHCA reported crisis assessments are recorded on the Department's Crisis Assessment form when conducted.

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

The center did not utilize a Baker Act or Marchman Act procedure during this review period; therefore, this indicator rates as non-applicable.

Standard 4: Health Services

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

The center has a current contract with Maxim Healthcare Services, Inc. to assume the responsibility for the provision of medical services to all youth. The contract outlines the provision of a State of Florida board-certified licensed physician with a specialty in pediatrics, family practice, or internal medicine. A review of documentation found the designated health authority (DHA) is a board certified licensed physician who holds an unrestricted license to practice in the State of Florida, with an expiration date of January 1, 2020. The DHA provides comprehensive on-site medical services, preventive care, sick call, episodic care, acute treatment, chronic medical treatment, medication review and ordering new medications, communication with facility staff regarding youth medical needs, coordination of off-site care as needed, and to provide follow-up care to youth in custody at the center. The DHA provides on-site services one day a week for two hours. The DHA is available twenty-four hours a day, seven days a week by telephone and e-mail. An interview with the DHA, in comparison with a review of sign-in and out logs for the past six months, found the DHA was on-site, as required. The provider has two advanced registered nurse practitioners (ARNP), who work in collaboration with the DHA. However, at the time of the annual compliance review, one ARNP had been out on medical leave since February 7, 2019.The center has a collaborative protocol for both ARNPs which will expire on July 31, 2020 and April 30, 2021. The active ARNP works in collaboration and under the direction of the DHA and is consistently on-site for six hours on Sundays, which was verified by a review of sign-in logs for the last six months. The DHA verbally arranges coverage during scheduled vacation or absences, a designated licensed physician provides services to the center. Reviewed documentation supported all medical staff licenses were active. An interview with the DHA confirmed their role in the development and implementation of healthcare services.

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 maintains a written policy and procedures addressing health-related facility operating procedures (FOP) and protocols. The center maintains FOPs for all health-related procedures and protocols utilized at the center. The designated health authority (DHA) conducts an annual review of all health-related policies, procedures, and protocols. Reviewed documentation confirmed the DHA reviewed, updated, and signed all protocols on September 19, 2018. The superintendent reviewed and signed all health-related protocols on September 30, 2018. The psychiatrist reviewed and signed FOPs which are psychiatric-related, to include psychotropic medication procedures, on February 6, 2019. The nursing protocols were reviewed and a cover page was signed by nursing staff on September 15, 2018. A review of the center's staff roster found there had been no newly hired nursing staff since the last annual compliance review. However, the center's practice is to ensure all newly hired nurses receive a comprehensive clinical orientation to the Department's healthcare policies and procedures by the registered nurse.

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

The center maintains a written policy and procedures ensuring each youth has a signed and dated Authority for Evaluation and Treatment (AET) form in their individual healthcare record (IHCR). The AET is signed by the parent/guardian and is used as an informed consent for non-invasive medical procedures or for minor illnesses requiring over-the-counter medications approved by the designated health authority (DHA) to each parent/guardian. A review of seven youth IHCRs found each record contained an AET form. One of the seven youth IHCRs contained an original AET and three youth IHCRs contained a copy of the AET stamped with the word "COPY." The parent/guardian signatures along with a witness signature were present on all AETs. One youth had a Limited Consent for Evaluation and Treatment for a Department of Children and Families (DCF) youth. This youth did not have parental rights terminated. Limited Consent for Evaluation and Treatment was needed and completed for two applicable youth pending the completion of an AET or court order. Each of the reviewed AET and/or Limited Consent for Treatment was filed in each youth's IHCR in the appropriate sections.

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

The center maintains a written policy and procedures ensuring the parent/guardian is informed of significant changes in the youth's condition and obtains consent of new medications or treatment which is prescribed. Nursing staff reported parental notification is made in a timely manner once medication is prescribed by the designated health authority (DHA). A review of seven youth individual healthcare records (IHCR) found two youth were applicable for parental notifications. One additional youth record was selected and reviewed. One youth was referred for dental surgery and two youth were prescribed new medication. Telephone notification was made for two youth and documentation reflected a witness was present. One youth was prescribed medication and contact was made with the youth's parent/guardian in person and a copy of the parent/guardian driver's license was obtained and placed in the youth's individual healthcare record. Each record documented parental consent was also mailed regardless of telephone contact, as required.

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

The center maintains a written policy and procedures regarding parental consent and notification for the prescription of youth receiving new psychotropic medication, discontinuances, or psychotropic medication adjustments. The center's current practice is to maintain the youth on the same psychotropic medication the youth was receiving prior to admission, unless in the opinion of the psychiatrist there is a change in the diagnosis, behavior, side effects, or other signs, symptoms which warrant adjustments. A review of seven youth

individual healthcare records (IHCR) found one youth was applicable for being prescribed psychotropic medications. Two additional youth records were selected and reviewed. Each applicable IHCR confirmed contact was made with each youth's parent/guardian and page three of the Clinical Psychotropic Progress Note (CPPN) was provided explaining the initiation of the psychotropic medication. Reviewed documentation confirmed contact was made in person and a copy of the parent/guardian's driver's license picture was attached to the signed Acknowledgement of Receipt of the CPPN. There were no youth applicable to increases, decreases, or discontinuation of psychotropic medication.

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

The center maintains a written policy and procedures ensuring all immunization history is obtained and verified for each newly admitted youth. The center's nursing staff obtains the Florida Certification of Immunization and the immunization history through the Florida shots website for the designated health authority (DHA) and/or advanced registered nurse practitioner (ARNP) to review and sign. A review of seven youth individual healthcare records (IHCR), in comparison with an informal interview with the nursing staff, confirmed each youth's IHCR is reviewed to determine if it contains a complete history of immunizations. Each reviewed record contained a Florida Certification of Immunization and/or a Department Immunization Tracking Record. The center's practice is to obtain consent from the parent/guardian within thirty days and then refer to the health department to administer the immunization. An informal interview with the nursing staff confirmed the center notifies the health department after thirty days if consent is not obtained for any missing immunizations. One reviewed youth's IHCR found the youth required additional immunizations. The youth was admitted to the center on April 30, 2019 and is still within the thirty-day period. There were no applicable youth requiring a parent/guardian to provide a letter indicating exemption for religious reasons.

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

The center maintains a written policy and procedures ensuring each youth receives a healthcare admission screening to identify any additional medical or mental needs and/or necessary referrals for further evaluation or treatment. The center's policy indicates each youth shall receive a Medical and Mental Health Admission Screening at the time of admission by the intake officer. A review of seven youth individual healthcare records (IHCR) found all Medical and Mental Health Admission Screenings were initially conducted with the youth by the juvenile justice detention officer (JJDO) on the day of admission. Each screening was reviewed by the registered nurse within twenty-four hours. An interview with the superintendent confirmed the intake staff completes the Medical and Mental Health Admission Screening and the nursing staff reviews and signs off on the screening form within twenty-four hours. In the event a youth is admitted and identified with an immediate medical need, the designated healthcare authority (DHA) or advanced registered nurse practitioner (ARNP) is notified and the medical staff will complete an urgent assessment. If the DHA is not available on-site, an immediate transfer to the nearest hospital for emergency care services will occur.

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

The center maintains a written policy and procedures to alert staff of medical issues which may affect the safety and security of youth at the center. The center's practice is to place all youth identified with a chronic medical condition and/or medical grade two through five on the alert list in the Department's Juvenile Justice Information System (JJIS). A review of seven youth individual healthcare records (IHCR) found one youth was applicable for having a chronic medical condition or disability and was prescribed psychotropic medication. Two additional youth records were selected and reviewed. Both youth were applicable for having a chronic medical condition or disability. A review of the center's Facility Management System (FMS) confirmed each alert was visibly documented for each applicable youth. A review of JJIS confirmed the alerts were updated and/or removed as needed. During an informal interview, the superintendent confirmed medical staff are required to review and verify medical information daily. All youth alerts are reviewed each day during shift briefings with staff. Seven staff were interviewed. Each staff confirmed they are made aware of alerts through alert forms and shift meetings. Three of the seven staff also indicated they were made aware of alerts through the logbooks. Each interviewed staff reported the center's alert communication process is very good.

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

The Suicide Risk Screening Instrument was completed within twenty-four hours of admission and reviewed by the mental health staff and filed in the youth's mental health record; therefore, this indicator rates as non-applicable.

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

The center maintains a written policy and procedures to ensure all youth are oriented to the general process of healthcare delivery services at the center. Each newly admitted youth receives a health education curriculum/program which covers general healthcare procedures, as well as health related issues, trauma, gender-specific topics, and sexual assault during the orientation process. The orientation process also includes information on what constitutes an emergency and who to notify, medication process to include how medications are administered, access to sick call, notifications to staff, right to refuse care, the role of the healthcare providers, and the list of healthcare contacts. The center's policy also indicates orientation must be provided in Spanish or other languages in which the youth use as a primary language. Provisions shall be made for youth who are hearing or visually impaired. Additionally, any youth with cognitive deficits, the school district personnel or teachers shall provide information as to how to present this information to youth who are deemed impaired. A review of seven youth individual healthcare records confirmed each each youth received orientation upon admission to the center and all required orientation topics were covered with each youth. Each applicable youth signed a youth healthcare orientation form which was documented in the binder.

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

The center maintains a written policy and procedures to ensure the designated health authority (DHA) is notified in accordance with the Department's requirements. An informal interview was conducted with the registered nurse and indicated the DHA is notified the same day of admission, by email. A review of seven youth individual healthcare records (IHCR) found one applicable youth identified with a chronic condition and taking psychotropic medication at the time of admission. Two additional records were requested and reviewed to meet the minimum sample size. Each applicable record was found to have youth identified with a chronic condition and taking psychotropic medication at the time of admission. Reviewed documentation supported the DHA was notified within twelve hours of admission for each applicable youth. In addition, each youth was documented on the center's chronic conditions log identifying the date and time, youth name, medical condition, Department identification number, and DHA notification. There were no youth applicable which were identified in need of emergency care. None of the youth required emergency care upon admission.

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

The center maintains a written policy and procedures ensuring each youth receives a healthcare admission screening at the time of admission. All youth readmitted into the center are rescreened utilizing the Medical and Mental Health Admission Screening Form. A review of seven individual healthcare records (IHCR) found one youth was applicable whose custody changed during their stay at the center. Two additional records were requested and reviewed to meet the minimum sample size. Each applicable record contained documentation which validated a new healthcare rescreening was completed upon the youth's return to the center for reasons such as court and youth's placement from another detention center. The healthcare admission screening form was completed by the juvenile justice detention officer (JJDO) and reviewed by nursing staff within twenty-four hours.

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

The center maintains a written policy and procedures ensuring each youth receives a Health-Related History (HRH) form no later than seven calendar days following admission to the center. A review of seven youth individual healthcare records (IHCR) found a new HRH form was completed for three youth within seven days of admission. Three youth's IHCR found documentation to support an updated HRH form was completed within seven days of admission. One youth was admitted on February 28, 2019 and a review of the IHCR found the HRH form was completed on March 9, 2019 which was past the seven-day time frame. However, documentation in the progress notes reflected the youth had refused two appointments with medical staff during this time frame. The designated healthcare authority (DHA) or advanced registered nurse practitioner (ARNP) documents their review on the HRH form by signing the form or on the completed Comprehensive Physical Assessment (CPA).

Reviewed documentation validated the DHA or ARNP reviewed and signed off on each HRH form. Documentation supported each HRH form was completed prior to the completion of the CPA.

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

The center has a policy and procedures to ensure a Comprehensive Physical Assessment (CPA) form is completed for all youth admitted into the physical custody of a Department program. A review of seven youth individual healthcare records (IHCR) found a CPA was completed for two youth within seven days of admission to the center while five youth already had a CPA on file, which were less than one year old. Each applicable record contained an updated CPA to support a focused evaluation was completed and the designated health authority (DHA) or advanced registered nurse practitioner (ARNP) reviewed and signed off on the CPA. One youth was admitted on February 28, 2019 and a review of the IHCR found the CPA was completed on March 21, 2019 which was outside the seven-day timeframe. However, documentation in the chronological notes showed the youth refused three medical appointments during this timeframe. Reviewed documentation confirmed each CPA documented the youth's medical grade. One youth had a medical grade of five. A review of the center's alert list found the youth was documented on the medical alert list and the Department's Problem List was updated as required. Each CPA was completed in full by the DHA and all sections were completed in full utilizing an "O" or "X". A review of seven IHCRs found seven CPA had documentation of youth refusals in parts of the examination. Each IHCR contained documentation in which the youth signed the refusal for the portion of the CPA which was refused. The DHA documented on each CPA the deferment reason in each occurrence.

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

The center maintains a written policy and procedures ensuring all female youth over twelve years of age who are sexually active or identifies their menstrual cycle as two weeks late shall receive a qualitative urine pregnancy screening. Youth can also request a pregnancy test be given while in the center. The center also refers female youth for a gynecological exam if there are medical concerns present and the youth verbal consents to the exam. A review of seven youth individual healthcare records (IHCRs) found there were no applicable records for review. Three additional closed healthcare records were selected and were applicable for review. Each applicable IHCR found each youth consented to a qualitative urine pregnancy test. The test was conducted on each youth and the results were documented in the laboratory section of the IHCR. One applicable youth was referred for a gynecological examination by the designated healthcare authority (DHA). The DHA completed a written order and documentation of the youth's verbal consent was found in the chronological notes. The center's practice is to refer youth to their Palm Beach County Department of Health or the youth's primary doctor. Seven youth were interviewed, and each youth indicated gynecological, obstetrical, and prenatal care was not needed.

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

The center maintains a written policy and procedures ensuring all youth be screened for tuberculosis (TB) upon admission. All youth receives a Tier 1 tuberculosis screening (TST) for TB upon admission into the center. If the screening shows signs the youth has symptoms which may be of active tuberculosis, the youth is not placed in general population. An interview with the registered nurse confirmed the center's practice is if a youth has not been screened for TB a test is completed upon admission and read within two days. Youth with tests which are older than one year are retested. Youth which have had a test which is less than a year old are not required to have a new test completed. All youth who receives a positive skin test, or chest x-ray is ordered by the Designated health authority (DHA). A review of seven individual youth healthcare records (IHCR) found documentation to support each youth received a TST within seventy-two hours of admission. Six out of seven reviewed IHCRs verified a tuberculin skin test was completed within the last twelve months. There were no applicable youth who showed active symptoms of tuberculosis. Reviewed documentation supported all six tuberculin skin test results were documented on the Comprehensive Physical Assessment (CPA) and the Infectious and Communicable Diseases (ICD) form. One youth was referred for a chest x-ray as he refused several times to complete a tuberculin skin test. The results were documented in the x-ray section of the IHCR.

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

The center maintains a written policy and procedures to ensure completion of the sexually transmitted infection (STI) screening. A rescreening is required to be completed if any youth has been out of the Department's custody for more than thirty days. Seven youth individual healthcare records (IHCR) were reviewed and each youth was applicable for STI screening. Each reviewed IHCR had documentation to support the STI screening completed. Documentation confirmed each youth was screened and evaluated for STIs. Each youth was referred to the designated healthcare authority (DHA) for further evaluation. Testing was ordered and performed for each youth. Testing results were filed in the appropriate section of the IHCRs and the screening results were documented on the Infections and Communicable Disease form. There were no youth who were out of the Department's custody for more than thirty days which would require a rescreening.

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

The center maintains a written policy and procedures ensuring all youth at risk for human immunodeficiency virus (HIV) shall be offered counseling, testing and referrals for medical treatment. The facility collaborates with the local county Health Department to provide HIV counseling and testing services. Consent must be obtained from the youth and each youth must sign the HIV Antibody Test Youth Consent form. The youth's health education record in the youth's individual healthcare record shall be updated each time a youth receives pre-counseling

and post-counseling. A review of seven youth individual healthcare records (IHCR) confirmed each youth was offered the opportunity to receive counseling, testing, and treatment services for HIV. Six out of seven youth consented to testing and one youth refused testing. Reviewed documentation supported the pre-test and post-test counseling was documented in IHCR on the health education record. The HIV results were placed in a sealed envelope which was marked "confidential" with the youth's name on the outside of the envelope filed in the laboratory results section of the IHCR. Seven youth were interviewed and indicated they could request to have an HIV test completed. Two youth indicated they could not. This information was provided to the superintendent.

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

The center maintains a written policy and procedures ensuring there is a system in place for the provisions of sick call. All youth are oriented on the sick call process, as well as the sick call hours at the time of admission to the center. Youth can put in a sick call request by notifying a juvenile justice detention officer (JJDO) or any medical staff. The JJDO enters the sick call request into the center's Facility Management System (FMS). The FMS electronically generates a notification of the completed sick call request to the nursing staff. The designated health authority (DHA) and/or advanced register nurse practitioner (ARNP) provides routine sick call and follow-up care when on-site and/or referred to by the nursing staff. The center has approved protocols in place for when nursing staff are not on-site to review sick call complaints. The juvenile justice detention officer supervisor (JJDOS) reviews sick call complaints and completes a non-healthcare report when nursing staff or the DHA is not on-site. The non-healthcare report will be provided to a nursing staff for review once a nursing staff returns on-site. The JJDOS contacts the DHA for direction as needed. Nursing staff interviews confirmed the average wait time for sick call is two hours. Seven individual healthcare records (IHCR) were reviewed and five were found to be applicable for sick call requests. None of the five applicable reviewed records were for youth with three or more sick call complaints within a two-week period or for youth in severe pain; therefore, there were no referrals required. Each applicable record found documentation of a sick call request form and a progress note in subjective objective, assessment, and plan (SOAP) format in the IHCR. Seven youth were interviewed regarding how quickly they can be seen once a sick call request has been submitted. Two youth responded immediately, three youth responded within one day, and two youth reported they have never requested a sick call.

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

The center maintains a written policy and procedures ensuring all youth can make sick call requests and have their medical complaints treated through the center's sick call system in a timely manner. Seven individual healthcare records (IHCR), including each youth's sick call index and the corresponding Facility Management System (FMS) generated sick call list were reviewed. Five of the seven reviewed IHCRs were applicable for sick call requests. Three IHCRs documented sick calls were conducted by a licensed practical nurse (LPN). Each IHCR documented a review was completed by a registered nurse (RN) or higher in less than twenty-four hours. Two applicable records had documentation to support sick calls were conducted by

a RN or higher. Four out of the five applicable IHCRs documented youth signatures or youth initials on the sick call referral at the time the youth was seen. One did not have a signature and was seen by the DHA. Four of the five applicable IHCRs found each sick call was documented on the Sick Call Referral Log. One youth IHCR contained one sick call on the Sick Call Index; however, there was no documentation of the youth on the Sick Call Referral Log. The center utilizes the Sick Call Referral Log for the youth to sign at the time of the sick call visit. Sick call is provided seven days a week, from 9:00 a.m. to 11:00 a.m., and 4:00 p.m. to 5:00 p.m. Monday through Friday, and 9:00 a.m. to 11:00 a.m. on Saturdays and Sundays. These hours were posted in the medical clinic, modules, and common areas. An informal interview with the RN confirmed sick call can be conducted throughout the day if needed and is not restricted to the posted times. Sick call was observed for one youth who gave permission to the annual compliance review team to observe the process during the annual compliance review. The captain brought the youth to the medical clinic and remained by the door of the clinic during the sick call visit. Sick call was provided by a RN. The youth was familiar with the RN and knew the RN by name. The RN discussed with the youth the nature of the youth's medical compliant. The sick call is logged into the sick call referral log and the youth was observed to sign the logbook prior to the examination. The examination was one-on-one with the RN which included vital signs, a verbal exchange of information, discussion of over-the-counter medication, and the administration of the over-the-counter medication. Seven youth were interviewed regarding who conducts sick call at the center. Six youth indicated the nurse conducts sick call. Four of the seven youth also indicated the doctor conducts sick call. Two youth indicated they have never requested a sick call at the center. Four interviewed youth rated the medical care at the center as good, one rated the medical care at the center as fair, and two indicated they were not receiving medical services. Seven staff were interviewed, and each indicated the nurse conducts sick call. Two of seven staff reported the doctor also conducts sick call.

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

The center has a written policy and procedures to ensure all youth in restricted housing or confinement have timely access to medical care, as required by the Department. A review of seven youth individual healthcare records (IHCR) found one youth applicable for medical confinement. Two additional youth records were selected for review and were applicable for confinement. A confinement report was generated in the Facility Management System (FMS) and contained a detailed narrative documenting the nursing staff making daily visits to each youth to include any treatment provided. Each youth in confinement received all prescribed medications, as ordered, on time.

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

The center maintains a policy and procedures regarding the practice of episodic/first aid care, inclusive of emergency situations. The center maintains twenty-one first aid kits located in master control, all three module sub-control offices, medical clinic, administration, kitchen, intake, transportation office, two classrooms, annex, maintenance shop, training room, and seven center vehicles. Nursing staff conducts monthly reviews of the first aid kits and items are replenished upon use. Nursing staff seal and date the first aid kits after replenishment and review. Inventory sheets are maintained with the first aid kit. Reviewed documentation

supported the DHA approves the first aid kit contents. The center maintains two automated external defibrillators (AED), one in the medical clinic and one in intake area. The center also utilizes an episodic care log to document episodic care and first aid treatment. The log contains all required information to include the date, name of youth, the youth's Department's identification number, nature of illness or injury, treatment rendered, staff initials, nurse initials, verification of who provided episodic care, and whether the youth was recommended for off-site care. A review of seven youth individual healthcare records (IHCRs) found two youth received episodic care. One additional IHCR was requested and reviewed. Each applicable record found each episodic event was documented in each IHCR, utilizing the subjective, observation, assessment, and plan (SOAP) format to capture all the necessary information. All treatment services were provided by nursing staff. There were no referrals for off-site care.

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

The center has a written policy and procedures to ensure emergency care and response to emergency situations. A review of emergency care procedures found the center has two automated external defibrillator (AED) units. One unit is maintained in the medical clinic and the other is maintained in intake. Each unit is checked daily by the medical records clerk or nurse. Both units were observed during the week of the annual compliance review and both were in working order as demonstrated by the nurse. Each AED's procedures were with the AED unit, which also provided audible instructions. Both AEDs are brand new and therefore the batteries and pads have never been replaced. A review of seven pre-service training records and seven in-service annual training records confirmed each staff with direct youth contact were confirmed to have current certifications in first aid and cardiopulmonary resuscitation (CPR) with AED, and epinephrine auto injector procedures training. Reviewed documentation validated medical drills were conducted at least quarterly on each shift since the last annual compliance review. Additionally, twenty of the reviewed drills included life saving measures. The center's practice is to review all medical drills during all staff meetings each month. Drills are reviewed by the superintendent, licensed medical staff, and/or licensed mental health staff as needed. A list of emergency numbers to include the poison control number was observed to be strategically placed throughout the center and accessible to staff. Seven staff were interviewed, and six staff indicated they can call 9-1-1, if needed. One interviewed staff reported they could not call 9-1-1, if needed.

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

The center maintains a written policy and procedures stating youth shall have timely referrals and coordination of medical services to an off-site healthcare provider as required by the Department. review of seven youth individual healthcare records (IHCRs) found there were no applicable youth for off-site care. Three additional youth records were selected for review and found applicable for off-site medical emergency care. Each applicable reviewed record included a summary of off-site care form filed in the IHCR, notification of the designated healthcare authority (DHA), and documentation of the DHA review and signature and/or initials of all off-site

care findings, discharge instructions, and information. None of the applicable youth IHCR contained documentation to support follow-up care or referrals were necessary.

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

The center maintains a written policy and procedures ensuring youth with chronic medical conditions receive regularly scheduled evaluations and treatment to include all necessary follow-up care, as required. The center maintains a chronic condition care log to document youth identified with chronic medical conditions. Seven reviewed youth individual healthcare records (IHCR) found there was one applicable youth identified with a chronic medical condition and/or taking prescribed medication. Two additional youth records were selected for review. Each applicable youth was placed on the chronic condition care log to be seen by the designated health authority (DHA). The center's practice is to notify the DHA through email and through a written chronic condition notification form. The chronic condition notification form is kept in a binder in the medical clinic after the DHA reviews the form. Reviewed documentation confirmed the DHA was notified. Each applicable youth was classified with a medical grade of two through five. There was one youth applicable for treatment for abnormal body mass index (BMI). Reviewed documentation also confirmed each youth was placed on the center's internal alert system. There were no youth identified as taking anti-tuberculosis medication. The center's practice is to evaluate applicable youth at least once every ninety days. However, an evaluation can be conducted more frequently, if deemed necessary. One youth was evaluated on-site and the evaluation was documented in the youth's IHCR. Two youth were not applicable for evaluations. Each reviewed applicable record contained documentation of clearly written treatment orders for clinical staff to follow. There were no lapses of care or periodic evaluations not completed.

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

The center maintains a policy and procedures ensuring when youth are admitted with prescribed medications, the prescribed medications can only be accepted if the medication is from a licensed pharmacy with a current, patient-specific label intact on the original medication container. The center's practice for the nursing staff is to verify medication with the parent/guardian delivering medication to the center. The Medication Receipt, Transfer, and Disposition Form is used to document medication received in the original packaging from a licensed pharmacy with a current legible patient-specific label affixed. The center shall continue all currently prescribed medications. A review of seven youth individual healthcare records (IHCR) found one youth applicable for medication management. Two additional records were selected and reviewed. Each applicable youth was admitted to the center with a current prescribed psychotropic medication. Each record contained progress notes within the youth's IHCR which confirmed medications were verified in the admission progress notes and the medications prescribed were continued, as ordered. Each record contained documentation of an order from the designated health authority (DHA) or advanced registered nurse practitioner (ARNP) to resume medication. Medical staff administers all medication prescribed to youth in the center. However, the center maintains facility operating procedures and nursing protocols developed by the DHA permitting trained non-healthcare staff to verify medications upon

admissions and assist youth with self-administration when medical staff are not on-site. The center has a list of non-healthcare staff training on the center's training curriculum for assisting with youth self-administration of medications. The nurse shall designate responsibility to non-healthcare staff once training has been completed and if the nurse deems the staff competent of the responsibility.

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

The center has a policy and procedures to ensure all medications have a current, valid order and are given pursuant to a current prescription or practitioner order. Youth admitted to the center are continued on psychotropic medication until completion of the initial psychiatric evaluation. A review of seven youth individual healthcare records (IHCRs) found one youth was taking medication upon admission. Two additional records were selected and reviewed. A review of each applicable youth's IHCR confirmed each youth was applicable for medication management and each documented a current and valid prescription order. Each reviewed IHCR documented the prescribed medication was continued, discontinued, changed, or a new medication was ordered. A review of the initial Medication Administration Record (MAR) for each applicable youth supported the continuation of the youth's medications. Each applicable youth was continued on their prescribed medications, after the nursing staff verified the prescription and notified the designated health authority (DHA). The nursing staff provides email notification to the DHA. Reviewed documentation supported the DHA or advanced registered nurse practitioner (ARNP) provided a written order for the nursing staff to continue the medication. There were no applicable youth in need of over over-the-counter medications not listed on the Authority for Evaluation and Treatment (AET).

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

The center has a policy and procedures to ensure all medications are stored in separate secured and locked areas, inaccessible to youth. Non-healthcare staff have limited access to medication and only have access when trained licensed medical staff are not on-site. Observations made during the annual compliance review, in comparison with reviewed documentation, confirmed all over-the-counter (OTC) and prescribed medications were stored in a separate secured locked cabinet in the medical clinic inaccessible to youth. Controlled medication is stored in a separate lockbox behind a double-locked door in the medication cart in the medical clinic. Medication which requires refrigeration is stored securely in a medication only refrigerator. Syringes and sharps are securely stored in a separate locked cabinet. The center maintains an active list of staff with access to the clinic and medication storage area. Reviewed documentation validated the center has a written contract with a consultant pharmacist. Reviewed documentation confirmed the consultant pharmacist was on-site monthly conducting inspections and inventory reviews. The consultant pharmacist's license expires on December 31, 2020. The center maintains a written policy and procedures for the destruction and disposal of expired or discontinued medications. All prescribed and over-the-counter (OTC) medication disposals requires the licensed nurse to be responsible for disposal. Two medical staff must dispose of the medications. All controlled medication is destroyed on-site by the consultant pharmacist and a licensed medical staff each month. The center contracts with Stericycle Inc. to

remove biohazard waste monthly. An interview with the center's registered nurse and reviewed receipts confirmed this practice.

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

The center maintains a written policy and procedures ensuring all controlled substance are inventoried, stored, and documented, pursuant to Board of Pharmacy and Department requirements. The medical clinic was observed to be well organized, with no loose equipment or unsecured medication. All medication was properly stored in secured cabinets or on the medication cart inside the locked medical clinic. All controlled medications are stored securely in a locked box within the securely locked medication cart located in the medical clinic. Administration of the medication shall be documented on the youth's Medication Administration Record (MAR), as well as the youth's individualized Controlled Medication Inventory Record. Observations made during the annual compliance review found there were no youth currently receiving controlled medications. However, observations confirmed there was a secure lock box inside the securely locked medication cart which is utilized to store controlled substances. Reviewed documentation and medical interviews confirmed all over-the-counter (OTC) medications were inventoried at least weekly. The center's practice is for OTC medication to be inventoried using a perpetual inventory daily and verified weekly. Perpetual inventories are maintained on all controlled substances with a shift-to shift inventory conducted by two licensed nursing staff. Syringes and sharps are counted through a perpetual inventory and validated weekly. Reviewed documentation found the inventories were conducted, as required. Observations of counts were during the week of the annual compliance review for three youth's prescribed medications, three OTC medications, and three sharps found each of the inventories were accurate with no discrepancies found.

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

The center maintains a written policy and procedures ensuring all controlled substances shall be inventoried, stored, and documented, as required by the Board of Pharmacy regulations and the Department's requirements. All controlled medications are stored in the securely locked box inside the locked medication cart inside the medical clinic. Observations made during the annual compliance review validated this practice. There were no youth prescribed controlled substances at the time of the annual compliance review. The center's practice is to conduct shift-to-shift inventories of all controlled medications with two nurses present. Reviewed documentation confirmed nursing staff documents all the shift-to-shift counts on the Department's Controlled Medication Inventory Records form. The center does not keep controlled medication inventory records for youth released from the center.

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

The center maintains a written policy and procedure ensuring the Department Medication Administration Record (MAR) shall be maintained at the center for each youth who has a current, valid medication order. The center utilizes the standard Department MAR, to document the administration of prescribed medication. A review of seven individual youth healthcare records (IHCR), found one youth IHCR was applicable for being admitted with medication. Two additional youth IHCRs were requested and reviewed. Each applicable MAR in the youth's IHCR documented medication was administered, as ordered, and each contained clear start and stop dates. Reviewed documentation of the progress notes and practitioner orders found there was no evidence of indications of lapses or errors in medication administration. A review of the three applicable youth MARs confirmed each was completed to include the youth's name, Department identification (DJJID) number, date of birth, assigned medical grade, allergies, medical precautions, medical alerts, and current photograph of the youth. Each applicable MAR indicated clear nursing staff documentation of weekly side effect monitoring, and youth and staff initials after each medication dose. There was no indication in the applicable records of youth refusing medication. There was no evidence of youth requiring parenteral medication.

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

The center maintains a written policy and procedure ensuring medication administration shall occur as scheduled in a complete and organized manner by a licensed nursing staff. The center's practice is to have nursing staff administer medications when they are on-site. Nursing staff are on-site Monday through Friday 8:30 a.m. to 8:00 p.m., and from 1:00 p.m. to 9:00 p.m. on Saturdays and Sundays. The advanced registered nurse practitioner (ARNP) is on-site for six hours each Sunday. The designated health authority (DHA) is on-site two hours from 9:00 a.m. to 11:00 a.m., typically on Thursdays, each week. The majority of medication is administered during nursing hours; however, trained juvenile justice detention officer supervisory (JJDOS) staff can administer medicine once approved by the registered nurse (RN) when nursing staff are not on-site. The center has an updated roster list of all approved staff which have been trained on the training curriculum for assisting youth with self-administration of medication. Medication administration was observed and conducted with one youth at a time during the annual compliance review. The medical clinic was observed to be clean and organized. The youth was escorted to the medical clinic by the juvenile justice detention officer (JJDO). Nursing staff verified the five rights of medication administration utilizing the correct Medication Administration Record (MAR). Nurse verified the youth's allergy, alert status and discussed any possible side effects of the medication. Staff and youth are to initial the MAR when JJDOS staff administer medication; however, it is the center's practice for both youth and nursing staff initial to the MAR in all medication administration. Nursing staff were observed to verify the youth had swallowed the medication by having the youth open their mouth and lift their tongue. During the observation of the medication pass, no refusals of medication were observed. However, medication refusals are clearly documented on the youth's MAR. Parenteral medications are only administered by licensed healthcare staff; however, there are no youth on parenteral medications in the center at the time of the annual compliance review.

Over-the-counter (OTC) medication administration is documented on a patient-specific pro re nata (PRN) Medication Log. Seven youth were interviewed and three indicated the doctor administers medication, five indicated the nursing staff administers medication, one indicated direct care staff administer medication, two indicated they do not take medication, and one indicated the white shirt staff administer medication if the nursing staff is not on-site.

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

The center has a written policy and procedures to direct medication administration by non-licensed staff. Select supervisory staff are the only trained non-healthcare staff allowed to administer medication. The center has an updated roster list of all approved staff which have been trained on the facility training curriculum for assisting youth with self-administration of medication by the registered nurse. All approved, trained staff are only allowed to administer over-the-counter (OTC) medications and oral prescription medications when licensed nursing staff are not on-site. The non-healthcare staff must maintain the five rights of medication administration and confirm allergy and alert status prior to providing medication to youth. The center's policy requires the non-healthcare staff and the youth to sign the Medication Administration Record (MAR). Refusals of medication are clearly documented on the MAR. Seven youth were interviewed and three indicated the doctor administers medication, five indicated the nursing staff administers medication, one indicated direct care staff administer medication, two indicated they do not take medication, and one indicated the white shirt staff administer medication if the nursing staff is not on-site. Seven staff were interviewed and indicated they do not administer medication, and one indicated they do administer medication.

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

The center maintains a policy and procedures to address psychotropic medication monitoring. A review of seven youth individual healthcare records (IHCR) found one youth was applicable for taking prescribed psychotropic medications. Two additional IHCRs were requested and reviewed to meet the minimum sample size. Reviewed progress notes documented notification to the required parties when youth were admitted on psychotropic medication. Reviewed documentation validated each applicable record showed the designated health authority (DHA) was notified upon admission and the psychotropic medications were continued until the psychiatrist conducted an initial diagnostic interview. The center utilizes the Department's Clinical Psychotropic Program Note (CPPN) for the initial evaluation/review and all subsequent follow-ups with youth on psychotropic medication. Reviewed practice and documentation supported the psychiatrist provided on-going medication management and all CPPNs were completed fully. Referrals to the psychiatrist were made within the required timeframe. Reviewed documentation supported an initial diagnostic psychiatric interview was conducted within fourteen days of admission for each youth. Each applicable youth on psychotropic medication received medication monitoring within thirty days by the psychiatrist. The center

does not maintain any standing orders for psychotropic medications, nor were there emergency treatment or pro re nata (PRN) orders for psychotropic medications.

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

The center maintains a written policy and procedures for ensuring there is an approved plan for infection control. The infection control plan outlines prevention, containment, treatment, and reporting requirements related to infectious diseases, as outlined in the Occupational Safety and Health Administration (OSHA) federal requirements and guidelines. The infection control plan was last updated, reviewed, signed, and approved by the superintendent and designated health authority in August 18, 2018. The infection control plan includes common infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial diseases, tuberculosis, hepatitis A, B, and C. Additionally, the plan addresses the human immunodeficiency virus (HIV) infectious diseases caused by blood pathogens, outbreaks in pediculosis and/or scabies, outbreaks or epidemics caused by other infectious agents, and food-borne illnesses. The plan also includes bio-terrorists agents, methicillin-resistant staphylococcus aureus (MRSA), and other emerging antibiotic-resistant micro-organisms, and chemical exposures. The center maintains procedures and policies for staff to adhere to for universal precautions. The center has protocols in place for needle stick post-exposure intervention and treatment. The center provides staff the opportunity to receive hepatitis B immunizations upon request. The center has a plan for biomedical waste disposal through a monthly medical waste pick-up through Stericycle, Inc. A review of seven pre-service training records and seven in-service annual training records validated staff completed training on universal precautions. Nursing interviews and reviewed documentation determined there were no instances in which the local county health department, Centers for Disease Control and Prevention (CDC) and/or the Department's Central Communication Center (CCC) should have been notified of an infectious disease.

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

The center maintains a written policy and procedures ensuring youth and staff are trained on the program's control of infectious and communicable diseases. Staff shall receive infection control pre-service infection control training upon hire and in-service training annual thereafter. A review of seven pre-service training records and seven in-service annual training records confirmed each staff received training on the center's exposure control plan. Seven youth individual healthcare records (IHCR) were reviewed and each documented completion of the required healthcare education. Reviewed documentation supported six out of seven reviewed IHCRs confirmed youth received infection control training within seven days of admission to the center. One reviewed IHCR showed the youth completed training on infection control; however, there was no date confirming when the training was completed. Training documentation supported each youth received training on hand-washing techniques, universal/standard precautions, communicable diseases, vaccinations, and Centers for Disease Control and Prevention (CDC) guidelines.

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

The center maintains a written policy and procedures ensuring the exposure control plan is written in accordance with the Occupational Safety and Health Administration (OSHA) standards to provide a safe environment for youth, staff, and visitors. The center maintains a written exposure control plan which was updated, reviewed, and signed by the superintendent and designated health authority (DHA) August 18, 2018. A review of the center's exposure control plan confirmed the plan was written in accordance with the Department of Labor and OSHA requirements to include risk assessment and methods of compliance. The plan also addresses infection control practices and engineering and work practice controls. The exposure control plan also addresses procedures on handwashing, proper disposal of needles and other sharps, procedures for maintain a clean worksite, procedures for handling contaminated laundry, procedures post-exposure evaluation and follow up, and a system of medical record keeping for employees with occupational exposure. Nursing interviews confirmed there were no documented incidents involving a contagious disease requiring the quarantining or hospitalizing of youth or staff during the annual review period. Additionally, there was no documented instances of staff experiencing an occupational exposure since the last annual compliance review.

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

The center maintains a written policy and procedures ensuring pregnant youth are provided prenatal care. The center's practice requires the nursing staff or trained non-healthcare staff to check in with pregnant youth daily and the medical doctor to track the youth's progress weekly. A review of three pregnant youth individual healthcare records supported prenatal care began immediately upon determination of the youth's pregnancy. Documentation supported the medical doctor or advanced registered nurse practitioner (ARNP) completed focused medical evaluations at least every thirty days. There were no youth which complained of issues related to pregnancy. Nursing staff clearly documented in each applicable record routine daily monitoring of each youth for any indications of pregnancy complications. There were no applicable youth which required post-birth psychological and physical care. The center did not have any youth sleeping on bunkbeds. Seven youth were interviewed, and each youth indicated gynecological, obstetrical, and prenatal care was not needed.

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

The center maintains a written policy and procedures ensuring pregnant youth are provided nutritious foods in sufficient quantities, meeting the standards of the minimum daily allowances

for pregnant youth. Each pregnant youth receive prenatal, post-partum, and parenting education including topics directly related to healthcare issues and medical risk for pregnant adolescents. pregnant youth individual healthcare records (IHCR) were reviewed and found to include documentation on the health education record for each youth receiving education on alcohol and drug usage, smoking, nutrition, sexually transmitted diseases, contraception, prenatal care, birthing process, postpartum care, basic baby care such as feeding, diapering, bathing, child/infant development, and parenting skills. Documentation reviewed supported each applicable youth received nutritious food in quantities appropriate for a pregnant youth and received routine monitoring of nutrition and weight status. Routine monitoring is provided by licensed healthcare staff and recorded in the IHCR.

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

The center maintains a written policy and procedures ensuring all non-healthcare staff involved in supervision or treatment of pregnant youth shall receive appropriate education and training on female healthcare by a licensed nurse. A review of seven pre-service records and seven annual in-service training records documented training in Detention Services Women's Health. The training included the topics of monitoring, observation, emergency care of the pregnant youth, and other prenatal healthcare educational topics. Documentation reviewed confirmed all training was conducted by the center's registered nurse.

Standard 5: Safety and Security

5.01 Active Supervision of Youth (Critical)	Satisfactory Compliance

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

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

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

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

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

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

The center maintains a written policy and procedures ensuring active supervision of youth outlining the conditions and preventive actions needed for the safety of youth and staff. Staff are required to be aware of the location of youth assigned to their supervision at all times. Throughout the annual compliance review week, observations were made of staff and youth interactions. Observations included line movement from the classroom to the module, cafeteria, medical clinic, mini-treatment team, and for transport to court. Observations determined the staff were appropriately supervising the youth in their care. Youth remained in sight of at least one juvenile justice detention officer (JJDO) at all times. The center conducts headcounts at the beginning and end of each shift and staff are required to know the number of youth under their supervision. Prior to any movement, staff conduct a headcount and report the count to master control. Master control confirms head count and authorizes youth movement. A review of the master control logbooks for the past six months verified headcounts were conducted, as required. Seven staff were interviewed regarding the methods by which counts are reconciled. All seven staff think there have been enough staff at the center to provide for the safety and security of the youth and staff. Seven interviewed staff indicated youth counts are conducted at the beginning of shift, end of shift, before and after school, and before and after meals. Seven staff were interviewed regarding what steps are taken if the count is not correct. Two staff indicated master control is contacted. Five staff indicated all movement stops immediately. Three staff indicated youth are counted and recounted, and one staff indicated the incident would be documented.

5.02 Ten-Minute Checks (Critical)	Satisfactory Compliance

Staff shall visually observe youth on standard supervision at least every ten minutes while they are in their sleeping quarters, either during sleep time or at other times, such as during an illness or room restriction.

Staff conducts observations in a manner ensuring the safety and security of each youth and documents real-time observation manually or electronically. Documentation must include the actual time of each visual observation and initials of the staff conducting the check; pre-printed times are not acceptable.

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

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

The center has a written policy and procedures to ensure the safety and security of each youth placed in a room whether for sleeping, confinement, or medical. The juvenile justice detention officers (JJDO) shall conduct visual observations every ten minutes to ensure the safety and security and notate the checks on the Visual Observation Reports (VOR). When conducting room checks, staff must pause at the door and look into the room to ensure there are no issues with the youth. Written visual observations are documented to include the time of the observation and the initials/identification of the JJDO completing the observation. All rooms checks are documented in real time. It is the expectation all JJDO staff conduct a visual room check at each pass and not be assigned to just one staff member on each shift. Any time a JJDO staff passes a youth's room, it is expected the JJDO staff will conduct a room check, even if it is in-between the required room check time frames. The center has a total of eighty-one operable cameras with a recording capacity of thirty days. The center utilizes Silver Guard, which is an electronic system used to document room checks. Reviewed video recordings found staff conducting ten-minute room checks from three different living modules, on B-shift and C-shift, and six different days and times. Reviewed practice found staff were conducting youth checks every ten minutes with a few exceptions. Thirty-six checks were conducted and five were one to three minutes late. Seven staff were interviewed as to how often are room checks conducted when a non-suicidal youth is placed in their room for sleeping or non-punishment reasons and each indicated every ten minutes. There was one staff who also indicated every five minutes.

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

The center maintains a written policy and procedures ensuring the census, counts, and tracking of all youth under the juvenile justice detention officer (JJDO) staff supervision shall be maintained at all times. Head counts shall be taken and called into master control at the beginning and end of each shift, following any emergency, prior to and following routine group movement, any time a population change occurs, and randomly on each shift. A review of the master control logbooks and module logbooks from B-1, B-2, and G-1 for the past six months found the center documented the daily census counts, new admissions, releases, and transfers. Formal counts were conducted and documented as required. No youth movement is conducted until master control confirms the counts, reconciles counts, and authorizes program activity to resume. Observations of seven youth being prepared for transportation to court found the JJDO staff conducted a physical head count and called it in to master control to request youth movement prior to departure. Informal staff interviews indicated no youth movement is conducted until master control confirms the counts, reconcile counts, and authorizes program activity to resume. Seven interviewed staff reported emergency counts are conducted when a youth is believed to be missing and six indicated when visibility is hindered or after a major disturbance. Two staff indicated during a code green escape and one indicated during drills.

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

The center maintains a written policy and procedures ensuring logbooks are maintained to document all events occurring in the event other records or sources of information are lost or destroyed. The center is required to maintain a logbook in master control and one for each living unit, van, visitors, and contracted staff. Reviewed practice found the center maintained master control logbooks, B-1 module logbooks, B-2 module logbooks, G-1 module logbooks, the Department's Central Communications Center (CCC) logbook, soft room logbook, visitor logbook, and a Silver Guard logbook to document when ten-minute checks are downloaded. Logbooks were observed bound with numbered pages and with the date documented at the top of the page. A review of logbooks for the past six months for master control and each living module verified entries were legible and written in ink. Master control logbook entries included emergency situations, incidents such as contacts to the Florida Abuse Hotline, CCC, drills, documentation of medical and mental health alerts, population counts at the beginning and end of each shift and throughout shifts as counts change, emergency situations, group movement, admissions and releases, presence of law enforcement, youth placed in confinement, and youth placed on and/or removed from precautionary observation or secure observation. Errors were not struck through with a single line and dated and initialed by the person correcting the error, as required. Observations found staff wrote over the error. There was no observed supervisor and/or lead officer recorded comments regarding corrected errors. An interview with the superintendent indicated management staff review the logbooks weekly and ensure staff are documenting all factual information and all incidents occurring on their module. Master control logbook is also reviewed by administration staff.

5.05 Logbook Reviews	Satisfactory Compliance

The superintendent or designee reviews all logbooks on a weekly basis.

The supervisor(s) reviews the facility logbook maintained at master control when he/she accepts responsibility for the facility.

The Juvenile Justice Detention Officer (JJDO) Supervisor(s) reviews logbooks maintained in each living area daily.

The JJDO(s) reviews the logbook maintained in his/her assigned living area when he/she accepts responsibility for the living area at shift change.

The center maintains a written policy and procedures regarding logbook reviews. Upon accepting the shift, the lead officer will review the previous shift's entries in the logbook. Each living module logbook shall document the date and time of an event, names of staff and youth involved, a brief description of the event, initials of the person making the entry, and the date and time of the entry. Reviewed documentationsupported the practice. The superintendent or designee shall review the master control and living module logbooks at least weekly and review the entries for the last seventy-two hours. The reviewed documentation must be highlighted in yellow marker. Reviewed documented practice found the superintendent or assistant superintendent documented their review; however, inconsistently, and the entry was never highlighted in yellow. Reviewed logbooks for six consecutive weeks in March and April 2019 found two weeks were beyond the weekly time frame.

5.06 Key Control	Satisfactory Compliance

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

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

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

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

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

The center maintains a written policy and procedures ensuring the proper usage, storage, and general security of facility keys. Center keys are maintained on a tamper-resistant ring with a brass tag identifying the ring number and the number of keys on the ring. Center keys for juvenile justice detention officer (JJDO) staff are securely maintained in the staff break room outside of master control. Observations found the center assigns keys by names and number. All restricted keys for medical, mental health, and education staff are stored in master control in a locked key box distributed by the master control operator. Observations found the center assigns keys by names and number. Staff are required to lock their personal keys in their assigned locker prior to entering the secure area. Interview with the superintendent and

assistant superintendent indicated emergency egress keys providing an outlet through the exterior doors are stored in each sub-control under the desk inaccessible to youth which staff are able to access with their assigned keys. In addition, a spare set of all keys is securely maintained in the staff assistant office. Interview with youth and staff indicated youth do not have access to center keys. Key inventory and issuance of keys is documented on each shift to include the date, time, name of person receiving the keys, time keys were returned, and name of supervisor issuing the keys. According to staff interviews, the center has had no incidents of lost keys in the last eighteen months. In the event a key is lost or missing, staff shall immediately report discretely away from the youth to the on-duty supervisor. The on-duty supervisor shall ensure all youth and non-essential movement stops. The superintendent is notified immediately, and a search of the center is initiated, which may include electronic and/or full body searches of youth. Interview with the superintendent indicated the Department's Central Communications Center (CCC) will then be contacted. A random check of three staff found each indicated their personal keys were securely locked in the assigned locker. Seven staff were interviewed and indicated the center maintains restricted keys for medical records, youth property area, and mental health records. Six staff indicated case management records, and five indicated the kitchen area. One staff indicated the supervisor's keys are restricted. The superintendent was interviewed and indicated each staff is assigned a key and issued by the shift supervisor. Keys are later checked back in at the end of the shift. The key box is stored in the staff break room under lock and key and camera.

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

The center maintains a written policy and procedures for transportation operation and maintenance of vehicles used to transport youth. The center has six multi-passenger vans of which two are awaiting surplus by the Department. The four applicable vans utilized to transport youth are locked in the secure sally port when not in use. Each vehicle is equipped with the appropriate number of seat belts, seat belt cutter, window punch, fire extinguisher, and a first aid kit. The center utilizes a vehicle maintenance daily inspection checklist, weekly vehicle checklist, monthly vehicle checklist, and a pre-trip vehicle inspection sheet. Prior to the vehicles being used, documentation reflected vehicle inspections were completed and included a check of the presence of leaking fluid, inflation of tires, excessive or uneven wear of tires, presence of objects hanging down from carriage, damage to windshield or windows, damage to mirrors, damage to headlights, turn signal, or tail lights, worn belts, low oil or steering fluid, seatbelts work properly, any unusual noises coming from the vehicle, and any other items needing to be reported. Documentation reflected each of the four vehicles utilized to transport youth received an annual vehicle inspection. Maintenance staff conduct weekly visual checks of each transport van including the water coolant, lights, oil, emergency equipment, brakes, horn, interior/exterior, and cleanliness. Maintenance also conducted a monthly check of each vehicle including the tires, battery, windshield and wipers, windows, mirrors, and damage. A transport of seven youth going to court was observed which reflected the vehicle was searched prior to use, youth were searched prior to transport, and the youth and staff wore seatbelts. Prior to the observed transport, staff completed an inspection of the van for contraband, verified seatbelts were securely anchored, tested the security screen, confirmed the vehicle folder contained the

vehicle logs, vehicle and mechanical restraint keys, gas credit card, and vehicle registration, and ensured the inspection was documented in the vehicle logbook. Reviewed checklists did not support the vehicle was inspected to ensure there was enough gasoline for the trip or to ensure a cellular telephone was assigned, charged, and turned on prior to departure.

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

The center maintains a written policy and procedures ensuring all tools and equipment related to maintenance are properly maintained, stored, and inventoried. The center's maintenance department was observed secured which requires authorized key access; however, not very organized. The tools were observed securely located in a separate closet on a shadow board. All tools were in place. A perpetual tool inventory is maintained in the Facility Maintenance System by the maintenance staff. When a tool is needed, maintenance staff signs the tool in and out on the tool list. Reviewed inventories supported the superintendent's review, as evidenced by their signature. There were no tools listed on the inventory which were missing and no tools present which were not on the inventory. Tools were all marked with an identification code identifying the tool as property of the Department. When items are lost or there is reasonable suspicion a youth may be in possession of a tool, a search is initiated by the supervisor. Any repair service personnel are identified prior to entering the center and are accompanied by a designated staff when in the secure detention area. After completion of the work, the shift supervisor inspects the work area to ensure no contraband has been left behind and is thoroughly cleaned before allowing youth access to the area.

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

The center maintains a written policy and procedures ensuring kitchen knives and other hazardous kitchen sharps shall be stored in a locked cabinet, drawer, or toolbox containing the cabinet's inventory. Kitchen knives and other utensils are stored in a pad-locked two-drawer system with an inventory maintained on the desk which is completed daily. Observations of the drawers found them initially unlocked; however, the assistant superintendent locked the drawers and requested the key from the kitchen staff. A random sample of kitchen sharps compared to the inventory found them incorrect; therefore, all inventoried utensils and knives were counted and compared to the inventory. After several attempts, it was determined the inventories were incorrect indicating there were two items listed twice when there was only one of each. During the annual compliance review week, the inventory list was revised to separate all knives, scoops, spoodle, whisks, and cooking utensils listed for easier and more accurate review. Kitchen staff interviews indicated there was not a system in place to ensure all equipment is

accounted for prior to the departure of the kitchen staff and discrepancies are then reported to the superintendent or designee. In practice, when the discrepancy was found during the inventory with the annual compliance review team, the kitchen staff did report the incident to the superintendent.

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

The center has a written policy and procedures regarding youth access to and use of tools and cleaning items and forbidding youth access to kitchen and/or medical equipment. Youth may use cleaning items such as mops, brooms, buckets, and other common household items under the direct supervision of the juvenile justice detention officer (JJDO) staff. An interview with the assistant superintendent indicated youth are allowed to sweep the dining room after each meal and mop the dining room floor after dinner. Staff mix the cleaning solutions with water and youth mop. Seven interviewed youth indicated they are permitted to utilize mops and brooms in the center. One youth indicated they have used a scrub brush.

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

The center maintains a written policy and procedures to ensure the proper storage and inventory of flammable, toxic, caustic, and poisonous items. The center maintains a master monthly inventory list of controlled materials identifying the item, location, beginning inventory, new stock, used stock, and ending inventory. Observations made during the annual compliance review week found some of the center's flammable, toxic, caustic, and poisonous items are stored in the maintenance room, flammable liquids locked cabinet located outside inaccessible to the youth, and chiller room. In addition, bulk supplies of cleaning fluids and equipment are stored in a separate secured shed located outside, inaccessible to youth. Interviews with staff indicated the maintenance staff and administration have access to these storage areas. Inventories and Safety Data Sheets (SDS) were maintained for all areas with the exception of the flammable liquids cabinet. Observations found the cabinet did not have the correct SDS

sheets or inventories. During the annual compliance review week, the administration updated the inventories and replaced the correct SDS sheets. Laundry items and applicable cleaning items were stored in the bulk storage shed and items are removed when needed. The SDS were observed located in the laundry room. Kitchen items were stored in a closet with a list of chemicals and a SDS for each item. A master SDS binder for all chemicals were maintained in the assistant superintendent's office along with the Poison Control telephone number inside the front sleeve of the binder.

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

The center maintains written a policy and procedures ensuring 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 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. Seven youth were interviewed and indicated they do not clean with chemicals.

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

The center maintains a written policy and procedures ensuring the maintenance staff 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) Standards. During an informal interview, the superintendent indicated the center does not utilize grease in the kitchen and there is no grease trap. All applicable foods are baked. All other kitchen liquid waste is disposed in the kitchen drain. Liquid waste resulting from work details is disposed of in the center's two utility sinks. Bio-hazardous medical waste is the responsibility of medical staff. All bio-hazardous waste is placed in bio-hazardous waste containers and all bio-hazardous solid waste is placed in a tear-resistant red bag clearly marked as bio-hazardous. The center maintains a contract with Stericycle and nursing interviews and reviewed documentation supported medical bio-hazardous waste is disposed of monthly by Stericycle. The center's policy indicates the spill kits shall be strategically placed throughout the facility and shall be used in the event of an emergency in which large amounts of blood, vomit, or other bodily fluids are present and pose a threat to the health of youth and/or staff. Monthly visual checks shall be made on each kit to ensure each kit is maintained. Observations, interviews with staff, and reviewed documentation supported the center maintains four bio-hazard spill kits placed in the medical clinic and one in each of the three sub-controls. Nursing staff are conducting the visual checks each month and documenting their check on stock inventory sheet. Informal interview

with the superintendent indicated there were no chemical spills since the last annual compliance review. If a chemical spill occurs, staff will notify master control of the location, a shift supervisor or master control will direct the shutdown of all air handlers, ventilation system, and close all windows and doors. Assistance from outside the center shall be contacted as necessary, consistent with the emergency procedures.

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

The center has a written policy and procedures addressing confinement under twenty-four hours. Staff are required to utilize behavioral confinement as an immediate, short term response strategy during volatile situations in which a youth's sudden or unforeseen behavior threatens the physical safety of self or others. Observations made during a tour of the center found there are six confinement rooms; however, two were not in use due to plumbing issues. Observations of the confinement module indicated room windows and cameras were free from obstruction and each room contained no non-fixed items. Youth who are in confinement have no contact with the general population. The center documents confinements under twenty-four hours in the Facility Management System (FMS). A review of nine confinement reports documented youth placed in confinement were afforded the same services as youth in the general population, which includes medical, mental health, education, exercise, showers, meals, clothing, bedding, and hygiene items. Confinement rooms were searched prior to youth being placed. Each report reflected a visual observation was conducted in accordance with policy. None of the reviewed confinement reports indicated the youth were at risk of suicide. Five of the nine reviewed confinement reports indicated they were not completed within the one-hour time frame. They were completed within two to three hours. One of the nine reviewed confinement reports was not reviewed by the juvenile justice detention officer supervisor within the required two-hour time frame. It was reviewed one and a half hours late. Each of the nine confinement reports indicated the superintendent and/or designee reviewed the confinement report within forty-eight hours. Seven staff were interviewed and indicated staff must complete the confinement report and document ten-minute checks when youth are placed in confinement. Each staff validated the room is search prior to placing a youth in confinement. One staff indicated the supervisor has to review the report.

5.15 Confinement Over Twenty-Four Hours	Satisfactory Compliance

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

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

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

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

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

The center has a written policy and procedures to address youth placed in confinement over twenty-four hours. Nine confinement reports over twenty-four hours were reviewed and each was approved by the superintendent or designee. Reviewed documentation supported the confinement room was searched prior to placement. The center's practice is to e-mail the Department's regional director for confinement approval every twenty-four hours after placement. Reviewed e-mail correspondence supported permission was granted for each youth. No youth remained in confinement to exceed three days. The juvenile justice detention officer supervisor (JJDOS) completed reviews evaluating the youth every three hours and documented the need for continued confinement based on the severity of the rule violations, past disciplinary history, or behavior while in confinement. Three of nine reviewed confinements did not support a mental health professional reviewed the status of the youth in confinement every twenty-four hours. Each was missing one twenty-four-hour period.

5.16 Continuity of Operations Planning (COOP) Drills	Satisfactory Compliance

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

The center maintains a written policy and procedures ensuring a plan is in place to effectively manage emergencies and disaster events, include those requiring the detention center to relocate its youth and staff while maintaining operations, safety, and security. The center has a Continuity of Operations Plan (COOP) which was approved by the regional director and superintendent on January 28, 2019 and contains a comprehensive approach to effectively manage emergencies and disaster events. Mock hurricane COOP drills were conducted on May 8, 2019 and May 2, 2018 and an evacuation drill was conducted on January 23, 2019. A review of documentation found there were written scenarios documented on the center's Emergency Drill Reporting Form with critiques and recommendations. In addition, e-mail correspondence and logbook documentation were maintained. An informal interview with the superintendent indicated COOP drills are conducted twice a year. During an informal interview, the

superintendent indicated the center's comprehensive safety program ensures all staff and youth are safe and secure. Safety and security is everyone's part. Communication is kept open at all times between management and staff. Hazards or safety concerns identified, or if staff feel they need additional training, they will notify their supervisor. Supervisors and management meet weekly to address any center concerns and also meet monthly to discuss concerns and take corrective action as warranted.

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

The center has a written policy and procedures to ensure staff are prepared to address youth escapes and prevention. Staff are required to remain alert and attuned to the moods, attitudes, and behaviors of the youth. The center is required to conduct mock escape drills quarterly with staff being trained annually. Reviewed documentation supported mock escape drills were conducted monthly on each shift with the exception of February 2019 on C-shift. Reviewed logbooks contained documentation of when escape drills were conducted. Drill documentation was reviewed and reflected the drill report provided details of the drill and a critique and recommendation. A review of seven staff training records verified annual escape training was completed by each reviewed staff. Five of seven interviewed staff indicated they have participated in an escape drill this year.

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

The center maintains a disaster preparedness plan which addresses fire safety and prevention. In addition, the center maintains a separate fire prevention plan ensuring the facility fire regulations are met and preventative maintenance occurs. Reviewed documentation supported the fire prevention plan was approved by the fire marshal on April 15, 2019. The annual fire alarm inspection was conducted on November 5, 2018. The fire marshal inspection was conducted on March 20, 2019 with no identified major fire safety violations. The center conducts monthly checks on the twenty-five fire extinguishers and conducts a monthly fire safety and emergency light inspection. A review of the emergency drill forms and the corresponding logbook documentation for the past twelve months verified the center conducts fire drills every month on each shift. Each completed drill documented a critique and recommendations for improved emergency response. Seven interviewed staff indicated each has participated in a fire drill this year. Six of seven interviewed youth indicated they have been instructed what to do in case of a fire. One youth indicated they have not been instructed.

Program Name: Palm Beach Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: Palm Beach County / Circuit 15
Review Date(s): May 14 - 17, 2019

MQI Program Code: 207
Contract Number: N/A
Number of Beds: 65
Lead Reviewer Code: 159

Overall Rating Summary

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

Limited Ratings	Failed Ratings
5.09 Kitchen Tools	