STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Pasco Regional Juvenile Detention Center

Department of Juvenile Justice

(State-Operated)
38534 State Road 52
San Antonio,, Florida 33576

Review Date(s): January 7-10, 2020

Promoting Continuous Improvement and Accountability
in Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Marvin D. Bliss, Office of Program Accountability, Lead Reviewer (Standard One)
Kara Brown, Office of Program Accountability, Regional Monitor (Standard Five)
Melissa Johnson, Office of Program Accountability, Regional Monitor (Standard Five)
Gregory MahoumNassar, Office of Program Accountability, Regional Monitor (Standard Five)
Jonathan Thompson, Office of Program Accountability, Regional Monitor (Standard Four)
April Walker, Detention Services, Senior Management Analyst II (Standard Two)
Bonita Williams, Office of Program Accountability, Regional Monitor (Standard Three)

Program Name: Pasco Regional Juvenile Detention Center
Provider Name: State of Florida
Location: Pasco County / Circuit 6
Review Date(s): January 7-10, 2020

MQI Program Code: 363
Contract Number: NA
Number of Beds: 36
Lead Reviewer Code: 173

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
	5.07 Vehicles and Maintenance
	5.17 Fire Drills

Standard 1: Management Accountability
Detention Rating Profile

Indicator Ratings

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

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

Standard 2: Youth Management
Detention Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Detention Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Detention Rating Profile

Indicator Ratings

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

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Program Overview

Pasco Regional Juvenile Detention Center is a state-owned detention center, operated by the Department, located in Gainesville, Florida. The center serves youth in Pasco County. Male and female youth who are detained pending adjudication, disposition, or placement in a residential commitment program are housed in the thirty-six-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 with the Pasco County School Board. The center's management team includes the superintendent, one assistant superintendent, one administrative assistant, seven juvenile justice detention officer (JJDO) supervisors, and thirty-eight JJDOs. Mental health and healthcare services are provided through the contracted provider, Maxim Healthcare Services. Mental health services are provided by two full-time licensed mental health professionals, one of whom serves as the designated mental health clinician authority (DMHCA), and a psychiatrist, who provides two hours of services a week. Clinical services provided by the center include mental health and substance abuse evaluations, mental health treatment planning, individual, group, and family therapy, mental health crisis intervention services, on-site psychiatric services, and availability for substance abuse services for youth with co-occurring disorders. Medical services are provided by a medical doctor (MD), who serves as the designated health authority (DHA), an advanced practice registered nurse (APRN), one registered nurse (RN), two full-time licensed practical nurses (LPN), and a medical records clerk. The medical clinic maintains nursing coverage Monday through Friday from 7:00 a.m. to 7:30 p.m. and on Saturdays and Sundays from 8:00 a.m. to 4:30 p.m. Food services are provided by Department staff and include menus, meal planning, meal schedules, special diets, nutritional analysis, daily allowance, food preparation, health certifications, food product standards, sanitation, and cleaning. Staff are responsible for the custody and control of youth in their care, providing youth supervision twenty-four hours a day, seven days a week. The center has three living modules which are divided by male and female. There are fifty-four security cameras at the center, all of which were operational. The center was clean and free of any noticeable graffiti, odors, or pests. At the time of the annual compliance review the center had no vacancies.

Standard 1: Management Accountability

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

The center has a policy and procedures for completing initial background screenings on all newly hired staff. Fifteen new staff members were hired, three volunteers were added to the volunteer list since the last annual compliance review and six new contracted staff were hired. All new staff members, volunteers and contracted staff were background screened prior to having contact with the youth or confidential youth records. None of the new hires, volunteers and contracted staff required an exemption. All the new direct care staff completed the pre-employment assessment tool and a passing score was documented in the employee records. The hiring authority ensured a review of the Central Communications Center (CCC) Person Involvement Report, the Staff Verification System (SVS) module, the Florida Department of Law Enforcement (FDLE) Automated Training Management System (ATMS) result and completed any agency personnel file review prior to hiring or utilizing a volunteer having contact with youth, or access to confidential youth records. The program completed the Annual Affidavit of Compliance with Level 2 Screening Standards and forwarded the form to the Department's Background Screening Unit (BSU) on January 2, 2020. The center utilizes teachers from Hillsborough County Schools. The school board completed the Annual Affidavit of Compliance with Level 2 Screening Standards and forwarded the form to the Department's (BSU) on January 8, 2020.

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

The center has a policy and procedures to address five-year re-screening for all staff, volunteers, mentors, and interns with the due date of a re-screening based on the original date of hire or volunteering. Two employees required a five-year re-screening. There were no volunteers or contracted staff requiring a re-screening. Re-screenings were completed on two applicable employees on or prior to the anniversary date of hire. Each re-screening was completed no more than twelve months prior to the anniversary date.

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

The center has a policy and procedures for employees and volunteers detailing the code of conduct when interacting and communicating with youth. The center is state operated, and staff are trained on the Department's code of conduct. The Department's code of conduct prohibits any form of abuse, profanity, threats, harassment, intimidation, horseplay, or personal relationships with youth. Three staff personnel records were reviewed, and each included a signed form indicating the staff received and reviewed the staff code of conduct. Three staff personnel records were reviewed for disciplinary actions for violations of the code of conduct. Two staff members received a verbal reprimand for violation of agency rule. One staff received written reprimands for violation of agency rule. Based on documentation in personnel records, management addressed all violations immediately. A review of three staff personnel records indicated one received commendations for appreciation, one for outstanding service, and one for outstanding food service. All three interviewed youth reported they felt safe in the center. The three youth stated they never needed to call the Central Communications Center (CCC) or the Florida Abuse Hotline. The three youth stated they have never heard staff use profanity, threaten them or other youth and felt staff were respectful of them. All three interviewed staff indicated never hearing staff use profanity. All three staff members indicated they have never seen a coworker use threats, intimidation, and/or humiliation when interacting with youth. One staff rated the working conditions at the center as good and three rated as fair. An interview with the facility superintendent was conducted and he had knowledge of the Florida Department of Juvenile Justice reporting procedures. The facility superintendent indicated a call would be made to the CCC, Florida Abuse Hotline, and parent/guardian for any incident occurring at the center. An investigation into the incident would be immediately started with any staff involved by removing the youth from the staff's supervision as soon as possible. A review of the incidents indicated no substantiated findings of improper conduct by staff.

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

The center has a policy and procedures to address incident reporting. The center had fifty-one reportable incidents since the last annual compliance review. A review of five incidents indicated one for a violation of rule, two for compliant against staff, one for battery on staff, and one for failure to report. All were reported within the required two-hour time frame or within two hours of staff becoming aware of the incident. All five incidents were documented in the center's logbooks. There were no internal incidents or grievances which should have been called into the Central Communications Center (CCC) or the Florida Abuse Hotline. All three interviewed youth reported they have never been stopped from calling the CCC or contacting the Florida Abuse Hotline. The superintendent was interviewed and was aware of the incident reporting procedures requiring the program to contact the CCC for any reportable incident within two hours of gaining knowledge of the incident or the actual incident.

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

The center has a policy and procedures to address Protective Action Response (PAR). A review of six PAR reports which occurred during the annual compliance review period found all reports were completed by the end of the staff member's workday and included statements from all staff involved. The PAR incidents did not result in injuries to the youth. None of the youth involved in a PAR incident alleged abuse. All reports included a review by a PAR certified instructor and/or supervisory staff. A post-PAR interview was conducted within thirty minutes after each incident. A review of the PAR incident report by the superintendent or designee was conducted within seventy-two hours of each incident. None of the six reviewed PARs required a PAR medical review. None of the PARs required the use of mechanical restraints. All techniques applied were approved by the Department and based on the center's approved PAR plan. All reports were completed in the Facility Management System (FMS), which is part of the Department's information system. A review of internal incidents, grievances, and logbooks found no indication of additional PAR incidents occurring. All three staff interviews found all staff reported they attempt to talk to youth prior to using any PAR technique. An interview with the superintendent indicated PAR information is entered into the Department's system and reviewed during the superintendent's meetings. The center's PAR rate during the annual compliance review period was 25.9, which is above the statewide Detention PAR rate of 23.40.

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

The center has a policy and procedures in place for pre-service/certification requirements for newly-hired staff including completion of the Department's Juvenile Detention Officer Academy, within 180 days of their hire date. The center's training plan and documentation verified new staff completed a minimum of 120 hours within 180 days of hire in accordance with Florida Administrative Code. A desk review of the required five staff training records based on the youth census was completed the week prior to the actual review start date. At the time of the review, the youth census dropped to a required three records review. All five records reviewed will be reflected in the findings. A review of five newly hired staff training records indicated the new staff completed pre-service requirements prior to contact with any youth. Each staff was certified in Protective Action Response (PAR), first aid, cardiopulmonary resuscitation (CPR), and automated external defibrillator (AED) within ninety days of hire. All pre-service trainings were documented in the Department's Learning Management System (SkillPro). Five staff interviews indicated the staff felt adequately trained to perform their assigned job.

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

The center provides twenty-four hours of in-service training including mandatory topics specified in the Florida Administrative Code each calendar year and based on their annual training calendar. The center maintains an approved annual in-service training calendar for all staff which is updated as needed. Three in-service staff training records were reviewed and each staff had a current first aid, cardiopulmonary resuscitation (CPR), and automated external defibrillator (AED) certification. The three staff training records indicated the staff completed the required twenty-four-hour annual in-service training. The staff received the annual eight-hour Protective Action Response (PAR) update training as required. The staff also completed professionalism, ethics, and suicide prevention training. One had fifty-eight total hours, one had fifty-one and a half total hours of training and the third had sixty-eight and a half hours of total training hours. Of the three in-service staff training records reviewed, one was applicable for the mandatory supervisor training. The supervisor had fifty-eight hours of annual training with eight hours meeting the required supervisory training. All in-service trainings were documented in the Department's Learning Management System (SkillPro). The superintendent's interview indicated he was knowledgeable of the Department's training requirements and ensures staff receives the required training.

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

The center has a policy and procedures for entering and sharing alerts in the Department's Juvenile Justice Information System (JJIS). All entries and updates are completed by the appropriate medical, mental health, and supervisory staff in JJIS. The JJIS alert report is reviewed by administration and supervisors to ensure alerts are correctly documented in JJIS during shift briefings. During the annual compliance review, the center had a total of twenty-five alerts. All applicable alerts for the three youth reviewed were documented in JJIS appropriately. The alerts were downgraded, updated, or discontinued by medical, mental health, or administration staff. The center utilizes an internal alert system through the Facility Management System (FMS) in JJIS. Three staff were interviewed, and each stated the center provides each staff a copy of the JJIS alert form and discuss updates with staff during shift briefing.

Standard 2: Assessment and Performance Plan

2.01 Admission	Satisfactory Compliance

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

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

The center has a policy and procedures to ensure youth are admitted to the center in accordance with Florida Administrative Code. Three youth records were reviewed for admission. All records contained an arrest affidavit/custody order or courtesy hold order, a Detention Risk Assessment Instrument (DRAI), and Suicide Risk Screening Instrument (SRSI). All three records had the admission wizard printed and placed in the record. Each admission wizard documented youth were searched, allowed to make a telephone call, electronically searched, stripped searched, and had medical, mental health, and substance abuse screenings. All three admission wizards documented youth were offered a snack or meal. An annual compliance review team member observed an admission of a youth into the center. The admitting juvenile justice detention officer (JJDO) spoke in a calm voice and explained the admission process and paperwork involved. The youth was electronically searched, frisk searched, and stripped searched by an officer of the same gender as the youth. The youth made a phone call to her parent/guardian and she was given a lunch tray. The youth took a shower and she was provided with clean detention clothing.

2.02 Orientation	Satisfactory Compliance

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

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

Three youth records were reviewed for orientation. Documentation revealed orientation was completed within twenty-four hours of admission to each of the youth, with youth acknowledging

the orientation by signature. The orientation process included identification of key personnel, the daily activity schedule, the center's rules and regulations, youth rights, visitation, telephone calls, grievance procedures, access to medical, mental health, and substance abuse services, access to the Florida Abuse Hotline and Central Communications Center, behavior expectations and related consequences, and possible new law violations for destruction of property. Three youth were interviewed. All three youth reported someone provided them with information about the center's rules and regulations, daily schedule, education services, visitation, abuse reporting, and the behavior management system.

2.03 Classification	**Satisfactory Compliance**

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

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

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

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

The center has classification procedures to ensure all youth admitted to the center are classified to provide the highest level of safety and security. Three youth records were reviewed. Admission wizards were completed in each record, which included a review of the youth's history, sex, height, weight, age, level of aggressiveness, identified special needs, history of sexual offenses, the Victimization and Sexually Aggressive Behavior (VSAB) form, medical, suicide risk identified or suspected, escape, gang affiliation, and security. Youth were assigned to rooms based on classification procedures. Alerts were entered into the Department's Juvenile Justice Information System (JJIS), as applicable. At the time of the review, no youth were classified as being a suspected gang member or as a gang member. There were no youth classified as being sexually aggressive in the three records reviewed.

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

A review of three youth records indicated all youth were screened for gang affiliation during intake. Information from intake is passed on to the shift supervisor regarding alleged gang information, and subsequently forwarded to the center's gang representative (currently a representative juvenile probation officer (JPO) from circuit six). According to the Juvenile Justice Information System (JJIS), the center has not identified any youth as being associated gang members during the review period. The superintendent reported the center shares gang information with the youth's assigned JPO and local law enforcement as well as the gang representative. Gang alerts are entered in JJIS by detention and probation staff.

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

Three youth records were reviewed. Each record documented youth property was inventoried by the admitting juvenile justice detention officer (JJDO) and entered into the Department's Juvenile Justice Information System (JJIS). A Property Receipt form was printed and signed by the youth and JJDO in each record. Youth property is placed in a bag with a copy of the Property Receipt form and youth information, and the bag is placed in a secured room. Money and other valuable items are placed in a clear tamper-proof bag and placed in a drop safe, which is under camera surveillance. The tamper-proof bags are labeled with the youth's name, Department identification number, a listing of the items in the bag, and youth and staff signatures. A log is kept to document items placed in the drop safe. All records contained a signed Letter of Acknowledgement regarding unclaimed property. Three youth were interviewed. All three youth reported staff checked their personal property and they signed a property receipt upon admission to the center. An interview with the superintendent confirmed the process for the receipt of youth property. There was one incident regarding lost or stolen property since the last compliance review.

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

Upon entering the center, youth personal property is stored within two separate areas in the center. Youth clothing is stored in a property room with access restricted to supervisors and intake personnel. Valuable property is turned over to the shift supervisor. Valuable property items are secured in a tamper-proof bag and secured in the drop safe, which is under

surveillance. Currently, only administration and the staff assistant have access to the drop safe. Valuable property is removed daily and stored into the main safe area, which is also under surveillance. Property bags are listed in binder by date order. Property is purged by the staff assistant after a youth departs the center and notice of thirty-day disposal is sent to the parent/guardian. A review of Central Communications Center (CCC) reports for the past six months indicated there was one incident related to youth property reported. The superintendent was interviewed and clearly explained all procedures related to storage of youth personal property.

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

Three closed records were reviewed for release documentation. The records showed the center was consistent in photocopying the identification (ID) cards of people to whom youth were released. For youth released to HUB transporters, IDs were photocopied, and the center did identify the transporter by name. Each of the three records documented court orders and other paperwork related to the release were reviewed by the supervisor. Each record documented the youth's identity was confirmed prior to release. One release was observed. The supervisor reviewed the release order and related paperwork. The youth was not on precautionary observation at the time of his release and no notifications of suicide risk were applicable. The property receipt was also reviewed with and signed by the youth and parent/guardian.

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

Three closed records were reviewed for release of youth personal property. All three records contained a copy of the property receipt on file, all were signed by the youth and parent/guardian. The valuable property logbook documented valuable property was released to youth upon release from the center. There is a process in place to purge property and send a letter to the parent/guardian informing them of the intent to dispose of the property if the property is not picked up after thirty days. The superintendent interview indicated property not picked up is either donated to a non-profit organization or discarded.

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

Three examples of youth released from the center with medication were reviewed and two were found applicable. A Medication Receipt form was completed in each record. All forms were signed and dated by all required parties. Observations and a review of reports found the supervisor advised medical staff a youth was being released from the center, checking to see if the youth had any medication upon their release. Medical staff will bring the medication to the lobby area, complete a review and count of the medication with the parent/guardian. The parent/guardian, medical staff, and a witness sign the medication receipt.

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

The superintendent reported the center has designated a juvenile justice detention officer II (JJDO II) to serve as the detention review specialist to coordinate detention reviews weekly. The superintendent advised the weekly reviews include representatives from mental health, medical, and education services at the center along with probation staff from the circuit. The superintendent indicated the meetings address youth alerts, confinements/behavior issues, current court status, any issues relative to youth's placement (if committed), education, and medical or mental health concerns. Documentation of detention reviews occurring during the past six months was reviewed and a detention review was observed. All youth on detention status were reviewed, which included any follow-up information needed from previous reviews, pending court dates, commitment status, release dates, and other pertinent information. The reviews were attended, either in person or by phone, by circuit probation staff and all departments within the center.

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

The daily activity schedule is posted in each living area and outlines the days and times for each youth activity. Logbooks reviewed, three youth and three staff interviews, and observations during the annual compliance review indicated the center follows the daily activity schedule. The schedule includes times for personal hygiene, meals, visitation, education, indoor and outdoor recreation, shift change, faith-based services, groups, shower time, bed time, and down time for youth.

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

Observations during the annual compliance review confirmed youth moved to and from class, meals, and other activities as scheduled. Logbooks documented the schedule was followed unless an emergency event or disturbance occurred. Any changes to the schedule must be approved by the shift supervisor or administration. Three staff and three youth were interviewed, and all reported the activity schedule is followed.

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

The center integrates educational instruction into the daily activity schedule. Each youth attends school for five hours each day. Youth are enrolled in educational programs and have the opportunity to earn course credit for completion of the education and training experience. The center provides education on a 250-day calendar over twelve months. The teachers have teacher training and planning days up to ten days a year. Reviewed logbooks showed youth received education services in accordance with the schedule. Three youth were interviewed. All three youth reported they attend school Monday through Friday and each youth identified common subjects/classes taught during school (math, english, and social studies). Three staff and the superintendent were interviewed, all reported there is minimal interference in education activities.

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

The center provides career education to all youth. The center provides Type 1 programming, which includes life skills groups, activities, and instruction. The youth at the center receive instruction in the areas of communication, interpersonal, and decision-making skills.

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

The center has a behavior management system in place, which includes point cards and levels. The superintendent explained there are three levels of the behavior management system. The superintendent identified the incentives for youth obtaining Level 3, such as access to a video game room, special parties, additional phone calls, sibling visitation, and extra snacks. A behavior matrix is posted within each module for youth to view and reference. Details are provided for the three different levels, privileges for each level, and how to move up within the level system to earn additional points/activities/items. Three staff were interviewed. All three staff reported staff speak with youth to discuss the consequences being imposed. Youth are given the opportunity to explain their behavior, and staff explain alternative acceptable behaviors. All three staff said they receive input from supervisors on their implementation of the behavior management system, with the input being provided weekly or as needed. All three of staff said they felt the behavior management system was effective. Three youth were interviewed and asked to rank the behavior management system. All three ranked it as good. When asked if consequences they had received were fair or unfair, all three youth said consequences they had received were fair. Observations were made daily during the annual compliance review, which included observations of use of the BMS. The BMS was also posted throughout the facility.

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

The center's behavior management system prohibits the use of group punishment, corporal punishment, or use of drugs to control youth behavior. Three staff were interviewed. All three staff advised consequences for inappropriate behavior never include loss of meals, snacks, sleep, school, or other rights and they had never witnessed a co-worker utilize such a consequence. All three staff said they have never witnessed a co-worker encourage a youth to

beat up another youth. Three youth were interviewed. None of the youth reported having rights taken away as punishment. All three youth received consequences and stated the consequences were loss of points or reduction of level. Each of the three youth advised they are not allowed to punish other youth.

2.17 Grievances	Satisfactory Compliance

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

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

The center has policy and procedures regarding each youth's right to grieve and to be treated fairly, respectfully, without discrimination, and their rights are protected. The process includes an informal phase, a formal phase, and an appeal phase. Youth have access to grievance forms within their module by asking staff who will enter the grievance into the Facility Management System (FMS). Completed FMS forms are reviewed by staff and forwarded to the shift supervisor, who reviews the grievance. The supervisor reviewing the grievance will either resolve the issue/concern or forward the grievance to the superintendent. A review of five grievances filed since the last compliance review indicated the grievance process and appeal were completed within the required time frame. All three interviewed staff and three youth were able to explain the grievance process. The superintendent interview clearly outlined the three the phases of the grievance process. The superintendent also indicated grievances are entered into and maintained in the Facility Management System (FMS).

2.18 Trauma-Informed Care	Satisfactory Compliance

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

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

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

The superintendent interview indicated the center has a soft room, bulletin boards throughout the facility explaining processes to youth, and murals painted throughout the facility and in youth rooms. The superintendent also stated staff are trained in trauma-informed care practices.

Observations and a review of ten staff training records confirmed the information provided in the superintendent interview.

Standard 3: Mental Health and Substance Abuse Services

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

The center maintains a contract with Maxim Healthcare, Inc. who sub-contracts mental health and substance abuse services with Camelot Community Care who provides services to all applicable youth in the center. Camelot provides a licensed mental health counselor (LMHC) who serves as the designated mental health clinician authority (DMHCA). The DMHCA is clear and active license in the State of Florida, as required by Chapter 491, Florida Statute and expires March 31, 2021. The DMHCA is on-site forty hours a week. During an interview, the DMHCA verified they monitor and ensure services are delivered to youth who need it, by reviewing records, unlicensed mental health staff work, and juvenile justice information system alerts.

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

The center has Facility Operating Procedures in regards to licensed mental health and substance abuse clinical staff. Each of the licensed clinical staff are contracted through Camelot Community Care. The center has one licensed clinical staff. The licensed clinical staff has a clear and active license in the State of Florida, as required by Chapter 491, Florida Statute and expires March 31, 2021. The center also has a psychiatrist scheduled to be on-site weekly and is available twenty-four hours a day, seven days a week for consultation as needed. The psychiatrist has a license which is clear and active in the State of Florida, as required by Chapter 491, Florida Statute and expires January 31, 2021.

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

The center has Facility Operating Procedures regarding the non-licensed mental health and substance abuse clinical staff. The program currently employs one full-time non-licensed and one part-time mental health and substance abuse clinical staff. Both non-licensed clinicians have a master's-level degree in social work. There is documentation each non-licensed clinician received the required twenty hours in Assessment of Suicide Risk (ASR), as well as mental health crisis intervention and emergency mental health services. The designated mental health

clinician authority (DMHCA) provides weekly on-site face to face supervision as evident of logs indicating weekly supervision for non-licensed clinicians. The DMHCA confirmed weekly supervision with non-licensed staff occurs. There is documentation the DMHCA reviews and signs all mental health related documentation for non-licensed clinicians. The center has a license in accordance with Chapter 397, Florida Statutes to provide substance abuse services and expires April 1, 2020.

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

The center has Facility Operating Procedures regarding mental health and substance abuse admission screening for youth entering the center. The center currently administers the Massachusetts Youth Screening Instrument-Second Version (MAYSI-2) and Suicide Risk Screening Instrument (SRSI). The center's medical staff and/or mental health staff completed the admission forms in entirety and each of the screens were administered by a trained staff. Of the three youth records reviewed, each contained a MAYSI-2 and SRSI completed at the time of their admission to the center. Each of the forms were located in the youth record and in the Department's Juvenile Justice Information System (JJIS) and were filled out in entirely. In the three youth records, each indicated the need for further assessment. In each case, the staff completed a referral as a result of the MAYSI-2 and SRSI. Each of the three youth indicated suicide risk elevation and were referred for an Assessment of Suicide Risk (ASR). The superintendent and mental health clinical staff were notified of the results. During an interview, the superintendent reported the mental health, substance abuse and suicide risk screenings are completed by the juvenile justice detention officer's, supervisor's, nursing, and mental health staff. The center uses the MAYSI-2 and SRSI. The superintendent reported the intake officer, nursing and mental health completed admission screenings such as the mental health/substance screening and suicide risk 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 has Facility Operating Procedures regarding the completion of mental health and substance abuse evaluations for applicable youth. None of the youth reviewed were applicable for evaluations; therefore; an addition two youth records were provided by the center. None of the evaluations were completed by a community provider, each of the evaluations were completed by the detention provider, Camelot Community Care. Both applicable youth were identified after admission and referred to the detention provider. The comprehensive mental health and substance abuse evaluations were completed within thirty days of the referral.

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

The center has a Facility Operating Procedure regarding mental health and substance abuse treatment provided to youth in the center. Each of the three youth records reviewed were applicable for mental health and substance abuse treatment. For each youth, an Authorization for Evaluation and Treatment (AET) and when needed, a consent for substance abuse treatment, were found in the youth records. All three youth required treatment and were assigned to a mini-treatment team. None of the three youth had a treatment team until the week of the annual compliance review. At which time, each youth attended and participated in their mini-treatment team meeting. Each of the three youth received individual counseling as required by their plans, which was documented on the Department's Mental Health/Substance Abuse form and contained all required elements. None of the youth were applicable for group counseling. One youth reported during interviews the mental health/substance abuse services is fair, one reported very good, and the last one reported not receiving services.

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

The center has Facility Operating Procedures regarding treatment and discharge planning. In each of the three youth records, the initial treatment plans were completed within seven days of the initiation of treatment. The initial treatment plans were developed on a Department form, which contained all the required information. The plans included the reason for referral for treatment, diagnosis/symptoms, initial treatment methods, initial treatment goals, psychiatric services, mental health/substance abuse clinical staff, and youth signature. During the annual compliance review, one mini-treatment team was observed. During the meeting the team member reviewed the youth's mental health, substance abuse and medical history and current status. Team members included the psychiatrist, education, medical, mental health and direct care staff. The youth's mother was contacted by telephone for input. None of the youth records reviewed included individual treatment plans; therefore, the center provided one record for review. The plan was developed with the youth thirty-first day of admission. The plan included; symptoms, treatment goals, strengths/abilities and preferences/needs. The plan was treatment focused and signed by the designated mental health clinician authority (DMHCA) within ten days of completion. The youth record included progress notes indicating youth received

services as outlined on the treatment plan. This youth was not on medication; therefore, medication review was not applicable. In addition, the youth was discharged from the center before a thirty-day review was able to be initiated. Three closed records were reviewed for mental health/substance abuse treatment discharge summaries. All three discharge summaries were completed on the Department form, which contained all required elements. In each of the three youth records, there was documentation the youth, parent/guardian and juvenile probation officer were provided a copy of the discharge plan.

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

The center has Facility Operating Procedures regarding psychiatric services for youth in the center, which includes the services of a psychiatrist. The psychiatrist has a license which is clear and active in the State of Florida, as required by Chapter 491, Florida Statute and expires January 31, 2021. The contract requires the psychiatrist to visit the center for a minimum of two hours a week. Logbook review indicated the psychiatrist is on-site at least two hours a week. The center does not utilize the services of a psychiatric advanced practice registered nurse. Two of the three youth reviewed were applicable for psychiatric services; therefore, an additional one record was provided for review. The psychiatrist completed an initial psychiatric interview and evaluation for all three youth; the evaluation was completed on the Clinical Psychotropic Progress Note (CPPN) within fourteen days of admission to the center. The initial psychiatric interview includes: reason for the referral, history, mental status examination, diagnosis, treatment recommendations, prescribed medication, explanation of the need for psychotropic medication and frequency of medication management. All three of the youth records included an in-depth psychiatric evaluation completed within thirty days of their admission. Each CPPN included all three pages. Each of the three youth had a signed Authorization for Evaluation and Treatment (AET). None of the youth received new medications while in the center. The designated mental health clinician authority (DMHCA) reported meeting with the psychiatrist weekly to review each youth information and the psychiatrist is available twenty-four hours a day, seven days a week for consultation as needed.

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

The center has a suicide prevention plan, which was approved and reviewed by the designated mental health clinician authority (DMHCA) and superintendent on September 9, 2019. The plan includes all required elements, such as identification and assessment of youth at-risk of suicide, referral, communication, immediate staff response, notification, levels of supervision, suicide precautions, staff training, documentation, and review process.

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

The center has Facility Operating Procedures regarding suicide prevention services. The facility utilizes suicide precautions as the method for supervising, observing, monitoring, and housing youth identified through screenings, available information, or staff observations as having suicide risk factors or identified through assessment as a potential suicide risk. Youth placed on suicide precautions are maintained on one-to-one or constant supervision. The superintendent has a review process for every serious suicide attempt or serious self-inflicted injury and a mortality review for a completed suicide. Three youth records reviewed were applicable for suicide prevention services. A review of the Juvenile Justice Information System (JJIS) indicated the appropriate alerts were entered and removed, as required. Each of the three applicable youth identified to be at risk at admission was placed on precautionary observation. Reviewed documentation reflected staff observations were included on the Suicide Precaution Observation Logs and an Assessment of Suicide Risk (ASR) was completed for each youth during the required time frame. Each of the ASRs were completed by the designated mental health clinician authority (DMHCA). None of the youth required a follow up ASR. Reviewed logbooks reflected staff documented the beginning and ending times each youth was placed on precautions; except one youth there was no entry in regard to the youth being placed on precautionary observation. The program did not have any youth placed in secure observation during the review period. Of the three youth interviewed, all three stated being placed on precautionary observation upon intake. Each youth reported staff watched them at all times. The superintendent reported secure observation is used when a youth is either on close watch or precautionary observation and their behaviors escalate to where confinement is needed. Three staff were interviewed and reported when a youth expresses suicidal thoughts, staff are to notify the supervisor and mental health, placed on youth constant sight and sound, document supervision, and search youth.

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

The center has Facility Operating Procedures regarding supervision of youth placed on suicide precautions. The center uses the Department's Suicide Precaution Observation Log forms for youth placed on precautionary observation. A review of three precautionary observation logs, reflected the logs were maintained for the duration of each youth placed on precautionary observation. Each of the logs were reviewed and signed by the supervisor and mental health clinical staff. None of the youth displayed warning signs while on observation. Youth supervision

while on precautionary observation was documented in thirty-minute intervals; however, none of the times were documented in real time. Interview with three youth placed on precautionary observation reported the staff were with them at all times.

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.	

Three staff training records were reviewed for completion of required suicide prevention training. Each of the staff completed the required six hours of annual training on suicide prevention and implementation of suicide precautions. A review of the emergency drill evaluation forms found each mock suicide drill included the date, time, shift, and the participating staff. The drills also included life saving measures such as first aid, suicide response kit and cardiopulmonary resuscitation. Each current staff member participated in drills semi-annual. Mock suicide drills were held on each shift quarterly. Three staff reported during interviews the knife-for-life is kept in master control and medical office.

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

The center has a written mental health Crisis Intervention Plan which was approved and signed by the designated mental health clinician authority (DMHCA) and superintendent on July 31, 2019. The plan addresses the notification and alert system, means of referral to include youth self-referral, communication, supervision levels, documentation, and review, as required.

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

The center has a written Emergency Care Plan which was approved and signed by the designated mental health clinician authority (DMHCA) and superintendent on September 9, 2019. The plan addresses immediate staff response, notifications, communication, supervision of youth, authorization to transport for emergency services, transportation for emergency mental health and/or substance abuse evaluation and treatment, documentation, training, and review.

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

The center has Facility Operating Procedures regarding mental health crisis intervention plan and procedures. The plan details crisis intervention procedures including a notification and alert system, means of referral including youth self-referral, communication, supervision, documentation, and review. The center's plan was reviewed, approved and signed by the designated mental health clinician authority (DMHCA) and superintendent on September 9, 2019. The center has not had any crisis assessments in the past six months.

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

The center has Facility Operating Procedures regarding the Baker Act and Marchman Act procedures. The center has not had any incidents of using the Marchman Act since the last annual compliance review. The center had one Baker Act since the last annual compliance review. The youth was under the supervision of the licensed mental health clinician. Upon re-admission to the center the youth was placed on precautionary observation. The youth was under constant supervision until properly transitioned to a lower level of supervision. The youth was not stepped down until the assessment was completed and the designated mental health clinician authority and superintendent/designed conferred. The mental health referral and Mental Status Examination (MSE) was completed. The center entered and closed the suicide risk alert in the Department's Juvenile Justice Information System (JJIS).

Standard 4: Health Services

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

The center maintains a policy and procedures to ensure clinical services are provided to youth who are in the center. The center has a contract agreement with Maxim Healthcare Services, Inc. A licensed physician serves as the designated health authority (DHA) and performs administrative duties. The DHA holds an unrestricted clear and active license which expires January 31, 2021 and meets all requirements for independent and unsupervised practice in the State of Florida. The DHA has specialized training in pediatrics. The DHA is on-site on once a week for an hour or more each visit and is available twenty-four hours a day, seven days a week to communicate with staff regarding youth medical needs, acute medical concerns, emergency care, and coordination of off-site care. The contract also requires an advanced practice registered nurse (APRN) to provide eight hours of medical treatment a week to youth. The center APRN who holds an unrestricted clear and active license to practice in the State of Florida which expires July 31, 2020 and provides direct on-site care to youth. The DHA and APRN have a Collaborative Practice Protocol in place which is filed with the Department of Health and approved by the DHA on February 26, 2019. When the DHA is on vacation or scheduled absence Maxim Healthcare Services provides for back-up medical doctor coverage. The augmenting doctor holds an unrestricted clear and active license which expires January 31, 2021 and meets all requirements for independent and unsupervised practice in the State of Florida. A review of the medical sign-in and sign-out logs for the past six months verified coverage is provided on-site in accordance with contractual obligations for all weeks, with one exception. The week of Thanksgiving, physician coverage was missed due to augmenting doctors' misunderstanding of needed coverage for DHA absence. The review team determined the program has a standing practice of providing proper coverage and attributed the week of missed coverage to miscommunication. Reviewed documentation validated the DHA completed comprehensive physical assessment (CPAs), sick calls, periodic evaluations, reviewed youth medication, and prescribed medication for applicable youth. In the DHA interview, the physician indicated she had no current concerns in relation to providing of health care at the center.

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 policy and procedures for all health-related procedures and protocols utilized at the center. A review of the center's Facility Operating Procedures (FOP) for all health-related procedures and treatment protocols utilized at the center found they were signed by the DHA on August 2, 2019. This process is followed each time a new policy, procedure, or protocol is developed and/or an existing one is changed. Additionally, psychiatric services specific FOP's were signed by the psychiatrist on July 30, 2019. Reviewed documentation supported nursing staff reviewed, signed, and dated a cover page on which all FOPs, treatment protocols, and other procedures are listed. New policies or changes in policies made during the year are reviewed, signed, and dated by each nurse on each individual policy. A review of the protocols found the center's superintendent signed all of the protocols. All newly employed health care personnel receive a comprehensive clinical orientation to the Department's health care policies

and procedures conducted by the registered nurse (RN). The center had three new clinicians hired since the last annual compliance review and a review of all three personnel records indicated a clinical orientation was completed.

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 policy and procedures to ensure the completion of the Authority for Evaluation and Treatment (AET) or Limited Consent for Evaluation and Treatment authorizing specific treatment for youth in the custody of the Department. A review of three youth Individual Health Care Records (IHCR) verified each record contained a valid AET signed by the parent/guardian and witnessed by a Department representative. Two of the three youth records did not contain original AET's and were properly marked with a legible "COPY" stamp on each form. One youth record already had an active AET on file which was dated February 2, 2019. None of the youth IHCRs were applicable for a Limited Consent for Evaluation and Treatment as none of the youth were eighteen years of age or older. In all cases, AETs were obtained prior to providing any medical services to the youth.

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

The center maintains a policy and procedures to inform the parent/guardian of significant changes of the youth's condition and obtain consent when new medications and treatments are prescribed. Three reviewed youth Individual Health Care Records (IHCR) found one applicable for parental notification. One of the reviewed records were applicable for over-the-counter (OTC) medications or vaccinations not covered by the Authorization of Evaluation and Treatment (AET) and the record included a parental notification. There were no Religious Exemption as indicated from the three youth Immunization forms submitted since the last annual compliance review. None of the three records were applicable for emergency off-site care. One youth was prescribed new medication and parent/guardian telephonic contact was accomplished to gain verbal consent for the youth to be administered the medication. A follow-up letter by way of certified mail was signed and returned by the parent/guardian. One of the three youth were admitted with psychotropic medication which continued with an increased dosage; therefore, parental notification was completed as required, notifying the parent/guardian of the increased dosage and continuation of the medication. Parental notification was acquired prior to the administration of the additional dose for this youth. None of the reviewed IHCRs required the parent/guardian to be notified of discontinued medication or youth being hospitalized.

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

The center maintains a policy and procedures to ensure the Department's Medical and Mental Health Admission Screening form is completed for each youth at the time of admission into center. Three youth Individual Health Care Records (IHCR) were reviewed. Each record contained a Medical and Mental Health Admission Screening form completed by a juvenile justice detention officer (JJDO) on the date of admission and each screening was reviewed by a licensed practical nurse (LPN) within twenty-four hours of the screening being completed. None of the reviewed youth had a change in physical custody since their arrival to the center. No youth were identified as sexually active with a mensural cycle at the time of admission, therefore, none of the three youth were applicable for qualitative urine pregnancy screening test. An interview with the superintendent indicated the designated health authority (DHA), advanced practice registered nurse (APRN), registered nurse (RN), and staff all indicate they participate in the completion of the healthcare admission screening form.

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

The center maintains a policy and procedures to ensure each youth in the center receives an orientation to healthcare services and health education. A review of three Individual Health Care Records (IHCR) supported a detailed healthcare orientation was completed on the Department's Health Education form within twenty-four-hours of each youth's admission. Each reviewed IHCR supported the youth received the required orientation topics to include access to medical care, sick call process, emergency situations, medication process, right to refuse care, what to do in case of sexual assault or attempt sexual assault, non-disciplinary role of healthcare staff, and a review of a list of healthcare contacts.

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

The center maintains a policy and procedures to ensure the designated health authority (DHA) is notified of any youth requiring emergency care within twelve hours upon admission. The center's practice is for the nursing staff to notify the DHA within twelve hours of the youth being admitted to the program. A review of three Individual Health Care Records (IHCR) indicated none were applicable for emergency care upon admission, however, same-day notifications were made for all three admissions regardless. All three applicable youth IHCRs supported the DHA was notified within twelve hours of admission of any youth with a chronic medical condition. DHA admission notifications were documented within the nursing admission related chronological notes for each youth. Each applicable youth was referred to the advanced practice registered nurse (APRN) or the DHA upon admission.

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

The center maintains a policy and procedures regarding the Health-Related History (HRH) form, which indicates the HRH form shall be completed no later than seven days following the date of admission. A review of three Individual Health Care Records (IHCR) validated two records contained a new HRH form and one contained an updated HRH form. Each form was completed on the most recent HRH form by a licensed nurse within seven days of the youth's admission and reviewed by the advanced practice registered nurse (APRN). Each of the three reviewed HRH were completed before the Comprehensive Physical Assessment (CPA).

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

The center maintains a policy and procedures to ensure each youth in the center has a completed Comprehensive Physical Assessment (CPA) upon admission into the center. A review of three youth Individual Health Care Records (IHCR) verified each contained a valid CPA. Each of the three CPAs were reviewed, and initialed by the advanced practice registered nurse (APRN) within seven days of admission. The medical grade was documented on each CPA and an alert was generated in the center's alert system for youth assigned a medical grade between two and five. Each CPA form was completed in full and included all required elements. None of the three reviewed records documented any youth refusal of any part of the exam. The Department's Problem List was updated as required for each youth accordingly. Each of the three records documented the Tuberculosis Skin Test (TST) was completed within seventy-two hours of admission and documented in the IHCR prior to entering general population. Additionally, none of the reviewed youth required further evaluation prior to entering general population. The center's internal alert system coincided with the Department's Juvenile Justice Information System (JJIS) and each applicable alert was updated, as required.

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

The center maintains a policy and procedures to ensure each youth in the center is evaluated and treated for sexually transmitted infections (STI). The center provides human immunodeficiency virus (HIV) counseling by a certified counselor for youth who consent to HIV testing. The Department of Health provides a certified HIV counselor to conduct pre-and post-counseling on-site once a month. Three Individual Health Care Records (IHCR) were reviewed and identified all three youth as being sexually active. One youth was screened for STIs and received further evaluation. The two youth signed the HIV testing sign-up sheet for testing which is slotted to take place on January 10, 2020. The one applicable youth's screening taking place was documented on the Infectious and Communicable Disease form and results were located in a sealed envelope marked "Confidential" and located within the IHCR. Pre-test counseling was conducted and documented for all three youth. Post-test counseling was conducted and documented for the one applicable youth. Documentation confirmed all HIV counseling to be

conducted by a certified HIV counselor as required. None of the reviewed youth were out of the Department's custody for more than thirty-days. Three youth were interviewed, and each stated they were offered HIV testing at the center upon admission and could request a test at any point.

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

The center maintains a policy and procedures regarding Sick Call Requests. The center conducts sick call seven days a week to respond to a youth's medical illness or injury of a nonemergency nature by a healthcare professional. Sick call hours are posted throughout the center and printed in the youth handbook. The center conducts sick call Monday through Friday twice a day, once a day on Saturday and Sunday, and on an as-needed basis. Youth who requires a sick call will inform staff of their complaint and staff will generate a Sick Call Request in the Department's Juvenile Justice Information System (JJIS). In the absence of licensed clinicians, shift supervisors are trained in procedures to provide sick call within four hours of submittal. Only one of the three youth records included a sick call, therefore, the reviewer requested, and the program supplied two additional applicable records. A review of the three youth Individual Health Care Records for Sick Call forms validated each documented the nature of the complaint, assessment, and plan to include subjective, objective, assessment, and plan format (SOAP). Each of the three Sick Call Requests were conducted by a registered nurse (RN). Each of the three reviewed sick calls were documented on the center's Sick Call Referral Log. None of the reviewed youth presented a similar sick call complaint three or more times within a two-week period. None of the youth complained of any severe pain which staff were unfamiliar. No sick calls were conducted or observed during the annual compliance review period. Three staff were interviewed, and each stated the doctor and nurse conduct sick call. Three youth were interviewed on how quickly they can be seen by the nurse. Two stated immediately and the third indicated they have never requested a sick call. Two youth stated the medical services at the center is very good and one stated the medical service is fair.

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

The center maintains a policy and procedures for the provisions of episodic care and first aid. The center utilizes an episodic care log to document episodic care and first aid treatment. The policy requires all staff to contact 9-1-1 in the event of a potentially life-threatening emergency involving youth. All staff are required to maintain certifications in first aid, cardiopulmonary resuscitation (CPR), and automated external defibrillator (AED). Ten staff pre-service and in-service training records validated each staff's training and certification to provide emergency care. Additionally, reviewed documentation confirmed supervisory staff had been trained in the proper utilization of an epinephrine auto-injector. Each nurse was current in first aid and CPR certifications. A list of emergency telephone numbers, including poison control, is posted in the medical clinic for quick reference.

Only one of the reviewed youth Individual Health Care Records (IHCR) was applicable for episodic care, therefore, the reviewer requested, and the program supplied two additional applicable records. Each of the three applicable youth IHCRs identified the youth in need of episodic care or first aid. Each reviewed record contained a progress note identifying first aid or emergency care, the date and time of care, nature of the complaint, findings regarding care, and treatment rendered. One youth was applicable for an off-site care referral and follow-up plans for future care and was placed on the center's alert list and parental notification was conducted. Each youth's progress note identified the staff rendering aid, signature of the staff, the center's name, and was entered on the episodic care log. All of the reviewed youth received episodic care from a non-healthcare professional; therefore, a follow-up evaluation was required and conducted by the licensed healthcare professional. The center has a total of fourteen first aid kits strategically located in areas frequented by youth. Examination of three first aid kits verified each kit was stocked with approved supplies, none of the contents were expired, each kit was monitored monthly by the nursing staff and were replenished with materials as needed. The center has two automated external defibrillators (AED) located in the clinic and master control with automated instructions. The nurse checks the AEDs monthly to ensure the unit is charged and operable. AED Maintenance and Inspection Logs were collected since March 2019 and utilized to verify this practice. Each AED log annotated monthly checks are conducted by nurses and documented as required. The center conducts emergency drills at least quarterly on each shift with only one exception. Documentation of completion of an emergency drill on second shift for the second quarter could not be located or produced by the program. Of the twelve mandatory emergency drills eleven were properly documented and logged in the master control logbook. Emergency drills including cardiopulmonary resuscitation (CPR)/AED are held on a regular basis. Eight staff training records verified staff received CPR and AED training. Three staff were interviewed, and each stated they can call 9-1-1, if necessary.

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

The center maintains a policy and procedures to provide timely referrals for off-site healthcare. One of the three reviewed records were applicable for off-site care; therefore, an additional two records were reviewed to gain a sample of three. The three applicable youth Individual Health Care Records (IHCR) indicated a summary of off-site care form was completed and discharge documentation was filed in the IHCR. Two youth were taken off-site for emergency care and one youth were take off-site for routine follow-up care. The designated health authority (DHA) was notified for each emergency event. Each youth record contained a Summary of Off-Site Care form, discharge documentation, and instructions. Reviewed documentation confirmed the DHA reviewed and signed all off-site care findings, instructions, and information. All off-site emergency care was documented on the Episodic Care Log. None of the applicable youth required follow-up care.

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

The center maintains a policy and procedures to ensure youth with chronic conditions receive regular scheduled evaluations and follow-up care. A review of three youth Individual Health

Care Records (IHCRs) found three youth were applicable for the existence of chronic conditions and each were taking medication. Each youth was classified with a medical grade between two and five. None of the youth were diagnosed with a communicable disease, considered obese, or taking medication for tuberculosis. None of the three youth records were applicable for periodic evaluations being conducted prior to renewing of prescription medication. The program provided two applicable records for periodic evaluations and each record contained evidence of the evaluation in within the chronological progress notes with clearly written treatment orders. One youth had an off-site evaluation which was documented on the Summary of Off-Site Care Form, filed in the youth's IHCR, and updated on the Department's Problem List. There were no indications of missed or lapsed periodic evaluations.

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

The center maintains a policy and procedures for medication management. Verification of medication is conducted by the center's nurse whenever a youth is admitted with medication. Youth who are taking medication while in the care of the center are administered medications by the healthcare professionals. Additionally, supervisors are trained in medication administration and administer medication only in the absence of the healthcare professionals. A review of three supervisor training records verified they were trained in medication management. A review of three youth healthcare records identified all three youth were taking prescribed medication upon admission and were applicable for medication management. Reviewed documentation validated medication was either verified by a licensed pharmacist or the youth's primary physician for each youth. All medication was stored in a container intact with the original label and approved medication. In each instance, the physician or psychiatrist was contacted to obtain an order to resume the medication and consent was documented in the youth's Individual Health Care Record (IHCR). There were no youth in restricted housing requiring over-the-counter medication not listed in the Authorization for Evaluation and Treatment (AET). There were no undocumented explanations for lapses or errors in administered medication in any of the three records. Documentation was found within each record to reflect daily medication side-effect monitoring was conducted for the three youth by clinicians and captured on the Medication Administration Record (MAR). Review of three youth IHCRs verified the medication administration was documented on the Department's MAR which documented the youth's name, Department identification (DJJID) number, date of birth, allergies, precautions, medical grade, medical alerts, youth current picture, start and stop dates, and monitored side-effects. Further review of the MARs indicated the youth received the medication as ordered, and staff along with youth initialed the MAR after the administration of the medication. None of the three youth refused medication. During an informal interview, the nurse stated if a youth refuses medication, an "R" is documented on the MAR where the youth would initial to confirm if the medication was administered and a refusal form is signed by the youth. A review of three additional youth records confirmed this practice. Upon admission, one of the youth required an inhaler and two prescribed psychotropic medication while in the center. The two youth were on psychotropic medication prior to admission and in each instance, the designated health authority (DHA), psychiatrist, and the designated mental health clinician authority (DMHCA) were notified upon admission, and the medication was continued until a diagnostic psychiatric interview was conducted. None of the youth on psychiatric medications remained in the center over thirty days, therefore, did not receive a review of medication monitoring by the psychiatrist. An interview with the center's nurse verified there were no standing orders of psychotropic

medication, no emergency treatment orders for psychotropic medication, and no pro-re-nata (PRN) orders for psychotropic medication. An observation of the medication management indicated; the Six Rights of Medication Administration was verified for each youth, the nurse verified any allergies to the medication, the nurse observed the youth swallowing the medication, and the nurse and youth initialed the MAR. None of the medication was pre-poured from the original packaging or placed in another container. Observations of medication storage indicated all medications were stored separately by type, stored in a locked area designated for storage, and inaccessible to youth. The center maintains a list of staff who are required to have access to the clinic and medications. There was no current medication requiring refrigeration. Medication which cannot be returned to the pharmacist for a credit or medication requiring disposal is documented on the Medication Disposal form and disposed of using drug buster container. The center maintains a contact with a provider who disposes of all biohazard material once a month. Three staff were interviewed and stated they do not administer medication to youth and only supervisors, nursing staff, and the doctor administer medications. Three youth were interviewed on who gives youth medication and all stated only nurses and supervisors can administer medication.

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

The center maintains a policy and procedures to ensure medical equipment and medications are secured and inventoried. The center maintains a perpetual daily inventory of medications to include prescribed and over-the-counter (OTC) medications. Documentation of each individual dosage of medication administered to youth is maintained on the Medication Administration Record (MAR) to demonstrate the distribution of medications. Medical equipment, to include sharps, is secured and inventoried using a perpetual inventory count subtracting from the count as a sharp is used. A review of the perpetual inventory for the past six months verified the inventory count was accurate and medical supplies are being properly stored. Observations of the clinic validated storage is secured with limited access to the healthcare professional, supervisors, superintendent, and assistant superintendent. The healthcare professionals maintain a locked medication cart which contains prescribed and OTC medications, as well as sharps. There were bulk OTC medications and sharps stored in locked cabinets within the clinic. Controlled medications are maintained within the locked medical cart within a separate locked storage box. A random review of three prescribed medications, three controlled medications, and three OTC medications were verified. All counts during the annual compliance review period were accurate. Additionally, review of the daily inventory of prescribed and OTC medications matched the random count.

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

The center maintains a policy and procedures to ensure proper procedures are followed to prevent the spread of infectious diseases or illnesses and provide staff with the knowledge of appropriate prevention, containment, treatment, and reporting requirements of infectious diseases. The center also maintains an Exposure Control Plan/Infection Control Plan approved by the designated health authority (DHA) on August 2, 2019. Reviewed documentation indicated the Exposure Control Plan/Infection Control Plan was written in accordance with Occupational Safety and Health Administration (OSHA) guidelines to include risk assessment and methods of compliance. The plan also included common childhood infectious diseases, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, tuberculosis, Hepatitis A, B and C, human immunodeficiency virus (HIV), bloodborne pathogens, other outbreaks and epidemics, and outbreaks of pediculosis. In addition, the plan included methicillin resistant staphylococcus aureus (MRSA) and other antibiotic-resistant micro-organisms, foodborne illnesses, bioterrorism agents, chemical exposures in the workplace, and protocols for needlestick post-exposure intervention and treatment. A review of three youth Individual Health Care Records (IHCR) indicated each youth received infection control training within twenty-four hours of admission to include hand-washing techniques, universal/standard precautions, prevention/transmission of communicable diseases, vaccinations, and the Centers for Disease Control and Prevention (CDC) guidelines for infection control. The center ensures Hepatitis B immunization is made available for staff and all staff have access to protective equipment. A review of ten staff training records indicated each staff received pre-service and in-service training on the center's Exposure Control Plan/Infection Control Plan. There were no reportable incidents for which the local county health department, CDC, and the Department's Central Communications Center (CCC) should have been notified since the last annual compliance review.

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

The center maintains a policy and procedures for the care of pregnant youth to include procedures for medical issues, nutrition, education, and medication. During the week of the annual compliance review, the center only had two applicable pregnant youth in secure detention since the last annual compliance review. A review of the youth's Individual Health Care Record (IHCR) indicated the youth have received prenatal care as recommended by her primary doctor including off-site medical prenatal, obstetrical, or gynecological appointments. Each of the youth were released prior to thirty days of pregnancy notification, therefore, a focused medical evaluation at least once every thirty days by the designated health authority (DHA) and/or advanced practice registered nurse (APRN) were not applicable. A review of the healthcare chronological notes indicated daily monitoring of danger signs of pregnancy complications. A review of the healthcare education record indicated each youth received pre-natal education to include alcohol and drug use, smoking, nutrition, sexually transmitted

infections, contraception, prenatal care, birthing process, post-partum care, basic baby care, child/infant development, and parenting skills. While at the center, nursing staff monitored the youth for weight and nutritional status. The youth also received nutritious meals in quantities appropriate for a pregnant youth. A pregnancy alert was entered into the Department's Juvenile Justice Information System (JJIS). A review of ten staff training records verified each staff received Girls Health training specific to working with pregnant youth. One applicable pregnant youth was interviewed and stated she received prenatal care.

Standard 5: Safety and Security

5.01 Active Supervision of Youth (Critical)	Satisfactory Compliance

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

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

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

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

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

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

The center maintains a policy and procedures ensuring the adequate staffing of the center to ensure the safety and security of the youth. Daily observations made during the annual compliance review confirmed the active supervision of youth by detention staff. Staff were observed supervising youth during daily activities such as school, recreation, meals, bathroom breaks, and line movements. Staff were observed to be positioned allowing them full view of youth in the area and maintained constant sight and sound of the youth. When asked by the review team members, staff were aware of the number of youth being supervised. Prior to any movement, staff were observed using two-way radios requesting permission from master control to move the youth to a new location. Staff were observed to have positive interactions with the youth. The daily census is tracked in several ways. A daily census roster from the Department's Juvenile Justice Information System (JJIS) is used to track the youth population. There are white boards located in the mods which document the number of youth assigned to each mod. The review of master control logbooks for the past six months substantiated youth headcounts were completed consistently at the beginning and end of each shift, at least once randomly on each shift and prior to each youth movement. All three interviewed staff acknowledged there is enough staff at the center to provide for the safety and security of the youth and staff. Each interviewed staff reported youth counts are completed at the beginning of each shift. Two staff indicated counts are conducted at the end of each shift, before/after school, and before/after meals. All three staff addressed the required steps to take to reconcile incorrect counts.

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

The center maintains a policy and procedures ensuring staff visually observe youth at least every ten-minutes while they are in their rooms for sleeping or other reasons. The center uses the Guard One Plus electronic system to document ten-minute checks at night. Visual Observation Reports (VOR) are completed when youth remain behind locked doors during the day. While completing a ten-minute check, the juvenile justice detention officer (JJDO) is required to look into the room to observe the youth behind the closed door, before the check point sensor is activated with the wand. Observations of youth rooms confirmed there were no obstructions over windows and areas where direct line of sight is needed. The superintendent downloads the data from the wands on a daily basis. The center has a total of fifty-four operable cameras with a recording capacity of thirty days. Video was used to observe ten-minute room checks with corresponding ten-minute logs. Observations were conducted on the two modules, from six different shifts on different days at various times. The observations confirmed the ten-minute checks were being conducted as required in real time, every ten-minutes or less. All three interviewed staff indicated room checks are completed every ten-minutes. The superintendent was interviewed and explained the ten-minute check process. The superintendent indicated when a youth is placed in a room, whether for sleeping or other reasons, officers shall conduct visual observations to ensure safety and security. The superintendent indicated pre-printed times are prohibited and the center uses the electronic cell check system.

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 policy and procedures ensuring headcounts are conducted as required. Observations throughout the review week confirmed staff requested permission from master control to move the youth to a new location prior to any movement. A random review of two days a month for each shift for the last six months was completed for the master control logbooks and mod logbooks. The review of master control logbooks for the past six months substantiated youth headcounts were completed at the beginning and end of shift, at least once randomly on each shift, prior to each youth movement, and following any emergency. There were several examples where the beginning and end counts were not documented in the mod logbooks. In the Alpha mod logbooks, there were three dates where there was no end count conducted on first shift. There was one day where there was no beginning head count documented on second shift. There were three occasions where staff documented, "headcount conducted and cleared", but there was no documented number for the youth headcount. In the Bravo mod logbooks, there was one date where there was no end count conducted on first shift. There was one date where there was no beginning count conducted on second shift. There were two dates where there was no end count conducted on second shift. There was one date where there was no beginning count conducted on third shift. The master control logbook and mod logbooks documented occasions when the population counts changed due to youth admissions and releases. As required, documented counts did not include youth who were not physically present with the staff. Two of three interviewed staff indicated emergency counts are conducted after a major disturbance. Two staff indicated emergency counts are conducted when a youth is believed to be missing and when visibility is hindered, such as an electrical outage.

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

The center maintains a policy and procedures ensuring logbooks are maintained by master control and in each living area in accordance with Florida Administrative Code. The logbooks used at the center are bound with numbered pages. The center uses these logbooks in master control, each mod, for visitors, and contracted staff. There were five pages in the master control logbook and six pages in the Bravo mod logbook missing the dates on top of the pages. A review of master control and mod logbooks for the past six months verified all entries included the time of the event and staff did not use military time. The a.m./p.m. was not consistently documented with the entries. Overall, staff maintained a very good practice of documenting all the events in the master control and mod logbooks. The name of the staff and youth involved, a brief description of the event and the initials of the staff making the entry were documented in the logbooks. Entries impacting the safety and security of the facility, including medical/special needs and mental health alerts were highlighted. Reviewed master control logbooks included emergency situations, incidents, the name of youth placed in confinement, including the time confinement began and ended, the name of youth placed on precautionary/secure observation, including the time precautionary/secure observation began and the time it was discontinued. Escape drills were documented in the master control logbooks. Fire drills were documented in the master control logbook except for the fire drill conducted on August 18th and September 1st, 2019.

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 policy and procedures ensuring logbook reviews are conducted. The center's logbooks for the past six months were reviewed to ensure the superintendent or

designee reviews the logbooks on a weekly basis and documents any discrepancies and/or issues. Documentation supported weekly reviews were completed by the designee. A random review of two days a month for each shift for the last six months was completed for the master control and mod logbooks to validate the juvenile justice detention officer supervisor (JJDOS) from each shift documented a review of the logbook prior to accepting the shift and the JJDOS coming on-duty documents a review of the logbook as well. There was documentation to support master control staff were reviewing the master control logbook prior to accepting the shift. There was missing documentation to support the JJDOS reviewed logbooks maintained in assigned living area when accepting responsibility for living area at shift change. There were three occasions in the Alpha mod logbook where the JJDOS accepting the second shift did not document a review of the logbook. There were seven occasions in the Bravo mod logbook where the JJDOS did not document a review of the logbook; three times on first shift, three times on second shift, and twice on third shift. The superintendent was interviewed and asked about management's role in regards to logbooks. The superintendent indicated he or a designee shall review all logbooks (excluding the visitor's logbook) at a minimum of weekly and review the entries for the last seventy-two hours.

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

The center has policy and procedures in place regarding key control in the facility. All facility keys are placed on a tamper-resistant key ring to prevent keys from being removed. All floor staff keys are maintained on a black tamper-resistant ring, and all supervisor keys are maintained on a red tamper-resistant ring. Emergency key rings are identifiable and located separately from other keys, in a locked key box, in the hall near master control. The center has a key inventory for all facility keys which includes the ring number, the number of keys on each ring, the capability of each key, and to whom the key ring was issued. A random sample of four key rings, kept in a secure lock box, were observed to determine if the key rings on the inventory matched the key rings in use. The inventory listed to whom all key rings were issued to and the capability of each key listed. Three of the four key rings had the correct ring number and number of keys. One key ring was labeled as ring number "43" on the inventory but was labeled as ring "SGT 5" on the key ring. The inventory stated there should be ten keys on the key ring, however there were eleven keys on the key ring. Two of the keys on the ring were misidentified or not identified on the inventory. A sample of three key rings assigned to staff were observed and compared to the inventory. All three key rings were assigned to proper staff, and the ring numbers and number of keys matched the inventory. The center had no inactive key rings. The emergency key ring was included on the inventory.

The issuance of keys and key ring numbers was documented on each shift report. The shift supervisor gets the keys from a lock box, assigns them to staff, and documents the issuance of keys and ring numbers on each shift report. The center also maintains a key inventory logbook including the date, staff's name, ring number signed out, time the ring was signed out, and time the ring was turned back in. A random sample of thirty entries from six random dates was reviewed. Twenty-seven of thirty entries included all appropriate information. One entry was missing the ring number signed out, one entry was missing the date, and one entry was missing the ring number and the date. All staff who are issued keys always carry the keys on them, do not allow youth to handle keys, and do not remove keys from the center. Youth do not have access to any center keys. Observations during the annual compliance review, and three staff interviews, revealed staff turn their personal keys in to master control upon entrance into the center, and the keys are then secured in a lock box. Supplemental interviews with staff reflected if a staff is to leave the center with center keys, they must immediately inform the supervisor, and return the keys within two hours. There were no reports of any lost or missing center keys in the last six months. All three interviewed staff indicated the following keys are restricted; medical, mental health and case management records, youth property area, and kitchen. All three staff were able to explain the centers process for tracking keys. All three staff indicated personal keys are given to master control upon entry and program keys are assigned to staff. Two staff indicated personal keys are securely stored and there is a daily tracking of keys with the key log. The superintendent was interviewed and asked about permanent keys issued to staff. The superintendent indicated there are permeant keys issued to staff. The superintendent explained how the center maintains security of the permanent issued keys. The superintendent indicated administration maintains a form to be signed by all staff. Each staff person is responsible for maintaining inventory and control of all permanently issued keys.

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

The center maintains a policy and procedures ensuring any vehicle used by the program to transport youth is properly maintained and maintains documentation on the use and maintenance of each vehicle. The center has a total of seven vehicles; one is on the surplus list and six vehicles are used to transport youth. Reviewed documentation substantiated each vehicle had an annual safety inspection conducted by a certified automobile mechanic. Observations of the seven vehicles throughout the annual compliance review week confirmed each was locked when not in use. Inspection of the six working vehicles confirmed each vehicle had the appropriate number of seat belts, current fire extinguisher, seat belt cutter, and a window punch. All vehicles contained a first aid kit with approved items. There were items in the first aid kits such as gloves and band-aids that appeared to be compromised by the heat. These items had changed color and did not appear to be useable. Each vehicle had a corresponding binder and logbook. Each binder contained the vehicle mileage log, mechanical restraint key, gas card, vehicle policy, and vehicle registration, confirmed by observation of the review team. A review of the vehicle logbooks confirmed staff documented the date and time of trip, the destination, and the number of youth on the trip. Observations confirmed search of youth and vehicle were completed upon return to the center. The center's Facility Operating Procedure (FOP) required, prior to each use documented vehicle inspections are completed and include a

check of twelve specific items addressing vehicle safety. Reviewed documentation did not consistently document the pre-trip inspection was completed. None of the pre-trip inspections addressed the twelve items listed in the FOP. Contraband inspections were documented consistently. For the majority of the time, documentation supported the safety cage and seat beat inspection were completed. The review the daily vehicle usage log for van one van reflects it was used in July 2019, however the documentation in the transportation log ended in May 2019. A transport of two youth was observed during the annual compliance review. The review team was not able to observe staff completing the pre-trip inspection or search for contraband. The JJDOs explained the inspection and search was completed earlier that morning when the van was moved from the parking lot into the Sally Port. The inspection and search was documented in the vehicle logbook. Review team members were able to observe the JJDOs search the youth prior to placing the youth in the vehicle. One JJDO assisted the youth in securing the seatbelt. The JJDOs were in possession of the assigned cell phone, vehicle logbook, transportation procedures, and binder. Documentation confirmed weekly and monthly vehicle inspections were completed by the maintenance staff. The weekly inspection checklist included; inspection of water coolant, lights, oil, emergency equipment, brakes, horn, interior/exterior, and cleanliness of the vehicle. The weekly inspections were not dated to verify the specific day of the week the inspection was completed. One van was missing weekly checks for the month of August 2019. There were two weekly check forms completed in August for another van. This van was missing weekly checks for the month of December. There were two weekly check forms completed in December for another van. Major Williams indicated staff wrote the wrong numbers on the forms. The first week of December 2019, the weekly inspection for all vans was not completed due to staff being on leave. Weekly checks were completed for the first week in January 2020, but the supervisor did not sign to indicate they reviewed the form. The emergency equipment was not included on the weekly check form to support this equipment was included in the weekly inspection. Overall, the results of each weekly inspection indicated all was good with each vehicle. There were several examples of invoices where vans were taken to the mechanic shop. The review team questioned the validity of the information on the weekly inspections since no issues were identified as a result of the weekly inspection; however, some time during the month the van required attention at the mechanic shop. It should be noted the superintendent was not able to inform the review team what type of repair/preventative maintenance was provided to those individual vans. A review of the monthly vehicle checks supported the maintenance staff completed a visual check on the tires, battery, windshield, wipers, windows, mirrors, and possible visual damage. The monthly inspections were completed on the required form.

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

The center maintains a policy and procedures ensuring all tools and equipment are properly maintained, stored, and inventoried. The center's maintenance tools are maintained in a locked portable building located on the outskirts of the center's parking lot. Observation of the storage of tools substantiated the tools are maintained on a shadow board and marked with an identification number to identify the tool is property of the Department. A perpetual tool inventory list was inclusive of the tools located in the maintenance portable and was maintained daily by maintenance staff. The inventory documented the issuance and return of tools. A monthly inventory is also completed by the maintenance staff. A review of the perpetual and monthly inventory substantiated they were completed as required. The superintendent signed the monthly inspection of tool area for the last six months except the months of November and

December 2019. The maintenance staff was not available to interview during the week of the annual compliance review. Regional maintenance staff assisted the review team but were not able to answer if there were any broken or missing tools within the past six months. Observation of the kitchen supported all equipment, including knives were secured when not in use. The knives, thermometers, and scissors were maintained on a shadow board which is kept locked. Other kitchen equipment such as mixing spoons, ladles, and measuring cups are maintained in a storage cart. The shadow board and cart are located in the kitchen manager's office. A perpetual inventory of kitchen tools is maintained, and counts are documented three times day; two counts by kitchen staff and one count by the juvenile justice detention officer supervisor (JJDOS). Recently, the kitchen manager reduced the number of knives maintained in the kitchen. Documentation supported the FOP was followed when the equipment was disposed of. An interview with the superintendent confirmed there have been no missing tools in the past six months. Three staff were interviewed regarding the center's practice for damaged or missing tools. One staff indicated they would follow the chain of command and inform their supervisor who would inform maintenance and the superintendent. The second staff indicated they would write the tool off and hand it over to maintenance. They indicated with missing tools, all movement should be stopped, and a search should begin. The third staff indicated they were not sure what the policy was as there has never been any damaged or missing tools. Three staff reported a work order is completed for damaged or missing tools. Two staff reported administration and JJDOS are notified. Two staff reported there have been no missing tools. One staff reported they get rid of the damaged tools and there have been no missing tools.

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

The center maintains a policy and procedures ensuring youth do not have access to any tools, including kitchen or medical equipment. Youth are permitted to use cleaning items such as mops, brooms, buckets, and other common household items for general cleaning under constant supervision of staff. Observation during the annual compliance review supported this practice. All three interviewed staff indicated youth can use mops, brooms, and scrub brushes. Two staff stated youth do not have access to any tools. All three interviewed youth indicated they are permitted to use mops and brooms. One youth indicated they can use scrub brushes.

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

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

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

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

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

The center maintains a policy and procedures to ensure all flammable, toxic, caustic, and poisonous items are inventoried and secured when not in use. The center maintains all flammable, toxic, caustic, and poisonous items in two separate locked, secure storage areas with limited access. One secure storage building stores the chemicals the maintenance staff use to complete maintenance responsibilities around the center. The second secure portable building stores the chemicals used inside the center such as cleaning chemicals for the kitchen and the center. Observations of both areas confirmed Safety Data Sheets (SDS) logbooks were located at the location in which the chemicals were stored. The review team members were able to locate SDS for three randomly selected chemicals. A review of weekly inventory sheets confirmed all items in both storage portables were inventoried weekly. The maintenance staff completed the weekly inventory for the maintenance portable and the administrative assistant complete the weekly inventory for the portable containing the chemicals used in the center. A comparison of three random chemicals in each storage container with the current inventory confirmed all items matched the inventory list. Both storage containers were neatly organized. The current chemical inventory system the center uses meets the requirements of the indicator, however; the lack of detail in tracking chemicals once the chemical is removed from the storage container does not meet the purpose of safeguarding the chemicals. The center was not able to explain how the chemical is tracked once the chemical is signed out of the storage portable.

5.11 Access to all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory Compliance

Flammable, toxic, caustic, and poisonous fluids and other dangerous substances may only be drawn or acquired by authorized personnel.

Youth shall not be permitted to use, handle, or clean-up dangerous or hazardous chemicals or respond to chemical spills. Youth shall not be permitted to clean, handle, or dispose of any other person's bio hazardous material, bodily fluids, or human waste.

The center maintains a policy and procedures ensuring flammable, toxic, caustic, and poisonous items may only be drawn or acquired by authorized personnel. Observations made throughout the review week support all chemicals and toxic items were stored as required and

not accessible to the youth. All three interviewed staff confirmed youth are not allowed to use substances which are toxic, flammable, or poisonous. Two of the three interviewed youth indicated they clean with cleaning agents. They indicated staff spray the chemical and the youth just wipes the chemical off. One youth indicated they did not use any cleaning agents.

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

The center maintains a policy and procedures ensuring the disposal of flammable, toxic, caustic, and poisonous items. The maintenance staff was not available to interview during the week of the annual compliance review. The center has a safety plan in place to address any chemic spills or leaks. A review of various documents supported the center has not had any instances of chemical spills in the last six months. The center has not needed to dispose of any flammable, toxic, caustic or poisonous items in the last six months. The center has a contract with a company to dispose of flammable, toxic, caustic, and poisonous items when needed.

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

The center maintains a written policy and procedures ensuring confinements under twenty–four hours are used as an immediate, short term response to a youth's sudden or unforeseen onset of behavior imminently and substantially threatens the physical safety of self or others. Observations during the annual compliance review indicated the confinement rooms were free from obstruction and each room contained no non-fixed items. The center documents confinements under twenty-four hours in the Facility Management System (FMS). The center had seventy confinements under twenty-four hours during the annual compliance review period. A review of seven confinement reports documented rooms were searched prior to youth being placed in confinement. Each report confirmed visual observation was conducted in accordance with policy and procedures. Five out of seven reports were not completed by the juvenile justice detention officer (JJDO) within one hour of the incident. A review of seven confinement reports found documentation which confirmed the juvenile justice detention office supervisor (JJDOS) reviewed the report and indicated the reason for confinement. Five out of seven reviewed confinements did not have a three-hour review completed by the JJDOS. Three out of seven confinement reports had a late superintendent or designee review completed. Each superintendent or designee review completed had documentation to support the need for continued confinement based on the severity of rule infraction, past disciplinary history, or behavior confinement. Each reviewed confined report showed documentation of the report being communicated to school personnel. Three staff were interviewed regarding confinements, and two staff reported they must search the confinement room prior to placing a youth in confinement. Two staff also indicated a confinement report must be completed each time. All three staff indicated ten-minute checks must be completed. Two staff indicated five-minute checks are completed the first hour of confinement.

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

The center maintains a written policy and procedures ensuring confinement over twenty–four hours are approved by the superintendent or designee as well as the regional director or designee. An interview with the superintendent was conducted. The superintendent confirmed confinements are reviewed after two hours, and every three hours after. The superintendent must review any request to exceed twenty-four hours of confinement. All confinements are tracked in the Facility Management System (FMS). Additionally, regional detention management reviews the use of confinement, lockdown, and restraints through FMS reporting, video surveillance review, and logbook reviews as needed. The center had three confinements over twenty-four hours during the annual compliance review period. Each confinement report reviewed confirmed the juvenile justice detention officer supervisor (JJDOS) completed reviews, evaluating youth every three hours, and documented the need for confinement based on the severity of the rule, violations, past disciplinary history, or behavior while in confinement. Each confinement report showed documentation which indicated the superintendent or designee reviewed and approved the confinement. Two of the three reports reviewed did not include a review by the mental health professional. Two of the three reports reviewed did not indicate the regional director approved the confinement beyond twenty-four hours. None of the confinements extended beyond three days; therefore, no confinement hearing was required.

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

The center has a Continuity of Operations Plan (COOP) reviewed and approved by the superintendent on August 25, 2019 and the regional director on August 28, 2019. Documentation confirmed COOP drills were completed as required. The center conducted a hurricane drill May 6-9, 2019. The documented drill included written scenarios and drill forms and emails used to document the drill. There was no documentation to indicate if exceptions to the drill were noted and needed correction. The superintendent indicated the drill went well. The

review team recommended the positive feedback of the drill needs to be documented. The previous COOP drill was completed in October 2018 and was reviewed during the last annual compliance review. The center will complete the second COOP drill at the end of this fiscal year in preparation for the hurricane season. Two of three interviewed staff indicated they have participated in a weather drill and major disturbance drill in the last six months. One staff indicated they participated in a flood drill within the last six months. An informal interview with the superintendent reflected the center conducts various safety, emergency, and medical drills monthly.

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

The center has a Continuity of Operations Plan (COOP) to include the center's escape prevention plan. Documentation of drills confirmed escape drills were completed on a quarterly basis for the last twelve months. All drills were documented on the required drill form and in the master control logbook. A review of three staff training records confirmed the three staff completed the annual escape prevention training. All three interviewed staff indicated they participated in an escape drill within the last six months.

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

The center has a Continuity of Operations Plan (COOP) to include the center's fire evacuation and prevention plan. The center's fire prevention plan and evacuation plan were reviewed and approved by the local fire marshal. A review of fire drills for the last twelve months found the following drills were not conducted for the following shifts; April 2019 on the second shift, June 2019 on the second shift, July 2019 on the first and second shifts, August 2019 on the first shift, September 2019 on second shift, November 2019 on the first shift, and December 2019 on the sift shift. It is noted for the month of August the drill form indicates two different times on the form. In one section of the drill form the time of the drill indicated 9:19 a.m. and in a different section of the form the time of the drill was documented as 9:19 p.m. Documentation of fire drills completed included a staff sign-in roster for those in attendance. Completed fire drills were documented in the logbook except for the following dates; August 18, September 1, and November 6, 2019. The center was not able to provide the logbook for the June 9, 2019 drill. All three interviewed staff indicated they participated in fire drills. Two of the three staff indicated the drills were conducted monthly. Three youth were interviewed. None of the youth indicated they were instructed on what to do in case of a fire.