STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

PROGRAM REPORT FOR

Pasco Regional Juvenile Detention Center

Department of Juvenile Justic

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

Review Date(s): February 26-March 1, 2019

PROMOTING CONTINUOUS IMPROVEMENT AND ACCOUNTABILITY
IN JUVENILE JUSTICE PROGRAMS AND SERVICES

Rating Definitions

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

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

Review Team

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

Felicia Goldstein, Office of Program Accountability, Lead Reviewer (Standard 1)
Marvin Bliss, Office of Program Accountability, Regional Monitor (Standard 4)
Donna Connors, Office of Program Accountability, Regional Monitor (Standard 4)
Melissa Johnson, Office of Program Accountability, Central Region Supervisor (Standard 2)
Bridget Letthand, Pinellas Regional Juvenile Detention Center, Assistant Detention Center Superintendent (Standard 2)
Amy Nelson, Office of Program Accountability, Regional Monitor (Standard 5)
Joey Nice, DJJ Office of Education, West Region Education Coordinator (Standard 2)
Jennifer Schad, Office of Program Accountability, Regional Monitor (Standard 3)

Program Name: Pasco Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: Pasco County / Circuit 6
Review Date(s): February 26-March 1, 2019

MQI Program Code: 363
Contract Number: N/A
Number of Beds: 36
Lead Reviewer Code: 146

Methodology

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

Persons Interviewed

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

Documents Reviewed

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

Observations During Review

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

Comments

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

Standard 1: Management Accountability
Detention Rating Profile

Indicator Ratings

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

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

Standard 2: Youth Management
Detention Rating Profile

Indicator Ratings

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

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

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

Indicator Ratings

Standard 3 - Mental Health and Substance Abuse Services		
3.01	Designated Mental Health Clinician Authority (DMHCA)	Satisfactory
3.02	* Licensed MH/SA Clinical Staff	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	Limited
3.12	* Suicide Prevention Training	Satisfactory
3.13	* Mental Health Crisis Intervention Services	Satisfactory
3.14	*Emergency Care Plan	Satisfactory
3.15	*Crisis Assessments	Satisfactory
3.16	* Baker and Marchman Acts	Satisfactory

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

Standard 4: Health Services
Detention Rating Profile

Indicator Ratings

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

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

Standard 5: Safety and Security
Detention Rating Profile

Indicator Ratings

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

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

Program Overview

The Pasco Regional Juvenile Detention Center is a state-owned detention facility, operated by the Department, located in San Antonio, Florida. The center serves youth in Pasco Country in Circuit 6. The Juvenile Assessment Center (JAC) is located within the Pasco County Sheriff's office. 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 by the Pasco County School Board. The center's management team includes fifty-three total positions which include the superintendent, one assistant superintendent, one administrative assistant, seven juvenile justice detention officer supervisors (JJDOS), one of which is the field training officer, and thirty-eight juvenile justice detention officer (JJDO) positions (twenty-two JJDO II and sixteen JJDO I). Mental health and healthcare services are provided through the contracted providers, Camelot Community Care Inc., and Maxim Health Services. Mental health services are provided by the following: one board certified and licensed psychiatrist, two licensed mental health professionals (one of which is the designated mental health clinician authority and the other works pro re nata), and two master's-level mental health professional registered interns. Additionally, the center has an additional medical doctor designated to serve as back-up to the psychiatrist, when needed. Oversight of mental health services is provided by Camelot's central region clinical director and licensed mental health professional. 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 the following: two medical doctors (one of which is the designated health authority), one advanced registered nurse practitioner (ARNP), one registered nurse, and two licensed practical nurses. Additionally, the center has one medical records clerk and Maxim has a regional ARNP to provide services and oversight, as needed. The medical clinic maintains nursing coverage Monday to Friday from 7:00 a.m. to 7:30 p.m. and on weekends 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 from graffiti. The center's therapeutic soft room is almost complete and mural projects are ongoing. The center has a room/office which is used for youth on level three status in the behavior management system to play video games, listen to music, and watch television. The room can also be used as a soft room due to the comfortable seating and soothing room decor. The bravo module was in the process of a remodel but temporarily stopped for funding reasons. In September 2018, the master control panel caught on fire in the master control area. This electrical fire left permanent damage to the control panel which has resulted in the inability to lock and unlock doors automatically. Opening doors within the center must be done manually. At the time of the annual compliance review, the center had nine vacancies, which included: one assistant superintendent, one food service worker, and seven JJDO positions.

Strengths and Innovative Approaches

- The center has a relationship with community agencies and local universities which has helped in obtaining numerous volunteers, mentors, and mental health interns.

- Suncoast Kids Place comes to the center twice a week to provide a grief support group to youth in need.

- Several local churches have donated clothing items to the center for youth who need items once released.

- The center recognizes staff each month by presenting an employee of the month award. Staff are recognized with a certificate of appreciation and a gift card. All gift cards are donated by the center's advisory board.

Standard 1: Management Accountability

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

The center has a policy and procedures outlining the required background screening process. A review of documentation verified the center conducts background screenings on all new staff, volunteers, mentors, and interns who will have access to the youth and/or their confidential information. The center uses the Department's Background Screening Unit (BSU). Since the center's last annual compliance review, the center has hired nine new staff and acquired six contracted staff, one volunteer, and two mental health interns. A review of background screenings found all eighteen individuals hired to work/volunteer at the center since the last annual compliance review had a screening completed prior to the person's hire date with one exception. The center indicated one mental health counselor was hired by Camelot Community Care Inc. on May 29, 2018; however, her level 2 background screening was not completed until June 4, 2018. Documentation provided by the center shows this staff's first day of work at the center was June 18, 2018. All reviewed documentation of staff and volunteers indicated each received eligible ratings during the background screening process and none required an exemption. Each of the eight applicable direct care staff completed a pre-employment assessment tool, prior to their hire date, and received a passing score. Each staff person's personnel record contained a copy of the completed assessment. Each of the applicable volunteers/interns were added to the Clearinghouse employee roster, as required. Teachers at the center are employees of the Pasco County School Board. The Affidavit of Compliance with Level 2 Screening Standards for the center and school board were submitted to the BSU on January 31, 2019 and January 23, 2019, respectively. The contracted providers for mental health and medical services submitted their Annual Affidavit of Compliance with Level 2 Screening Standards to the BSU January 9, 2019.

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

The center has a policy and procedures for rescreening for all applicable staff, volunteers, mentors, and interns every five years from their date of hire. A review of the center's staff and volunteer roster revealed three Department staff and one volunteer were eligible for a five-year re-screening during the annual compliance review period. All rescreens conducted on the

Department's staff were completed at least four months prior to the individual's anniversary date. None of the contracted staff were applicable for a five year rescreening. All reviewed five-year rescreens yielded eligible ratings.

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

The center has a policy and procedures regarding the staff code of conduct. The center utilizes the Department's employee handbook, and the Code of Ethics Agreement form which is to be signed by each new staff upon hire. The center's policy and code of conduct prohibits any form of abuse, intimidation, harassment, or the use of profanity when interacting with a youth. Physical abuse of youth is prohibited by law and a suspicion or knowledge of abuse must be presorted to the Florida Abuse Hotline and the Department's Central Communications Center (CCC). The code also states when interacting with youth, officers shall maintain professional behavior and relationships. Staff are not to engage in or allow "horseplay," either verbal or physical with and/or between youth or any other staff member. The code further mandates officers must maintain youth confidentiality at all times and are not to have personal relationships or discuss any personal information regarding themselves or other staff with the youth. During the annual compliance review, five personnel records were reviewed, and each documented the staff member's acknowledgement, receipt, and review of the Department's code of conduct and the employee handbook. Staff acknowledgment of human resource policy, procedures, and employment information requirements are documented electronically in the Human Resource Employment System. None of the center's records were applicable for disciplinary action for code of conduct violations. Two of the selected personnel records documented disciplinary actions for violations of policy; one additional record was provided by the center for the review. All three applicable staff were disciplined for violating policy/rule (failure to make a timely report to the Central Communications Center (CCC) and improper supervision) and all three received a policy refresher training. During the annual compliance review period, the center has had two substantiated CCC incidents of improper conduct by staff; however, both staff resigned during the investigation process. Reviewed documentation indicates administrative staff responded appropriately to allegations of staff misconduct in a timely manner while also positively reinforcing and commending positive staff efforts and behavior. In addition to addressing disciplinary incidents, documentation provided indicates

administrative staff seek opportunities to recognize and show appreciation for staff, at least monthly. An interview with the superintendent confirmed the center selects an employee of the month each month, and an employee of the quarter, to help boost morale. Photos provided by the superintendent show these awards being given. Additionally, the superintendent stated he will periodically provide food at the all staff meetings to show his appreciation for staff.

During the annual compliance review, interviews were conducted with five youth and five staff. When asked regarding their experiences/observations of staff/youth interactions in the center, four youth indicated staff are respectful when talking with youth and they have never been threatened by a staff member, or observed another youth being threatened by staff in the center. One said some staff are disrespectful since they use profanity in talking to youth. Four youth state staff use profanity and one youth stated they have never heard staff use profanity. Two youth state they have heard it once, two stated occasionally or often and one youth stated they have never heard staff curse. When asked about whether they have been stopped from reporting abuse, three said they have never been stopped and two youth said they never had a reason to call. Five of five interviewed staff reported they have observed staff using profanity with youth. All five stated they have never seen staff use threats, humiliation or intimidations with youth

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

The center has a policy and procedures addressing incident reporting to the Department's Central Communications Center (CCC) in accordance with Florida Administrative Code (F.A.C.) 63F-11. The center had thirty-two incidents reported to the CCC during the last six months, four of which are still pending closure. A review of the center's logbooks, incident reports, and youth grievances did not reveal any additional incidents which should have been reported to the CCC. A review of all CCC reports was conducted to determine accuracy, timeliness, and the completion of follow-up reporting, as applicable. The reported incidents included medical and mental health incidents, program disruption, complaints against staff, and youth behavior incidents. A review of the CCC reports confirmed it is the center's practice to contact the CCC to report incidents in a timely manner with minor exceptions. Four of the thirty-two incidents were substantiated as late reports. Three late reports were for staff who delayed the reporting of information to a supervisor and one staff failed to make a report upon discovery of a reportable incident. Reviewed documentation reflected staff documented each incident reported to the CCC in the center's master control logbooks typically at the time the CCC was contacted. According to the superintendent, the center complies with the CCC reporting requirements. Additionally, he stated a call is facilitated by staff whenever a youth makes a request to call the Florida Abuse Hotline.

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

The center has a policy and procedures outlining the use of physical intervention techniques, as indicated under the Department's approved Protective Action Response (PAR) matrix in accordance with Florida Administrative Code. When an incident occurs during the use of a PAR technique, the center's practice is to generate a PAR incident report. There were fifty-six recorded PAR incidents at this center during the six months prior to the annual compliance review. Last year's annual compliance review report noted the center had seventy-eight incidents prior to the review. This is a reduction from last year. The annual compliance review team did not find any other incidents when PAR physical intervention techniques were used during a review of the center logbooks, incident reports, or grievance forms. Six PAR incident reports were reviewed for compliance with Florida Administrative Code 63H-1. Reports were completed in the Facility Management System (FMS), located on the Department's Juvenile Justice Information System (JJIS). Overall, the reviewed reports were observed to be complete and timely with three exceptions. One report was missing the signatures from a supervisor and a PAR instructor (or certified staff), post-PAR interview results, and a superintendent/designee review. The second report had only one of two required staff statements and the third report was missing the superintendent/designee review. None of the reports included the use of mechanical restraints. None of the reports included allegations of abuse, which needed to be reported to the Florida Abuse Hotline. All five post-PAR interviews occurred within thirty minutes and none required further medical attention. A review of six PAR reports verified the center's practice of maintaining all PAR reports in the Department's electronic FMS/JJIS database. The center's PAR rate during the annual compliance review period was 8.35, which is below the statewide detention PAR rate of 10.87. Documentation verified the center experienced a decrease in the number of PAR incidents since the last annual compliance review. In an interview, the superintendent stated all PAR incidents are reviewed daily in FMS and trends are tracked in the tableau system. Five interviewed staff reported they have observed the center's practice of implementing verbal de-escalation techniques prior to physical restraints.

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

The center has procedures regarding the training of all new staff. Training consists of two phases: workplace training and training at the Department's Academy. Five staff training records were reviewed, and each record reflected staff completed the certification process within 180 days of hire. All staff completed the required training and certification related to cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), and Protective Action Response (PAR) within the first ninety days. Each of the five reviewed records indicated the staff also completed essential skills trainings related to mental health and substance abuse, suicide recognition, prevention and intervention, the Prison Rape Elimination Act, human trafficking, safety, security, and youth supervision, as well as, the Department's Detention facility operations and procedures prior to the staff being in direct contact with any youth. Each staff member had documentation in their records and in the Department's Learning Management System (SkillPro) indicating the successful completion of the phase one curriculum. Each completed training was documented in SkillPro.

1.07 In-Service Training	**Satisfactory Compliance**
All detention staff completes twenty-four hours of in-service training, including mandatory topics specified in Florida Administrative Code, each calendar year, effective the year after pre-	

service/certification training.

Supervisory staff completes eight hours of training (as part of the twenty-four hours of in-service training) in the areas specified in Florida Administrative Code.

The center has a policy and procedures regarding annual, in-service, training for all staff. In-service training begins the calendar after a staff completes his/her certification (pre-service) training. The center maintains an annual training calendar to ensure every staff is trained in all mandatory topics, as specified in Florida Administrative Code and the Department's approved training plan. Training opportunities are provided on the Department's Learning Management System (SkillPro), as well as, through attendance and participation in instructor-led courses. Five staff training records were reviewed for completion of mandatory in-service training. Each record revealed staff obtained more than the required twenty-four hours of training, which included training in all mandatory topics. Two of the five reviewed staff training records reflected supervisor positions. These records also documented more than the required eight hours of training in supervisory skills including leadership, management, employee relations and communication skills, as required for supervisory staff, with one staff completing thirty-three hours and the other staff completing thirty-five. Training was consistently documented in SkillPro. In an interview, the superintendent stated the center has an annual training plan which shows all staff are required to complete various trainings throughout each month.

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

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

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

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

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

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

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

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

The center has a policy and procedures for entering alerts into the Department's Juvenile Justice Information System (JJIS) and the use of an internal alert system. Upon completion of the Admission Wizard and intake screenings, the intake officer is to ensure all critical and

special alerts are entered into JJIS. Medical and mental health staff enter, update, and close alerts in JJIS, when appropriate. Additional alerts are later added by detention staff, if issues become known to staff or if a youth's behavior warrants. Five youth medical records, mental health and substance abuse records, and case management records were reviewed. Each of the five reviewed youth records had alerts documented and/or updated in JJIS by center staff either from the current or previous admissions to the center. Six specific alert types for youth were reviewed for compliance with the center's policy. Each of the six alerts were entered in to and closed by the authorized staff member. Observed alerts included medical restrictions, vulnerability and/or Prison Rape Elimination Act (PREA) sexual aggression, the prescription of psychotropic medications, and the placement and closure of youth on precautionary observation. The staff reviewed and updated the alert report daily to ensure the accuracy of the information regarding the youth's status in the alerts. Administrative and supervisory staff ensure the alert information is accurate each day. The supervisors then ensure the alerts are dispersed to appropriate staff and effectively addressed. A copy of JJIS alerts are reviewed at shift briefings and a copy of the alert print outs are available to all staff for review during the shift, if needed. Copies of the alert lists are carried by staff in the facility so they always have access to the information. A white board in master control lists youth who have critical and/or special alerts, so this information is readily accessible. A review of documentation and observations support the center's alert practice.

Standard 2: Assessment and Performance Plan

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

The center has a policy and procedures regarding the admission process. Five youth case management records were reviewed for admission documentation. All of the records contained a Detention Risk Assessment Instrument (DRAI), a copy of the arrest affidavit, a Suicide Risk Screening Instrument, a Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) screening, and an Admission Wizard. Each record documented the youth was searched and given an intake call. Each youth was offered a meal at the time of admission. An annual compliance review team member observed an admission of a youth into the center. The admitting officer was a juvenile justice detention center officer supervisor (JJDOS). She spoke in a calm voice and explained the admission process and paperwork involved. The JJDOS conducted an orientation to the center and an electronic search of the youth. Shortly after, a JJDO, who was the same sex as the youth, arrived and accompanied the youth to a shower area for a full body search. The youth took a shower and he was provided with clean detention clothing. The youth made a phone call to his parent/guardian and he was given a lunch tray.

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

The center has a policy and procedures regarding orientation of newly admitted youth. Orientation includes information such as rules, regulations, behavioral expectations, telephone

calls, and visitation hours. The orientation also includes abuse reporting, Central Communications Center (CCC) phone number, the grievance process, and information regarding the Prison Rape Elimination Act (PREA). A review of five youth intake records found they each contained an acknowledgement form signed by the youth confirming the orientation process took place within twenty-four hours of admission. A review of the orientation brochure provided to each youth found a summary of the essential information. An admission was observed during the annual compliance review and a juvenile justice detention officer reviewed orientation information and documents with the youth.

2.03 Classification	Satisfactory Compliance
All youth admitted to the detention center shall be classified to provide the highest level of safety and security. Considerations shall include, at a minimum: 1. *Physical characteristics (e.g. sex, height and weight);* 2. *Age and level of aggressiveness;* 3. *Special needs (mental illness, developmental disabilities, and physical disabilities);* 4. *History of violent behavior;* 5. *Gang affiliation;* 6. *Criminal behavior;* 7. *History of sexual offenses;* 8. *Vulnerability to victimization; and* 9. *Suicide risk identified or suspected.* *Youth shall be assigned to a room based on their classification and are reclassified if changes in behavior or status are observed. Youth with a history of committing sexual offenses or a victim of a sexual offense are not to be placed in a room with any other youth. Youth with a history of violent behavior shall be assigned to rooms where it is least likely they will be able to jeopardize safety and security.*	

The center adheres to a policy and procedures addressing the classification of youth upon admission to the center. The policy requires certain information to be reviewed prior to a youth being assigned to a sleeping room, which includes the youth's age and level of aggressiveness, special needs, history of violent behavior, gang affiliation, criminal behavior, history of sexual offenses, vulnerability to victimization, suicide risk identified, or suspected and physical characteristics. Youth are 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 are victims of 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 room where it is least likely they will be able to jeopardize safety and security. Much of this information is gathered through a review of available documentation at intake including the court documents reflecting the youth's charges. A review of five youth records verified a classification process is in place to ensure all required documents are reviewed prior to assigning a room. All five records contained a completed Vulnerability to Victimization and Sexually Aggressive Behavior screening (VSAB) and an Admission Wizard documenting the review of topics to be considered for the appropriate room assignment.

2.04 Classification of Gang Members	Satisfactory Compliance
All newly admitted youth are screened to determine if he or she is a criminal street gang member or is affiliated with any criminal street gang.	

In the event gang involvement is suspected, Detention staff should enter the "other suspected gang affiliation" alert into JJIS along with as much detailed information within the alert note as possible.

The center's policy and procedures address the need to identify street gang members and/or youth who engage in gang-associated behavior. All newly admitted youth are screened to determine if he or she is a criminal street gang member. A review of five records reflected the admission screening process seeks to identify a youth's gang involvement or affiliation. None of the youth were newly identified as having gang involvement; however, two of the five records reflect the youth were identified as gang members prior to admission. This information was listed as an alert in the Department's Juvenile Justice Information System (JJIS). The center has a dry erase board located in master control where it documents all youth with alerts for gang affiliation. Both youth were listed on the dry erase board. All information collected is shared by email, entries in logbooks, and included in the center's alert list. The center has a staff person who serves as a gang representative who reviews identified youth for suspected gang involvement.

2.05 Notification of Juvenile Probation Officer Circuit Gang Representative	**Satisfactory Compliance**

Each center shall identify the Juvenile Probation Officer designated as the Circuit Gang Representative to communicate suspected gang activity.

A referral on a youth for suspected gang involvement shall be shared, via email, with the Juvenile Probation Officer designated as the Circuit Gang Representative indicating suspicions of gang activity such as youth flashing gang signs, gang tattoos, gang-related drawings, or related activity.

Detention staff should include in the email all pictures (when appropriate), copies of written statements, drawings, graffiti, and a description of what gang signs the youth was "flashing."

The center has a policy and procedures in place to ensure information is shared regarding a youth's gang affiliation. Circuit 6 has a juvenile probation officer (JPO) designated as the circuit gang representative to communicate suspected gang activity. A referral on a youth with suspected gang involvement is shared by email, with the JPO representative indicating the center's suspicions of gang activity such as youth flashing gang signs, gang tattoos, gang-related drawings, or related activities. The center has a binder labeled "gangs." Inside the gang binder, the center maintains copies of gang related written statements, drawings, and graffiti. Additionally, the binder has educational information for staff to include pictures and descriptions of the most common gang sign. Two of the five youth records reviewed reflect the youth were involved in a gang and notifications were sent, as required. An additional record was reviewed. The additional youth selected did not have the email to the JPO; however, the oversight was corrected during the annual compliance review.

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

The center has a policy and procedures to address youth personal property. The center takes possession of each youth's personal property during the admission process. In the presence of the youth, all property is inventoried and documented on the Property Receipt Form. The form documents the youth's name, identification number, and the date of admission. Both youth and staff sign for the property. Items such as clothing, shoes, and belts are place in a bag and put into a locker. All valuable items such as cell phones and jewelry are also inventoried. These items are placed in a clear tamper-proof plastic bag, signed by the officer and the youth, and placed into a safe. Safes are located in the intake area and in master control, both are under camera view. All bags placed in the safes are logged into a safe logbook. A Letter of Acknowledgement regarding what happens to unclaimed property is signed by the youth during the admission process. A review of five youth records revealed the program's process for property inventory was followed in each case. Each youth signed the letter acknowledging the center's practice for unclaimed property and each of the property receipt forms contained the youth and staff signature.

The center has not had any incidents or Central Communication Center (CCC) reports of missing or lost items in the last six months. A review of three closed records was conducted. All three records documented the youth entered the center with valuable property. The signature portion of the clear tamper-proof bag was attached, along with the Property Receipt Form. The reviewer was able to observe a youth intake; the youth did not have any valuable property; but his clothing and shoes were placed in a locker along with the signed property form. All items listed on the form were the exact items the youth had in his possession. Five youth were interviewed, and all five stated the center's staff checked their personal property and then had them sign a form stating the property being secured was correct.

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

The center has a policy and procedures for the safe and secure storage of youth personal property. The center safeguards each youth's personal property until it can be returned to the youth and/or parent/guardian. Any personal property categorized as valuable is secured in a safe until the youth's release. The safe is always under camera review. All other non-valuable property is in the intake area in individual lockers. Once a youth arrives to the center, their property is inventoried. All items of value are placed in a clear, tamper-proof bag with the youth's information labeled on it. The youth signs the property receipt bag and form and their property is dropped in a safe, in the intake area, which is under constant camera view. The Superintendent or designee then gathers the bags and logs the bag numbers in a safe logbook. The bags are placed in a second safe located inside of master control. This safe is also under constant camera review. The Central Communications Center (CCC) is notified if a youth's property is lost or stolen. There were no incidents regarding lost or stolen property since the last annual compliance review. Observations of the property area in intake and each of the safe locations validated the center's practice.

2.08 Release	Satisfactory Compliance

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

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

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

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

The releasing officer shall verify the identification of the youth.

The center adheres to statewide detention policies and procedures ensuring all youth are released from the center appropriately. A review of three closed youth records found each record contained a copy of the Release Wizard, and a copy of the identification card for the person taking possession of the youth's property, and the signed property slips indicating the property was returned. Two youth releases were able to be observed during the annual compliance review. The court order, the Release Wizard, and all property slips were verified. Both youth and parent/guardian signed for the release of the youth's property. There were no other court dates to be reviewed/discussed. The releasing juvenile justice detention officer (JJDO) ensured all case record information was reviewed to prevent the negligent release of the youth. The on-duty JJDO supervisor (JJDOS) reviewed all paperwork prior to the releases. The releasing JJDO signed the forms indicating the center's release procedures were followed and the JJDOS signed the forms indicating their review and approval of the youth's release. There have been no reports to the Central Communications Center regarding unauthorized releases of youth during this annual compliance review period.

2.09 Release of Youth Personal Property	Satisfactory Compliance

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

The center has a policy and procedures in place regarding the release of a youth's personal property upon their release from the center. A review of three closed youth records confirmed each of the records contained property forms completed during the initial intake. The parent/guardian and the youth signed the property release form prior to the youth's release. A member of the annual compliance review team witnessed a youth's release. The juvenile justice detention officer (JJDO) retrieved the youth's personal property, to include all valuable property, maintained in the safe. The youth and the JJDO both signed the property bag. During an interview with the JJDO supervisor on-duty, she was able to confirm the center's process for disposal of all unclaimed property. The center mails out notices to the youth, of impending disposal of property. After thirty days, if the property has not been retrieved, the center will dispose of the property by donating it to a non-profit organization. The last disposal date was

documented on February 21, 2019 to Goodwill Industries. Upon the youth's release from center, the releasing JJDO, the youth, and the parent/guardian completes a review of all property being returned and signs the Property Receipt Form acknowledging the return of property.

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

The center has a process in place for the release of prescribed medications and medical instructions at the time of a youth's release. Each of the three reviewed closed youth records found the Department's Release Wizard indicated the youth had medication upon release. All records had Mediation Receipt, Transfer, and Disposition forms which indicated all medication accompanied the youth upon release. All three forms documented the name of each medication and the quantity of each medication returned to the youth and the parent/guardian. The form documents the name and signature of the person who received the medication. Interviews with the nursing staff confirmed the center's practice for releasing medication. During the annual compliance review, a review team member observed the release of a youth with medication. The parent/guardian was in receipt of the medication and the proper paperwork was signed.

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

The center uses the statewide written facility operating procedures addressing detention audits. Documentation provided by the center supported weekly detention reviews were consistently conducted throughout the annual compliance review period. Documentation for each detention audit included the meeting agenda, attendance sign-in sheet, and a print out of Department's Juvenile Justice Information System (JJIS) census with written notes. Those who consistently attended the reviews included the designee for detention administration, mental health staff, medical staff, education staff, representatives from the various probation offices in the circuit, and a commitment manager. During the meetings, attendees reviewed the JJIS list of youth in secure and home detention. Information for each youth was discussed to include court dates, releases, medical and mental health concerns, and any additional information pertinent to the individual youth. Information discussed during the meetings was recorded and maintained by the detention review specialist. Review team members were able to attend the detention audit meeting during the annual compliance review week. The meeting was led by the detention review specialist and attended by mental health staff, medical staff, representatives from the various probation offices in the circuit, and a commitment manager. There appeared to be great collaboration, as the group meticulously addressed each youth.

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

The center has a daily activity schedule which outlines the days and times for each youth activity. The daily activity schedule clearly addresses all required elements except for gender-

specific programming. The daily schedule was located throughout the center and observed during the annual compliance review tour. Activities such as large muscle activity and gender-specific and restorative justice groups were not clearly documented in logbooks; however, all life and social skills and gender-specific and restorative justice groups were documented in the Facility Management System (FMS). The center did not have specific curriculums for restorative justice and gender-specific programming; however, restorative justice and gender-specific groups with appropriate topics were documented in the FMS. All five interviewed staff were able to explain restorative justice and gender-specific programming provided to the youth. All five interviewed youth and five interviewed staff reported the center has a daily activity schedule.

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

The center has a daily activity schedule; however, documentation in the logbooks do not support the daily schedule is followed consistently. Logbooks for master control, Alpha mod, and Bravo mod were reviewed from the past six months. Logbook documentation indicated entries during the week were more detailed and supported the daily activity schedule was followed; however, there were examples in the Alpha and Bravo logbooks indicating the weekend daily activity schedule was not followed due to activities such as wake-up time, meal time, hygiene, and bedtime were completed at various times not consistent with the schedule. Weekend logbook entries did not detail what youth do throughout the day to support programming was offered. For example, the logbook documented when breakfast was started and when it ended and then when lunch began. There were no entries in between the meal times to document what activities the youth were doing. During the annual compliance review, observations of the daily schedule activities found the center was following the posted activity schedule. All five interviewed staff indicated the schedule cannot be followed because there are not enough staff working during the shift. All five interviewed youth indicated the schedule was followed.

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

The center has a policy and procedures regarding educational access. Education services, including the incorporation of career and technical education, are provided by the Pasco County School District. The center operates on a calendar providing 250 days of instruction, distributed over twelve months, with a minimum of twenty-five hours of instruction weekly. Youth enrolled in the educational program can earn course credit for completion of education and training experience. Education staff provide a variety of instructional methods in the classroom including direct instruction and the integration of technology. The district provides additional support for exceptional student education (ESE). A review of the program's daily schedule and logbook supported minimal interference of educational instruction. All five of the youth interviews

supported school attendance Monday through Friday and adherence to the daily schedule. While the review of the logbook and interviews supported education access, an annual compliance review team member observed the female population was moved to class, but the male students were not in class. When addressed by the review team, the reason provided was due to staff shortages because of court transfers. After being addressed, all youth were moved to the classrooms. There was no indication in any of the documentation reviewed indicating this is a regular occurrence.

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

The center has a policy and procedures regarding career education. The center provides career education programming based on the age, assessed educational abilities, the goals of the youth, and the typical length of stay to which each youth is assigned. The career programming provided by the center is a Type 1 program integrating personal accountability skill and behaviors leading to development of work habits to maintain employment and living standards. Career education programming includes communication, interpersonal, decision making and life skills.

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

The center has statewide facility operating procedures addressing the behavior management system (BMS). The BMS consists of three levels and includes rewards for positive behavior and consequences for not following the rules and expectations. Youth entering the center are placed on a level two and can earn a higher level by following the rules of the facility or decrease to a lower level when not following the rules. Youth are informed of the BMS during the orientation provided during the admission process. The BMS is addressed in the youth handbook. Rules and expectations of the BMS were observed posted in each living area with large pictures. Rewards earned included extra telephone calls, brand name hygiene products, and extra snacks. Potential consequences included being placed on a lower level of the BMS and receiving an earlier bedtime. Youth management/conduct cards are maintained for each youth while they are in the center. A review of the youth management/conduct cards supported rewards and consequences were provided, as required. The annual compliance review team observed documentation to support youth on level three received the extra telephone calls and extra snacks. The review team observed where the brand name hygiene products were maintained; however, the center did not have a tracking system to document when the youth received the hygiene products. Five youth were interviewed and two rated the BMS as fair and three rated the BMS as good. All five youth reported consequences were fair. All five interviewed staff indicated they do not believe the BMS is effective. Reasons why the BMS is ineffective included staff not assigning consequences consistently and youth not being given

their extra telephone calls and snacks. All staff reported staff speak with youth to discuss the consequences being imposed, youth can explain their behavior, and staff discuss alternative behaviors with youth. Each of the five staff reported a youth's level can be taken as a consequence. All five staff reported receiving feedback on the implementation of the BMS. The superintendent was able to explain the center's BMS.

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

Detention Services has written policies and procedures applicable to all juvenile detention centers statewide, prohibiting the use of unauthorized forms of punishment to include corporal punishment, the use of drugs to control youth's behavior, and group punishment, as well as youth are never to be permitted to impose discipline or sanctions on other youth. The center's behavior management system (BMS) clearly outlines consequences for a youth's negative behaviors. The use of verbal redirection and counseling are utilized to encourage youth to change their negative behaviors. During the annual compliance review, the team did not observe the use of any unauthorized form of punishment.

Five interviewed youth indicated they have never been allowed to punish other youth at the center. None of the interviewed youth indicated they had been or seen other's put in handcuffs or leg irons due to their behavior. Five interviewed staff indicated they have never seen a coworker take meals, snacks, clothing, education or medical care from a youth because they were acting out. Each staff indicated they never saw another staff encourage a youth to beat up another youth.

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

The center has statewide facility operating procedures addressing the grievance process. The center had twelve grievances filed in the last six months. Five grievances were reviewed for compliance. The grievances were completed in the Facility Management System (FMS) within the required timeframe with one exception. One youth filed a grievance in October 2018 and it was not signed by the youth or staff completing the grievance (phase I). The supervisor's review was blank and the youth nor supervisor signed the form (phase II). Four of the five grievances documented the youth's resolution with the grievance. All five staff interviewed were able to explain the grievance process. They indicated youth are given a piece of paper and pencil to write the grievance and then staff enter the grievance into the FMS. All five interviewed youth stated they have not had to file a grievance. An interview with the superintendent verified grievances are written by the youth on a piece of paper and then entered into the FMS by staff. The superintendent explained the different phases of the grievance process.

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

A review of five pre-service and five in-service staff training records revealed each of the records had documentation of training in trauma-informed care. The center has a soft room and there was evidence in the logbook where youth were allowed to use the soft room. Murals have been painted or are in the process of being painted in various areas of the center. Groups such as Sunrise, grief groups, yoga and mindfulness, and drum circle are offered to the youth. All five interviewed staff indicated they talk to the youth and process behavior with the youth prior to using any Protective Action Response interventions, supporting the trauma-informed care model. The superintendent verified the center promotes trauma-informed care through staff training, painting the murals, and redecorating the soft room.

Standard 3: Mental Health and Substance Abuse Services

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

The center has a policy and procedures regarding a single licensed mental health professional designated as the designated mental health clinician authority (DMHCA). At a minimum, the DMHCA must be on-site weekly for a sufficient time to ensure appropriate coordination and implementation of mental health and substance abuse services is taking place. A review of the sign-in log for the past six months confirmed the DMHCA is on-site five days weekly for a minimum of forty hours. The DMHCA is a licensed clinical social worker (LCSW) with a clear and active Florida license, expiring March 31, 2021. The DMHCA is also a qualified licensed clinical social worker. The DMHCA position description and contract were reviewed. An interview with the DMHCA confirmed her role at the center is to provide on-site support, development, and implementation with ensuring protocols for the Florida Administrative Code, facility operating procedures, and the Department's quality improvement standards are followed. The DMHCA indicated she conducts Assessments of Suicide Risk (ASR), Follow-up ASRs, review documents completed by non-licensed clinical staff, review suicide risk screening instruments, treatment plans, and provides individual counseling.

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

The center has a policy and procedures to ensure mental health and substance abuse services are provided by individuals with appropriate qualifications and licensure. The center's clinical staff includes two licensed mental health professionals, a regional licensed clinical director (RCD) and a psychiatrist. Along with the designated mental health clinician authority (DMHCA), the center has a licensed clinical social worker (LCSW) who works pro re nata (PRN). The RCD is a licensed mental health counselor (LMHC) and is available as needed. The psychiatrist is on-site weekly for two hours. All licenses were reviewed. The LCSW who works PRN has a clear and active license which expires March 31, 2019. The RCD has a clear and active license which expires March 31, 2021. The psychiatrist has a clear and active license which expires January 31, 2021 with a specialty in child and adolescent psychiatry. The contract requires the psychiatrist to be on-site two hours a week. A review of sign-in sheets for the past six months confirmed the psychiatrist was on-site weekly with one exception. For one week, the psychiatrist was on leave and another psychiatrist filled in to perform the services ensuring coverage, as required by the contract.

3.03 Non-Licensed Mental Health and Substance Abuse Clinical Staff [Contract Provider]	Satisfactory Compliance

The facility superintendent is responsible for ensuring mental health and substance abuse services are provided by individuals with appropriate qualifications. Clinical supervisors must ensure clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience.

The center has a policy and procedures to ensure mental health and substance abuse services are provided by individuals with appropriate qualifications as non-licensed clinical staff. The center has two non-licensed clinical staff, both who are registered interns. One staff began working at the center January 23, 2019 and is a registered clinical social worker, who achieved this status on February 18, 2019. The other staff is a registered mental health counselor with the status expiring March 31, 2022. Both non-licensed mental health clinical staff hold the appropriate master's-level of education necessary and in accordance with the contract. Both non-licensed staff work on the weekends and pro re nata (PRN). The center is licensed in accordance with Chapter 397, Florida Statutes to provide substance abuse services; certified by the Department of Children and Families, expiring in June 2019. Both non-licensed staff had documentation confirming they had staff completed the required twenty hours of training in completing Assessments of Suicide Risk (ASR). Clinical supervision was reviewed for the past six months. The designated mental health clinician authority (DMHCA), a licensed clinical social work (LCSW), provides one hour a week of on-site, face-to-face supervision with the non-licensed mental health clinical staff. The staff who started January 23, 2019 has had clinical supervision each week since starting. The other staff had clinical supervision each week she provided services, with no exceptions. Documentation of direct supervision is recorded on the Department's MHSA019 form. The licensed mental health professional providing direct supervision is responsible for reviewing ASRs, Follow-Up ASRs, and Crisis Assessments prepared by non-licensed mental health clinical staff within the required timeframes. The clinical supervisor assures the non-licensed staffing working under their supervision are performing services they are qualified based on education, training, and experience. A review of five youth mental health records confirmed non-licensed staff are providing services they are qualified to perform.

3.04 Mental Health and Substance Abuse Admission Screening [Detention Staff/Contract Provider]	**Satisfactory Compliance**

The mental health and substance needs of youth are identified through a comprehensive screening process ensuring referrals are made when youth have identified mental health and/or substance abuse needs or are identified as a possible suicide risk.

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

The center has a policy and procedures regarding mental health and substance abuse admission screening. Five youth mental health records were reviewed. All five records had screening documents completed by probation staff at intake to include the Suicide Risk Screening Instrument (SRSI), Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB), and Massachusetts Youth Screening Instrument – Version 2 (MAYSI-2). Four youth had a Positive Achievement Change Tool (PACT) completed by probation staff at intake. One youth record did not include the PACT, which was identified by the mental health staff in an email noting it was not included. All five youth records had a chronological note indicating the screening documents where reviewed by the clinical staff. All five records had documentation indicating the SRSI and MAYSI-2 were completed in the Department's Juvenile Justice Information System (JJIS). Four youth records had documentation the mental health staff

completed the required sections of the SRSI at intake. One youth record had documentation the nursing staff reviewed the SRSI and subsequently reviewed by the mental health staff. All five SRSIs were completed in their entirety. Four youth had a response on the SRSI requiring the youth be referred for an Assessment of Suicide Risk (ASR). All four applicable youth had documentation of a referral and an ASR completed by trained mental health professionals. Four youth had documentation showing the results of their PACT and/or MAYSI-2 indicated a need for further assessment. A referral for further assessment was documented in all four records. For each youth, the superintendent/designee was notified of the need for further assessment. Four youth indicated a need for further assessment in the suicide category of either the PACT or the MAYSI-2. All four youth were placed on suicide precautions.

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

The center has a policy and procedures regarding mental health and substance abuse evaluations. Five youth mental health records were reviewed. Four youth were applicable for a comprehensive mental health evaluation. Three of the four applicable youth had not yet been in the center for thirty days and were not yet due. Two additional youth mental health records were reviewed. All three youth records had documentation of a new comprehensive evaluation completed by a community provider within thirty days of the referral and a comprehensive assessment completed by a licensed person with the community provider. For one of the youth, the mental health staff contacted the assigned juvenile probation officer when the evaluation had not been received within fourteen days of the youth's admission. The other two evaluations were received within fourteen days of the youth's admission.

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

The center has a policy and procedures regarding mental health and substance abuse treatment. Five youth mental health records were reviewed. One of the five youth was applicable for mental health and substance abuse services but refused to participate in the services. There was documentation in the youth record indicating he was refusing mental health and substance abuse services. Three additional youth mental health records were reviewed for mental health and substance abuse services. Of the three youth applicable for treatment services, all three had a treatment team, proper consent obtained for treatment, and had treatment notes documented on the Department's MHSA 018 form. All three youth had group and individual counseling according to the frequency of their individual treatment plans. Each youth record contained a signed Authority for Evaluation and Treatment (AET). Group

counseling for mental health is limited to ten or fewer youth and group counseling for substance abuse is limited to fifteen or fewer youth. An interview with the designated mental health clinician authority (DMHCA) confirms she is responsible for the daily oversight of the center to include the development of treatment plans, individual counseling sessions, and group counseling sessions. The DMHCA is also responsible to chair weekly mini-treatment team meetings. Five youth were interviewed on how they would rate the mental health and substance abuse services they are receiving. One youth rated the services as very good and four youth stated they were 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 facility. *All youth who receive mental health and/or substance abuse treatment while in a detention facility shall have a discharge summary completed documenting the focus and course of the youth's treatment and recommendations for mental health and/or substance abuse services upon youth's release from the facility.*	

The center has a policy and procedures regarding mental health and substance abuse treatment and discharge planning. Five youth mental health records were reviewed. One of the five youth was applicable for mental health and substance abuse services but refused to participate in the services. There was documentation in the youth record indicating he was refusing mental health and substance abuse services. Three additional youth mental health records were reviewed for mental health and substance abuse services. Of the three youth applicable for treatment services, one youth had an initial treatment plan within seven days of the initiation of treatment, developed on the Department's MHSA 015 form. The other two youth were not applicable for an initial treatment plan; the youth had individualized treatment plans prior to starting services. The initial treatment plan documented the reason for the referral for treatment, an initial diagnosis, initial treatment methods, initial treatment goals, and psychiatric services. The initial treatment plan included the licensed mental health professional, youth, and other treatment team signatures. All three youth had an individualized treatment plan developed by the thirty-first day after the youth's admission to the center. All three were signed by a licensed mental health professional, youth, and other treatment team members on the date the plan was developed. All three individualized treatment plans included a diagnosis, symptoms, treatment goals, strengths, and psychiatric services. One youth record had progress notes documenting the youth was receiving treatment services as stipulated on the treatment plan. The other two youth had not started the services; the individual treatment plan was created during the week of the compliance review. One of the three youth were applicable for a thirty-day review and had the completed treatment plan review in the record. The treatment plan review was signed by the licensed mental health professional and youth. The weekly mini-treatment team meeting was observed as scheduled. All three youth were receiving psychiatric services. Each treatment plan included services provided by the psychiatrist. Three closed youth mental health records were reviewed. Each youth record had a mental health substance abuse discharge summary completed upon the youth's discharge. There was documentation each summary was provided to the youth, parent/guardian, and juvenile probation officer (JPO).

3.08 Psychiatric Services [Contract Provider] (Critical)	Satisfactory Compliance

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

Psychiatric services are provided at the center by a psychiatrist who is actively licensed, with no restrictions, in the State of Florida. Their license does not expire until January 31, 2021. The center does not utilize a psychiatric advanced registered nurse practitioner (ARNP). Five youth mental health records were reviewed. One of the five youth was applicable for psychiatric services but refused to participate in services. Three additional youth mental health records were reviewed for psychiatric services. Two of the youth were admitted into the center on psychotropic medications and one was referred for psychiatric services. All three youth received an initial diagnostic interview within fourteen days of admission or a referral for services. The initial psychiatric interview included the reason for the referral, history, mental status examination, diagnostic formulation, treatment recommendations, prescribed medication, explanation for psychotropic medication, and frequency of medication monitoring. The evaluations were signed by the practitioner conducting the psychiatric evaluation and included the Clinical Psychotropic Progress Note (CPPN) page 3. The CPPNs were completed in their entirety and attempts at parent/guardian notification were documented. None of the youth had been in the center long enough to have a review of psychotropic medications. An interview with the designated mental health clinician authority (DMHCA) indicated she meets with the psychiatrist formally each week through treatment teams. The DMHCA stated she has ongoing, informal communication with the psychiatrist through email and phone conversations, as needed.

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

The center has a written plan detailing suicide prevention procedures. The plan includes the identification and assessment of youth at risk of suicide, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and review process. The plan includes staff training of six hours annually on suicide prevention and implementation of suicide precautions with quarterly mock suicide drills. The plan was reviewed and approved by the superintendent on March 8, 2018 and the designated mental health clinician authority on March 9, 2018.

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

assessment of suicide risk.

Five youth mental health records were reviewed. Four records were applicable for suicide prevention services. All four youth were determined to be at risk during admission screening. Each youth had a Juvenile Justice Information System (JJIS) alert initiated and a referral for an Assessment of Suicide Risk (ASR). Each ASR was completed on the required Department form and was documented in real time. Each ASR recommended the youth be transitioned to standard supervision. Each youth had a precautionary observation (PO) log completed in their entirety to include documented safe housing areas. Each ASR involved a qualified mental health professional. Three of the four ASRs were completed by a licensed mental health professional. The ASR completed by the non-licensed staff was reviewed by licensed clinical staff. The superintendent/designee was notified immediately of the suicide risk for each youth. Each youth was placed on PO with authorization and none of the youth were placed in secure observation. Each of the four instances were found documented in the master control logbook from the start time of PO to end time of PO. All four youth JJIS alerts were removed when the youth were removed from PO.

The superintendent has an established review process for every serious suicide attempt or serious self-inflicted injury and a mortality review for a completed suicide. The center's suicide prevention plan includes the review process. The review process includes circumstances surrounding the event, facility procedures relevant to the incident, all relevant training received by involved staff, pertinent medical and mental health services involving the victim, possible precipitating factors, and recommendations. Five youth were interviewed regarding whether or not they had been placed on suicide watch at the center. Only one youth stated he was placed on suicide watch and stated he was watched by staff the entire time. Five staff were interviewed and all five stated if a youth expressed suicidal thoughts, they would notify mental health staff. One staff stated they would search the youth and room and one staff stated they would keep the youth in constant sight and sound.

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

Five youth mental health records were reviewed for precautionary observation (PO) logs and four records were applicable. All four youth were determined to be at risk for suicide during their admission screening. All four records had documentation the PO logs were maintained for the duration the youth was on suicide precaution. The PO logs clearly documented safe housing requirements. Observations of the youth's behavior were documented in real time. Two of the four PO logs had instances where the observation of the youth exceeded thirty-minute intervals. One PO log had an observation at thirty-six minutes and an observation at fifty minutes. One PO log had an observation documented at ninety minutes. The PO logs were reviewed and signed by each shift supervisor and licensed mental health professional. Three youth were informally interviewed regarding staff presence while on PO. All three youth stated they were continually in sight of staff while on PO including during applicable sleeping times. The youth stated sleeping while on PO took place in the day room area of the module.

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.	

Five staff annual in-service training records were reviewed. All five had the required six hours of suicide prevention training. Five staff were interviewed as to the locations of the suicide response kits. All five staff stated the kits are located in master control and the medical clinic. Suicide response kits were observed to be in master control and the medical clinic. The required contents were observed in the kits. The past three quarters of mock suicide drills were reviewed. There was a total of twenty-six mock suicide drills conducted for the past three quarters. There were nine drills each on the first and second shifts and eight drills on the third shift. The center was on two twelve-hour shifts from November 9, 2018 until February 22, 2019. The remainder of the time, the center has been on three shifts daily. All applicable staff participated in a mock suicide drill for each of the three quarters with two exceptions. One staff did not participate in a mock suicide drill for two of the three quarters and another staff did not participate in a mock suicide drill for one of the three quarters. The drills included examples of obtaining the suicide response kit, contacting 9-1-1, notifying medical staff, notifying mental health staff, cardiopulmonary resuscitation (CPR) demonstrations, and automated external defibrillator (AED) demonstrations at least quarterly. The center has a process in place to track each staff's participation in a mock suicide drill each quarter. The center does not have documentation of a process to review the drills for staff who were not present during the drill.

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

The center has a written mental health crisis intervention plan which details crisis intervention procedures. The crisis intervention plan includes a notification and alert system, means of referral including self-referral, communication, supervision, documentation, and review. The plan was reviewed and approved by the superintendent on March 5, 2018 and the designated mental health clinician authority on March 7, 2018.

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

The center has a mental health and substance abuse emergency care plan which includes immediate staff response, notifications, communication, supervision, authorization to transport for mental health or substance abuse services, documentation, training, and review. The plan includes transportation for Baker Act or Marchman Act to a specified local receiving facility in Lutz, Florida. Training for the plan includes an annual review of the plan and quarterly mock

suicide drills on each shift. The plan was reviewed and approved by the superintendent and designated mental health clinician authority on March 7, 2018. The plan is kept in the superintendent's office, the medical clinic, the mental health office, and the briefing room. The plan is also accessible to all staff electronically.

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

The center has a policy and procedures regarding mental health crisis intervention services. The policy includes the documentation of a crisis assessment on the Department's MHSA 023 form. The form includes a reason for the crisis assessment, method of assessment, current mental status, degree of dangerous youth presents to the self or others related to mental health crisis, initial clinical impression, supervision recommendations, treatment recommendations, recommendations for follow-up or further evaluations, and notifications. The center has not had any crisis assessments in the past six months. An interview with the designated mental health clinician authority confirmed the form the center would use for a crisis assessment.

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.	

In the past six months, the center has not had any Marchman Acts and four Baker Acts. Three youth mental health records were reviewed for Baker Acts. All three youth were placed on suicide precautions upon readmission from receiving Baker Act services. Each youth had a referral completed for a mental status exam. For each youth, the mental status exam was completed by a licensed mental health professional and the youth were maintained on constant supervision until properly transitioned to a lower level of supervision. For each youth, the supervision level was not lowered until an assessment was completed by a licensed mental health professional and consultation with the superintendent or designee. For each youth, discontinuation of the suicide risk alert in the Department's Juvenile Justice Information System was based upon the results from an Assessment of Suicide Risk. A review of the center's policy and procedures confirmed the center followed the proper procedures.

Standard 4: Health Services

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

The center has a written policy and procedures to address the responsibility of the designated health authority (DHA). The center contracts with Maxim Healthcare Services to provide healthcare services to the youth. Through this contract, a licensed medical doctor serves as the DHA. The current DHA started working at the center one week prior to the annual compliance review; there had been another doctor assigned as the DHA during the remainder of the review period. Both doctors maintained an active, unrestricted license to practice in the state of Florida. The licenses of both DHAs expired January 31, 2021. There was documentation to support the DHA completed CPAs, sick calls, periodic evaluations and reviewed medication prescribed to the youth and ordered new medications for applicable youth. The DHA assisted in the development of the health-related policies and conducted an annual review of all medical procedures. The contract provides for a doctor to cover the administrative and clinical duties in the event the DHA is not available. The doctor who substitutes for the DHA is licensed to practice in Florida; her license expires January 31, 2021. Both doctors are available twenty-four hours a day, seven days a week. All DHAs were cleared by the background screening unit. The contract requires the DHA to be on-site weekly, and to be available for consultation twenty-four hours a day, seven days a week. The sign-in logs for the medical staff were reviewed; there was documentation to support a DHA had been on-site weekly for the past six months. The DHA was interviewed; she reported the she on-call duties were split with her medical practice partner, who is the back-up DHA. The DHA reported she had no concerns regarding the health care at the center.

The contract also requires an advanced registered nurse practitioner (ARNP) to provide medical treatment for the youth. The center's ARNP has a clear and active license, which expires April 30, 2020. There is a collaborative practice protocol in place; a copy of the protocol is maintained in the center. There is a clear supervisory relationship between the DHA and ARNP. The ARNP's duties include the completion of physical assessments, periodic evaluations on applicable youth and examinations on youth who have been referred by the nursing staff.

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

The center has a policy and procedures to address health-related protocols. The current designated health authority (DHA) was hired one week prior to the annual compliance review. The health-related policies and procedures were reviewed and signed by the previous DHA and the superintendent on June 18, 2018. The policies and procedures were reviewed by the current DHA on February 26, 2019. There was a policy to address the provision of psychiatric services and psychotropic medication monitoring; this policy was signed by the previous DHA and the superintendent on June 18, 2018 and by the current DHA on February 26, 2019. The DHA conducted an annual review of written nursing protocols. The procedures were signed by each nurse; each nurse also signed the nursing protocol acknowledgement. There are protocols for

non-healthcare staff, which provide instruction to officers when youth require medical attention when nursing staff are not on-site; these were signed by the DHA on August 23, 2018. The center hired three nurses in the last six months. There was documentation to support each nurse received orientation on the medical policies and protocols; the orientation was provided by the medical provider's regional clinical director. The orientation included information on the facility operating procedures, health services forms and quality improvement standards. There were no general corporate policies.

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.	

Five youth healthcare records were reviewed for having a complete valid Authority for Evaluation and Treatment (AET). Each of the five records reviewed contained an AET, which was signed and dated by a parent/guardian and witnessed by a Department representative. Three AETs were original documents. Two were copies and stamped indicating it was a file copy. There were no AETs applicable where the parent/guardian refused to sign or could not be located, and the center had to obtain a court order. There were no examples of youth over eighteen years of age or older; however, the center's practice is to have the youth to sign the AET themselves. AETs were obtained prior to providing medical services. None of the youth reviewed were in the custody of Department of Children and Family (DCF) youth; therefore, limited AETs were not required.

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

Five youth healthcare records were reviewed for parent/guardian notifications. Two were found to be applicable and the center supplied a third record for review. The notifications included, over-the-counter (OTC) medications not covered by the AET, continuance of medications, off-site emergency care, on-site x-ray, and new medication being prescribed. For new medication, verbal attempts/contacts were documented in the chronological progress notes in the healthcare record by the person attempting or contacting the parent/guardian. There was documentation of a witness to all telephone call attempts and conversations noted in the chronological progress notes. Notifications were also sent to the youth's parent/guardian. Any verbal notification (in person or by phone) were followed up with a written parental notification.

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

Five youth healthcare records were reviewed, and none were applicable for youth taking psychotropic medications; therefore, the center provided three additional records for review. In each record, documentation revealed notifications were sent by mail, along with page three of the Clinical Psychotropic Progress notes (CPPN), and explanatory information for the initiation

of psychotropic medication. The CPPN was signed and dated. Consent was obtained prior to the initiation of new psychotropic medication. One youth was admitted with psychotropic medication and had no changes in his medication during his stay at the center. This youth was in the custody of the Department of Children and Families (DCF) with the parent maintaining their rights. The center had a completed DCF form 5339 and a court order.

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

All five reviewed youth healthcare records included documentation to verify the youth received the appropriate immunizations. None of the youth records documented any refusals for immunizations for any religious exemptions or medical reasons. None of the youth required an immunization update. The youth's immunization histories and statuses are verified through Florida Shot Records or the youth's school records.

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

The medical and mental health admission screening form was completed on the date of the youth's admission for all five youth records reviewed. The screenings were conducted by a juvenile justice detention officer (JJDO) and reviewed by a licensed practical nurse (LPN) or higher within twenty-four hours. Each of the reviewed records documented the youth were seen within twenty-four hours by a registered nurse (RN) or LPN. The RN signs off on their review of the admission screening if completed by an LPN.

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

The center's facility operating procedures includes medical alerts, which informs staff of medical issues affecting the safety and security of youth. Three of five reviewed youth records contained conditions warranting placement on the medical alert and the youth was placed on alert. The alerts were entered at the time the youth entered the center. Dietary alerts are posted in the kitchen and master control. All alerts are read aloud during shift briefings, and staff carry an alert list with them at all times. The medical staff are responsible for ensuring the alerts are current, accurate, and entered into the Department's Juvenile Justice Information System (JJIS). All five interviewed staff reported they are informed of medical alerts through shift meetings. Two staff reported they receive copies of the JJIS alert list, which they carry with them while on shift. One staff reported the nurse supplies information to them while on the floor. One staff reported the process for conveying the alert information is very good and four staff reported it as being good.

4.09 Suicide Risk Screening Instrument [Contract Provider]	Satisfactory Compliance

A Suicide Risk Screening Instrument shall be completed within twenty-four hours of admission and filed in the Individual Health Care Record.

Five youth healthcare records were reviewed. Each had a Suicide Risk Screening Instrument (SRSI) completed within twenty-four hours of admission and filed in the mental health section of the youth's healthcare record.

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

Five youth healthcare records were reviewed, and each contained documentation the youth received an orientation to healthcare services within twenty-four hours of admission. The orientation included access to medical, sick call process, what constitutes an "emergency" and who to notify, medication process and side effect monitoring, the right to refuse care and how it is documented, what to do in the case of a sexual assault or attempted sexual assault, the non-disciplinary role of the healthcare providers and notifying staff of medical concerns. Medical staff update the healthcare orientation each time the youth is admitted to the center.

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

None of the five youth healthcare records reviewed required notification of emergency care to the designated health authority (DHA) at time of admission; however, the DHA was notified of all youth admitted to the center regardless. An additional three records were reviewed for youth who entered the center with chronic conditions and the DHA was notified within the twelve-hour requirement. One of the three additional records was for a youth who entered the center on psychotropic medications and the DHA was notified upon the youth's admission. It was noted in policy, when a youth is admitted with serious or chronic conditions, it is the responsibility of the registered nurses and licensed practical nurses to notify the DHA. Referrals to the DHA are logged in the episodic care log, contact log, sick call log, and the medical doctor/advanced registered nurse practitioner (MD/ARNP) log of patient visits. Progress notes in all reviewed records confirmed each youth was seen and evaluated.

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

The center has a policy and procedures for conducting healthcare admission re-screenings. None of the five reviewed records required a healthcare admission re-screening; therefore, an additional three records were reviewed . All three reviewed healthcare records contained documentation the center completed a healthcare admission re-screening each time the youth was re-admitted. The screenings were completed by a licensed practical nurse or registered nurse.

4.13 Health-Related History [Contract Provider]	**Satisfactory Compliance**

The standard Department Health-Related History (HRH) form shall be completed for all youth admitted into the physical custody of a DJJ facility.

The Health Related History (HRH) form was completed for each of the five youth reviewed within seven days of admission. Each HRH form was completed by a licensed nurse and reviewed by the physician or advanced registered nurse practitioner. The HRH forms were completed prior to, or at the same time as, the Comprehensive Physical Assessments and reviewed by the designated health authority. Each of the HRH forms were documented on the most recent Department form.

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

Each of the five reviewed youth healthcare records contained a current Comprehensive Physical Assessment (CPA). The CPAs were completed by the designated health authority or advanced registered nurse practitioner within seven days of admission. Each of the five CPAs were completed in full and included the youth's medical grade. The clinician wrote "deferred by clinician" for any area not completed. There were signatures from the youth indicating their refusal. Two youth were admitted with a medical grade of two or higher and they were added to the center's medical alert system. It was not necessary to update the Department's Problem List.

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

Two of the five youth records reviewed were applicable for female-specific screenings or examinations; therefore, the center provided an additional record for review. Three female youth healthcare records were reviewed. Each provided consent for pregnancy testing. One youth consented for a gynecological examination and the designated health authority provided a written order. The results of the pregnancy test were noted on the admission progress note. Youth consents were noted on the Sexually Transmitted Infections Screening form. Five youth were interviewed, and one confirmed they received prenatal, obstetrical, or gynecological services, when needed, at the center the other four stated services were not needed.

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

All five reviewed youth healthcare records contained documentation of a verified tuberculosis screening. All five youth were negative for tuberculosis. A tier 1 tuberculosis screening was completed for each youth within seventy-two hours. None of the youth required separation from the general population due to showing symptoms. The facility operating procedures indicate tuberculosis screenings are completed yearly, after an Authority for Evaluation and Treatment is acquired.

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

Five youth healthcare records were reviewed, and documented the youth were sexually active and were clinically screened and evaluated for sexually transmitted infections (STIs). No further evaluation was needed for any of the youth. Each of the youth were re-screened when out of the Department's custody for more than thirty days. Screening results, clinical evaluations, and diagnosis were documented on the Infectious and Communicable Diseases form. When a screening indicates a need for further evaluation, the medical staff obtains urine sample and the youth is placed on the list for human immunodeficiency virus (HIV) testing completed by the Department of Health. STI screening, evaluation, referral, and testing is documented in the healthcare record on the STI screening form, HIV screening form, and health education record.

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

Five youth healthcare records were reviewed, and all five contained documentation indicating the youth were offered counseling, testing, and treatment (referral) of human immunodeficiency virus (HIV). A certified HIV counselor conducted the testing and pre-and post-counseling. Three of the five reviewed youth healthcare records indicated the youth requested HIV testing. Each of the three records documented consent from the youth. Each youth's health education record contained documentation of pre- and post-test counseling. All three records contained the HIV test results filed in an envelope marked "confidential." There were no release of information forms or consents signed by youth to release their HIV information to anyone other than themselves. It was noted in the records, the choice is given to the youth to either consent or refuse testing, which is documented on the HIV consent form. HIV pre- and post-test counseling services are provided by the Department of Health. All five interviewed youth reported they could ask for an HIV test.

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

Two of the five youth healthcare records reviewed were eligible for completed sick calls. The center supplied one additional record of a youth eligible for the sick call process. The center has regularly scheduled hours for sick call posted outside the medical department and printed in the youth handbook. Sick call is conducted twice daily, Monday through Friday, on weekends daily, and as needed. Follow-up was documented, when needed. For each youth, the sick call narrative progress notes conform to professional standards and include all elements of subjective, objective, assessment, and plan (SOAP) format. Sick call requests are recorded in the youth record. None of the youth presented with a similar sick call complaint three or more times within a two-week period. One youth presented with a complaint of severe pain with which staff was unfamiliar and was seen by the advanced registered nurse practitioner. Each of the sick calls were documented on the Sick Call Index. When there is not a licensed nurse on-site, there center has procedures in place for the supervisor to review all sick call requests no longer

than four hours after a request is submitted. Five youth were interviewed, and one indicated they were seen within one day of submitting a sick call request, two were seen immediately, and two had never used the sick call process.

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

Three of the five youth healthcare records reviewed were eligible for a completed sick call. The youth signed at the time they were seen for each sick call. Sick calls were documented in the center's Facility Management System (FMS). Each of the sick calls reviewed were conducted by a registered nurse (RN). Sick call forms documented vital signs, treatment, education, and follow-up plans. Sick call request forms were filed with the progress notes in the youth's healthcare record in reverse chronological order. Sick call was observed for one youth; the youth provided verbal consent for the observation. The sick call was conducted in the medical clinic by an RN. The youth was escorted to and from the clinic by a juvenile justice detention officer; the officer was in the room during the examination of the youth, however, was far enough away to provide privacy for the youth. The nurse asked the youth about his symptoms and asked the youth about any previous history with this current medical issue. The youth's vital signs were taken and documented on the sick call complaint form. The nurse consulted the nursing protocol and offered the youth an over-the-counter medication, which the youth refused. The youth was already on the list to be seen by the advanced registered nurse practitioner (ARNP) later in the day; there was documentation to support the youth was further evaluated by the ARNP. The youth was comfortable with the sick call process. Five staff were interviewed; all reported the nurses conduct sick call. Five youth were interviewed; two youth reported never having a sick call. Two youth reported being seen by a nurse immediately upon submitting a sick call request; one youth reported being seen within one day. All of the youth reported sick call was conducted by a nurse, and one youth reported sick call was conducted by a doctor.

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

The center has a policy and procedures addressing the use of restricted housing. Nursing progress notes for three youth in confinement were reviewed. Nursing staff made daily visits to ask about any health-related concerns and documented this in the youth record and on the confinement reports. When the nursing staff provided treatment, a detailed entry was completed. Youth in restricted housing received all medications, as ordered. A review of documentation confirmed youth in confinement had timely access to medical care.

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

The center has a policy and procedures to address episodic and first aid care for youth in the center. Four examples of episodic/first aid care were reviewed. Each instance was conducted by healthcare staff and conformed to professional standards. Standard narrative charting was used and contained all required elements. There is an on-site tracking log for episodic care and each episodic event was documented. The policy includes the approved list of items required to

be in the center's first aid kits. There are fourteen first aid kits located in various areas throughout the center. Three first kits (transport van, master control, and the kitchen) were reviewed. All of the kits were sealed, and each kit contained all required items. Each first aid kit contained alcohol wipes; however, all of the wipes in the kitchen's first aid kit expired in October 2017. In the remaining two kits, some of the wipes had also expired in October 2017, while other wipes did not contain an expiration date. Wipes in all kits were removed and replaced while the annual compliance review team was on-site. The first aid kits were inventoried monthly by the center's medical records clerk and all inventories were documented on a log. It was noted there were no items in the first aid kits which were sensitive to extreme heat.

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

The center has a policy and procedures to address emergency care for the youth, which requires all staff to contact 9-1-1 in the event of a potentially life-threatening situation involving a youth. The policy further requires medical emergency drills be conducted quarterly on each shift. All staff are required to maintain certifications in first aid, cardiopulmonary resuscitation (CPR), and automated external defibrillator (AED). The training records for ten staff were reviewed for receipt of pre-service and in-service training requirements. There was documentation in all reviewed records to support training in emergency care; each staff had current certifications in first aid, CPR, and AED. There was documentation to support supervisory staff had been trained in the use of an Epi-pen. Each nurse had current first aid and CPR certifications. A list of emergency telephone numbers, including poison control, is posted in the medical clinic.

The nurse consultant for detention services sends an email to each detention center at the beginning of each month, to provide the scenario for the monthly medical drill. There was documentation to support the center conducted monthly medical drills on each shift for the past six months. Each drill was documented on a drill reporting form, which included the type of drill, time/date/shift of drill, response time and the scenario; there was a space for recommendations for improved emergency response and reviewer's comments and suggestions, only one drill form contained recommendations or suggestions. Each drill form was reviewed and signed by the shift supervisor, the superintendent, and a nurse. The list of each staff participating in each drill was attached to each drill form. The center conducted drills for head injury, insect sting, tooth knocked out, shortness of breath, chest pains, bloody nose, pregnancy complications, chocking, and arm pain. Two drills demonstrated the use of CPR. One drill form did not contain a scenario, rather contained instructions of what staff should do. Seven drills documented the response time of the medical staff.

The center currently has two AEDs; one AED is in the clinic, and one is in master control. Prior to October 2018, there was only one AED, which was in the medical clinic. There was documentation to support the AED in the clinic was checked monthly to ensure the device remain charged and operable; this check was documented until October 2018. The checks were documented on the AED maintenance and inspection log. Upon the receipt of the second AED, the checks were continued; however, the form did not indicate the location of the AED which was checked and appeared to have been a check of one AED. The regional clinical director reported the checks were completed, however, the form completed to indicate both were checked. A new form will be developed which will include the location of each AED, and the date each was checked. The AEDs do not require the removal of the batteries to ensure the

device remains charged and operable. A check of both devices confirmed the green light was on, indicating each was operable. The battery in the AED in the medical clinic expires in April 2022; the pads expire in January 2019. The battery in the AED in master control expires in January 2023; the pads expire in December 2019. Five staff were interviewed and all five reported being able to call 9-1-1 in the event of an emergency.

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

The center has a policy and procedures to address the provision of off-site treatment to youth, which requires the center to have an arrangement with a local hospital to provide emergency services for the youth twenty-four hours a day, seven days a week. Five healthcare records were reviewed; none of the youth were applicable for being taken off-site for treatment. The center provided three additional records of youth requiring off-site treatment for review. The youth were taken off-site for shortness of breath, pregnancy complications, and hip and facial injury resulting from a youth altercation. The center notified the designated health authority (DHA) for each youth taken off-site. A Summary of Off-Site Care form was completed for each instance of off-site care. The discharge paperwork was filed in the applicable youth's healthcare record. The DHA or their designee initialed the paperwork to document their review of discharge instructions for the youth. One youth required follow-up treatment; this was documented, as required. All three instances of off-site treatment were documented on the center's episodic log.

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

Two of the five reviewed youth healthcare records warranted placement on the chronic conditions list. An additional three records were provided by the center for review. Four youth were classified with a chronic condition, two were taking medications for a period of three months or more, and all four were classified as a medical grade two or higher. There were no indications of lapses in care for four of these youth. Two youth had an evaluation completed prior to the renewal of prescription medications. The Department's Problem List was updated for each youth and the completed evaluations were documented in the youth's Individual Healthcare Record. The center monitors youth with chronic conditions by placing them on the chronic conditions roster. Protocol requires youth with chronic conditions to be seen every thirty days, if the youth are still at the center.

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

One of the five reviewed youth healthcare records were applicable for medication verification; therefore, the center provided two additional records for review. A review of documentation revealed each youth's medication regimen was ascertained upon admission to the center. Policy requires the process for verifying medications upon a youth's admission to the center is to contact the pharmacy or doctor who prescribed the medications. Only medications from a

licensed pharmacy with a current, patient-specific label intact on the original medication container were accepted into the center. Documentation of prescription verification process is in the youth record and completed by medical staff. At no time did non-licensed medical staff verify a medication or assist the youth in self-administration. The licensed nurse obtained an order from the designated health authority to resume the medication in the three applicable records.

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

Five youth healthcare records were reviewed, of which one was applicable for medication orders or prescriptions. The center provided two additional records for review. All medications had a current, valid order, and were given pursuant to a current prescription. There was documentation by the designated health authority in the youth records of medications to be continued, and new medications ordered after the youth's admission to the center.

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

The center has a policy and procedures regarding the storage of medication and items defined as sharps, which requires all medications to be stored in separate, secure areas which are inaccessible to youth. The policy includes a process for the destruction and disposal of applicable medications. All medications were stored in the medical clinic; the clinic was noted to be clean and well organized. The locked medication cart contained a working supply of over-the-counter (OTC) medications, as well as the prescription medications for the youth. The medication cart had separate drawers in which various types of medications were stored; the cart was always kept in the locked clinic. There were bulk OTC medications stored in locked cabinets in the clinic. All medications are inaccessible to youth. There were narcotics and a controlled medication on the medication cart; the controlled medication was behind two separate locks. There was a locked refrigerator in the clinic for medications and medical supplies requiring refrigeration; an observation of this refrigeration confirmed the placement of only medical supplies. There were sharps placed in the locked cabinet in the clinic. There was documentation to support the program followed their policy regarding the disposal of medications. During the annual compliance review, bio-hazardous waste was observed being removed by an outside contractor.

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

The center has a policy and procedures regarding the storage of medication and items defined as sharps, which includes procedures to follow in the event of any discrepancies in the counts of medications and sharps. The stock over-the-counter (OTC) medications and all sharps were maintained in the clinic. There was a locked medication cart which contained a working supply of OTC medications, as well as the prescription medications for the youth. The center securely maintained all bulk OTC medications, syringes, and sharps in the clinic. There were weekly and perpetual counts of the sharps and the OTC medications completed by the nurses. The

inventories for the past six months were reviewed; there were no discrepancies noted for the past six months. During the annual compliance review, the counts of three sharps, including ultrafine needles, scalpels, and scissors, were matched against the current inventory; all counts matched the inventory. Three OTC medications were inventoried and all three items matched the current inventory. Three stock prescription medications were counted; all matched the current count of the medication.

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

The center has a policy and procedures regarding the management of controlled medications, which includes a procedure for conducting shift-to-shift counts. All medications were maintained in a locked medication cart. Shift-to-shift counts of controlled medication were consistently documented on the applicable youth's Controlled Medication Inventory Record. The controlled medications were stored behind a second lock on the medication cart. At the time of the annual compliance review, one youth was taking a controlled medication. A shift-to-shift count of the controlled medication was observed; there were no exceptions noted. The Controlled Medication Inventory Record for two youth previously admitted to the center were reviewed; each record documented the date and time the medication was administered, the perpetual count and the number of pills following the medication administration. There were shift-to-shift counts documented on each record for each shift; the counts included the initials of the nurse and supervisor completing the count.

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

Five youth healthcare records were reviewed, of which one was applicable for medication administration. The center provided two additional records for review. The standard Department form was utilized to document medication administration. The Medication Administration Record (MAR) contained all required elements including the youth's name, Department identification number, date of birth, youth allergies, precautions, medical grade, medical alerts, and current picture of the youth. For youth taking medication upon admission, the initial MAR matched the medication list. There were no special circumstances where youth appeared overmedicated or medications had to be held. The MARs indicated the medication start and stop dates. Nursing staff and youth initialed each administered medication entry. The MAR indicated the youth received medications, as ordered. There were no indications of lapses or error in medication administration. The nursing staff documented weekly side effect monitoring on the MAR. Of the three MARs reviewed, there were no refusals of medications.

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

The center has a policy and procedures to address the medication administration process. The policy requires the medication delivery and supervision to be the sole responsibility of the nurse

during medication administration. Nursing staff do not conduct or supervise any other activity during this time. Most of the medications are administered to the youth by licensed healthcare staff. Five healthcare records were reviewed; there were no youth requiring the administration of parenteral medications. In October 2018, there was a call to the Central Communications Center to report a youth who did not receive her morning medication. The designated health authority was contacted; the youth was not exhibiting any adverse effects. The center provided corrective action for the nurse responsible. During the annual compliance review, the medication administration process by a licensed nurse was observed for seven youth. Inside the clinic door, there is a counter; the medication cart is located on back side of the counter. The youth were escorted to the clinic by a juvenile justice detention officer (JJDO); each youth was brought to the clinic separately. The youth and the JJDO stood on one side of the counter, with the nurse on the other side, with the medication cart. Each youth provided verbal consent for the observation of the medication administration. The youth were asked their name, the medication they were taking, and how the medication was working. The nurse's sole responsibility was to provide the medication, as the JJDO provided supervision of the youth. Each youth was provided a small paper cup containing the medication and a larger cup of water. After the youth swallowed the medication, the nurse had the youth open their mouth, then cough, to verify the youth swallowed the medication. The nurse and each youth initialed the Medication Administration Record. All youth were comfortable with the medication administration process. There were no pre-poured medications noted. Five youth were interviewed; four youth reported the nurse administers their medication and one youth reported not taking any medications

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

The center has a policy and procedures to address the medication administration process. The policy allows for trained non-healthcare to assist youth in self-administration of medications when licensed nurses are not available. There was a list of trained non-healthcare staff to assist youth in the self-administration of medication. The list identified staff by name and title; the list also documented the date of the training, and the date the training expired. The medication administration process by non-licensed staff was not observed during the annual compliance review. Five healthcare records were reviewed; there were no examples in which non-medical staff provided over-the-counter (OTC) medications to the youth. The Medication Administration Records (MAR) of three youth in which non-healthcare staff assisted in the administration of medication were reviewed. Each applicable MAR documented a supervisor assisted the youth with OTC medication. Each dosage was initialed by the youth and the supervisor. There was documentation to support the supervisor had been trained by the registered nurse. Five staff were interviewed; four reported they did not provide medication to youth and one staff reported assisting youth with medication.

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

Five youth healthcare records were reviewed, of which one youth was applicable for prescribed psychotropic medication. An additional two youth records were reviewed for psychotropic medication monitoring. All three youth were admitted with psychotropic medication and the appropriate notifications were made. The medications for all three youth were continued until an initial diagnostic psychiatric interview was conducted within fourteen days of admission. One youth was prescribed a psychotropic medication after admission and an initial diagnostic psychiatric interview was conducted within fourteen days. Two youth received a referral to see the psychiatrist by the mental health staff within twenty-four hours of admission. The licensed nurse monitors youth for side effects, on a weekly basis.

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

The center has a combined infection control and exposure control plan. The plan included all required elements, including the following: common, infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, tuberculosis, hepatitis A, B and C, human immunodeficiency virus (HIV), infectious diseases, other outbreaks or epidemics caused by any other infectious agent, outbreaks of pediculosis, and/or scabies, methicillin-resistant staphylococcus aureus (MRSA), food-borne illnesses, bio-terrorist agents and chemical exposure in the workplace. The plan was reviewed and signed on July 5, 2018 by the previous designated health authority (DHA) and the superintendent. The plan was signed by the current DHA on February 26, 2019. The plan addresses requirements for staff training, hepatitis B vaccination and post-exposure follow-up. During pre-service training, staff are provided information regarding hepatitis B immunizations; there was no documentation to support any staff requested immunization since the last annual compliance review. There have been no reportable incidents to the local county health department and/or Centers for Disease Control since the last annual compliance review. There are spill kits, and personal protective equipment such as bio-hazard bags, gloves, gowns, and masks available to the staff.

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

All five reviewed youth healthcare records reflected the youth received infection control training within twenty-four hours of admission. Each youth received specific training in hand-washing techniques, universal/standard precautions, prevention/transmission of communicable diseases, and vaccinations. Five pre-service and five in-service staff training records were reviewed and reflected each staff received training in infection control, exposure control, and blood borne pathogens upon.

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

The center has an exposure control plan. The plan addresses risk assessment, including a list of all job classifications in which there is the potential for occupational exposure, and a list of tasks which would cause staff to have exposure. There are methods of compliance, which include infection control practices, engineering control practices, definitions, personal protective equipment, post exposure evaluation, bloodborne pathogens training, post exposure prophylaxis and the hepatitis B vaccination program. The plan is located in the medical clinic and is available for staff to consult. The plan was reviewed by the previous designated health authority (DHA) and the superintendent on July 5, 2018. The plan was reviewed by the current DHA on February 26, 2019. There was training on the center's exposure control plan; the training was provided annually by the center's registered nurse.

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

The center has a policy and procedures to address care of pregnant youth. The policy includes notification requirements, and specialized care to be provided for pregnant youth. Five healthcare records were reviewed; none were applicable. There have been three pregnant youth in the center since the last annual compliance review; documentation was reviewed for all three youth. The designated health authority (DHA) was notified of the admission for all three youth; prenatal care began immediately for all three youth. The DHA ordered pre-natal vitamins for all three youth; there was documentation to support the vitamins were provided daily to one youth for the nineteen days she was in the detention center. The remaining two youth had been sent to a residential program, therefore their medical records were not available for review. During the daily administration of vitamins, the center reported the youth would be monitored for danger signs of pregnancy complications. None of the three youth were in the center long enough to receive a focused medical evaluation. One youth was sent to the emergency room for medical issues related to her pregnancy; upon her return to the detention center, she was examined by the DHA. The remaining two youth were released within four days of their admission to the center. There was no need to document a plan for post birth care for any of the youth.

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

The center has a policy and procedures to address care of pregnant youth; the policy requires pregnant youth to receive specific pre-natal education. The policy also addresses nutrition related to pregnancy; the policy requires monitoring of the youth's nutrition and weight. The center is to make dietary adjustments for youth experiencing morning sickness or who are lactating. The center has a binder of education topics related to pregnancy to be presented to pregnant youth. Five healthcare records were reviewed; none was applicable. There were three pregnant youth in the center since the last annual compliance review; information was reviewed for all three youth. There was documentation to support of the receipt of pregnancy related education, including alcohol and drug use, smoking, nutrition, sexually transmitted infections,

contraception, pre-natal care, birthing process, post-partum care, basic baby care, shaken baby syndrome, child development/milestones, health and nutrition, anxiety/depression, and parenting skills. The education was documented on the Health Education Record for each applicable youth.

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

The center has a policy and procedures to address the care of pregnant youth, which includes training requirements. The training records of five staff were reviewed for the receipt of annual, in-service training. There was documentation to support all five staff received training on monitoring, observation and emergency care of the youth. The training was provided by a registered nurse.

Standard 5: Safety and Security

5.01 Active Supervision of Youth (Critical)	Satisfactory Compliance

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

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

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

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

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

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

The center has a policy and facility operating procedures which address the active supervision of youth. During the four-day annual compliance review, staff supervision of the youth was observed by the review team. Observations determined the staff were appropriately supervising the youth in their care. Youth were observed during meals, medication pass, transitioning between activities, participating in school, and preparing for transport. Observations revealed youth were in sight of at least one juvenile justice detention officer (JJDO) at all times. Also, youth were accounted for and always accompanied by staff. JJDOs were in contact with master control utilizing their radios regarding youth movement and ensuring the movement was authorized by master control prior to the youth being moved. Interactions between staff and youth reflected active supervision as staff were positioning themselves to be able to observe the youth and respond if needed. A review of the center's logbooks further revealed the center consistently conducted resident counts at the beginning and end of each shift, as well as periodically during the shift.

Five staff were interviewed regarding the methods by which counts are reconciled. One staff indicated staff keep counting until the missing youth is accounted for, one responded youth movement will stop and sometimes a supervisor will walk around the center to get the actual count, and another staff stated if you miss a youth during count all movement stops and staff calls in all counts. All five interviewed staff reported they do not believe the center has enough staff to provide for the safety and security of the youth and staff. Four stated this is due to vacancies and one stated due to lack of staff training the youth could easily take over the center.

In the past six months, there were three reports made to the Central Communications Center (CCC) in which improper supervision was substantiated. On August 28, 2018, a call was substantiated for improper supervision due to a youth being able to pierce her eyebrow at the center. On September 5, 2018, a call was substantiated for improper supervision as two youth

were engaged in inappropriate behavior at the center. On December 18, 2018, a call was substantiated for failure to report contraband when parts of a JUUL (vape pen) were recovered.

5.02 Ten-Minute Checks (Critical)	Satisfactory Compliance

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

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

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

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

The center has a policy and procedures for conducting observations of youth while they are in their sleeping rooms. Policy requires youth to be observed every ten minutes while in their rooms. The center has fifty-four cameras, and all are operational. Video recordings are stored for thirty days. The center uses an electronic wand system which records the actual time the room checks were conducted. Ten-minute checks were reviewed for six different days at various times. A total of six and half hours were reviewed. Checks were completed, as required, with minor discrepancies. Video review revealed staff stopped at each door to observe the youth. Late checks were observed on video for Bravo on February 7, 2019, in which the check was two minutes late, and on February 5, 2019, in which two checks were two minutes late. Alpha module had five late checks conducted on February 13, 2019 ranging from one to four minutes late, and two late checks conducted on February 1, 2019 which were four and eight minutes late. Documentation reflected random checks of the video and wand reports are reviewed to ensure the checks are conducted within ten minutes, and discrepancies are forwarded to supervisors to review with their staff. Five staff were interviewed and each reported room checks are completed every ten minutes when youth are in their rooms for sleeping or non-punishment reasons.

5.03 Census, Counts, and Tracking	Satisfactory Compliance

Officers must know the exact number and location of all youth under their supervision at all times. Census counts of youth shall be taken, called into Master Control, and documented, at a minimum:

- *At the beginning and end of each shift.*
- *Following any emergency to include power outages, evacuation due to emergency drills, and any code called outside the secure walls. In the event a code is called in any location outside the main walls of a facility, it is critical all youth counts are reconciled prior to the movement of any group of youth.*
- *Prior to and following routine group movement.*
- *Any time a population change occurs.*
- *Randomly, at least once on each shift.*

Staff should not include youth in the count who are not physically present with the staff person at the time of the count (e.g., court, clinic, confinement).

The center has a policy and procedures regarding the census, counts, and tracking to assure staff know the exact number and location of all youth under their supervision at all times. Master control logbooks and logbooks which are maintained on each module were reviewed for the past six months. The daily census counts, new admissions, releases, and transfers were tracked in the master control logbook. A review of the logbooks confirmed formal counts were conducted at the beginning and end of each shift, prior to and following routine group movements, when a population change occurs, and randomly on each shift. Unscheduled counts were also documented following disturbances and drills at the center. As part of the observations during the course of the annual compliance review, counts were observed routinely occurring. Interview results reflected all five interviewed staff reported emergency counts are conducted when a youth is believed to be missing and when visibility is hindered, four reported after a major disturbance, one stated after a drill, and one during weather emergency.

5.04 Logbook Maintenance	**Satisfactory Compliance**

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

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

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

The center has a policy and procedures which addresses logbook maintenance and documentation of events which occur at the center. The center maintains a master control logbook, and a logbook for each living module. Each logbook was bound with numbered pages with the date documented at the top of the page. All entries reflected the time of the event in a.m./p.m. format with the name of the staff, youth involved, a brief description of the event, and the initials of the staff making the entry. There was one entry of those reviewed in which it was noted a youth was placed on close watch; however, the youth's name was not included in the entry. Most entries impacting the safety and security of the center, including medical/special needs and mental health alerts, were highlighted with the exception to this being the logbook for Bravo module. Errors were struck through with a single line, dated, and initialed by the staff correcting the error.

Master control logbook entries included emergency situations, incidents such as contacts to the Florida Abuse Hotline and the Central Communications Center (CCC), drills, documentation of medical/mental health alerts, population counts at the beginning and end of each shift and throughout shifts as counts change, group movement, admissions and releases, presence of

law enforcement, youth placed in confinement, and youth placed on precautionary/secure observation.

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

The center has a policy and procedures regarding logbook reviews. Master control logbooks and living module logbooks were reviewed for the past six months. Documentation reflected the superintendent toured the center during each shift and reviewed all logbooks on a weekly basis. Juvenile justice detention officer supervisors (JJDOS) reviewed the facility logbook maintained in master control when assuming center responsibility. The JJDOS reviewed logbooks maintained in each living module when accepting responsibility for the module at shift change.

5.06 Key Control	Failed Compliance
Each facility is responsible for maintaining inventory and control of all facility keys. *All keys shall be placed on a tamper-resistant key ring designed to inhibit the removal of keys.* *Emergency key rings shall be maintained separately from other facility keys, in master control, in a secure location designated by the Superintendent. These keys shall be notched or otherwise identifiable by touch.* *The key(s) on these rings shall provide egress through facility exterior doors providing access to evacuation areas.* *A key inventory shall be maintained by the Superintendent or designee at all times.* *(For the entire indicator statement, please reference the Monitoring and Quality Improvement FY 2016-2017 Detention indicators.)*	

The center has a policy and procedures regarding key control. In September 2018, the center's electrical panel caught on fire in the master control area, which previously, master control staff utilized to operate the locks for all of the center's doors. The doors are only operable if staff have the appropriate key corresponding to the door. According to the center's administration, the control panel is to be fixed in April or May 2019. Due to the control panel being down, and some key rings only containing keys to interior doors, the center placed a key in the window of master control for staff to be able to let themselves out of the secure area (staff must pass through one locked door before reaching the area where the key is available to open the remaining locked door which leads out to the lobby).

Observations were made in master control which revealed the key storage area is secure and center keys are maintained on a temper resistant ring. Master control maintains a key inventory sheet which, as observations were made, did not match the keys currently signed out. The master key inventory does not contain the time the key was signed out or signed back in. The center also maintains a key inventory logbook which contains the time the key was signed out and signed back in; however, several days were reviewed and the comparison of the key inventory sheet and key inventory logbook revealed discrepancies in who several sets of keys were signed out to. At times, multiple people were listed as being assigned the same set of keys. All staff who are issued keys carry the keys on them at all times, do not allow youth to handle center keys, and do not remove keys from the center. Personal keys belonging to staff or anyone entering the secure area, are secured prior to entering the secure area. Five staff were randomly checked to determine if they had their personal keys; they were each only in possession of center keys. Youth do not have access to the center's keys.

In the past six months, there were no reports of lost or missing center keys. Observations during the annual compliance review revealed multiple occurrences where one staff was supervising a group of youth and were not in possession of a key ring with egress keys to effectively escort the youth out of the building in case of emergency. These observations occurred while staff prepared youth for transport (a third staff had to be called to intake to open the doors, so the staff and youth could enter the van and depart), staff supervising youth in the classroom, and staff escorting youth between activities. Additionally, supplemental interviews with staff indicated staff do not maintain control of the keys they are assigned and are instead trading off keys with the oncoming shift, leaving master control unaware of who is assigned which set of keys.

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

The center has a policy and procedures regarding transporting youth, which also addresses the maintenance and operation of vehicles used for transport. The center has eight multi-passenger vans used for youth transportation. Each vehicle was inspected. The vehicles were all locked when not in use. The vehicles were equipped with the appropriate number of seat belts, seat belt cutter, window punch, fire extinguisher, and a first aid kit. Prior to the vehicles being used, documentation reflected vehicle inspections were completed and included a check of the presence of leaking fluid, inflation of tires, excessive or uneven wear of tires, presence of objects hanging down from carriage, damage to windshield or windows, damage to mirrors, damage to headlights, turn signal, or tail lights, worn belts, low oil or steering fluid, seatbelts work properly, any unusual noises coming from the vehicle, and any other items needing to be reported. Documentation also reflected all vehicles underwent an annual vehicle inspection. Additionally, maintenance staff conducted weekly visual checks of each transport van including the water coolant, lights, oil, emergency equipment, brakes, horn, interior/exterior, and cleanliness. Maintenance also conducted a monthly check of each vehicle including the tires, battery, windshield and wipers, windows, mirrors, and damage.

A transport was observed which reflected the vehicle was searched prior to use, youth were searched prior to transport, and the youth and staff wore seatbelts. Prior to the observed

transport, staff completed an inspection of the van for contraband, ensured the vehicle had enough gasoline for the trip, verified seatbelts were securely anchored, tested the security screen, confirmed the vehicle folder contained the vehicle logs, vehicle and mechanical restraint keys, gas credit card, and vehicle registration, ensured a cell phone was assigned, and ensured the inspection was documented in the vehicle logbook.

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

The center has a policy and procedures regarding tool inventory and management. Tools are stored in a building which is separate from the center and requires authorized key access. All maintenance tools are stored in this locked area when not in use. Tools were all marked with an identification code identifying the tool as property of the Department. Perpetual inventories were reviewed and reflected they were maintained appropriately and signed by the superintendent. There were no tools listed on the inventory which were missing and no tools present which were not on the inventory. All tools were displayed on a shadow board with a number corresponding to the inventory sheet. Monthly inspections of the tool area were also completed, and the results were submitted to the superintendent. Maintenance staff confirmed if tools are lost, or following the completion of a work project, the area is cleaned and inspected for contraband prior to allowing youth access. Maintenance staff explained if a tool was missing or damaged, a missing/damaged tool form would be completed and submitted to administration.

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

The center has a policy and procedures regarding kitchen tools. The inventory of kitchen tools was reviewed and compared to the actual kitchen tools on-site and determined to be accurate. Kitchen staff were familiar with the procedures regarding kitchen tools, stating youth were not authorized to be in the kitchen, and they were aware of the forms to completed if a kitchen tool was damaged. Kitchen knives and sharps were observed stored locked in a cabinet on a shadow board containing an inventory sheet. Documentation reflected kitchen staff conducted an itemized inventory of all equipment, including knives and other implements, upon reporting for duty and prior to their departure. Kitchen knives and sharps were accounted for daily. A review of the inventory of kitchen tools and the actual kitchen tools on-site revealed no discrepancies.

5.10 Youth Access & Use of Tools, Cleaning Items (Critical)	Satisfactory Compliance
Youth are forbidden to use or access any tools, including kitchen or medical equipment.	

Youth may use cleaning items such as mops, brooms, buckets, and other common household items under direct supervision.

The center has a policy and procedures regarding youth access to and use of tools and cleaning items. Chemicals are secured in locked areas inaccessible to youth. During the annual compliance review, none of the youth were observed using cleaning tools. Under direct staff supervision, youth may use cleaning items such as mops, brooms, and other common household items.

Five youth were interviewed regarding access and use of tools and cleaning items. All five reported they are permitted to use brooms and mops, and one reported also being permitted to use scrub brushes. All of the youth also indicated they are not allowed to clean with bleach, laundry soap, window, or toilet cleaner. Five staff were interviewed and all five reported youth are only allowed to use brooms and mops, and four staff stated youth may also use scrub brushes.

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

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

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

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

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

The center has a policy and procedure which addresses the inventory of all flammable, toxic, caustic, and poisonous items. The center's flammable, toxic, caustic, and poisonous items are stored in locked areas which are not accessible to the youth. The center maintains an inventory of all flammable, toxic, caustic and poisonous items which matches the actual items on-site. Safety Data Sheets (SDS) were observed posted near the items and available to staff. There was a SDS for each item.

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

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

Youth shall not be permitted to use, handle, or clean-up dangerous or hazardous chemicals or respond to chemical spills. Youth shall not be permitted to clean, handle, or dispose of any other

person's bio hazardous material, bodily fluids, or human waste.

The center has policy and procedures regarding access to flammable, toxic, caustic, and poisonous items. These items are stored in a locked building not attached to the center, and therefore, inaccessible to youth. This area is restricted to maintenance and administration staff. Five youth were interviewed and reported they do not clean with any type of cleaning agent such as bleach, window, or toilet cleaner. Five staff were interviewed and confirmed youth are not allowed to clean with substances which are toxic, flammable, or poisonous.

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

The center has a policy and procedures regarding the disposal of flammable, toxic, caustic, and poisonous items. In the last six months, the center has not had any instances of chemical spills. The center has a contract with a company to dispose of flammable, toxic, caustic, and poisonous items. The center uses another company to remove fats, oils, and grease generated in the kitchen. In the last six months, there have been no instances of chemical spills.

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

The center has a policy and procedures which address confinements under twenty-four hours. In the past six months there were 136 confinements under twenty-four hours. Thirteen of these were reviewed. Youth in confinement are afforded living conditions approximating those available to the general population including education, showers, meals, and bedding. Youth in confinement have no contact with the general population while engaged in the above activities. Of the thirteen reports reviewed, twelve reflected the room was searched prior to placement. All thirteen reports were completed within one hour and submitted to the juvenile justice detention officer supervisor (JJDOS) and the JJDOS reviewed these reports within two hours for fairness and appropriateness. In twelve of the reports, the JJDOS reviewed the report and spoke with the youth every three hours afterward. Twelve of the thirteen reports reflected the superintendent or designee reviewed the confinement within forty-eight hours. One confinement report indicated the youth room was not searched. One report reflected the JJDOS conducted their review one hour late, and one report the superintendent conducted his review two days late.

5.15 Confinement Over Twenty-Four Hours	Limited Compliance
Confinement beyond twenty-four hours must be approved by the Superintendent or designee. *The Superintendent shall approve confinements extended beyond twenty-four hours and every twenty-four hours afterwards. Reasons for extended confinement must be clearly documented on the confinement report.*	

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

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

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

Five confinement reports over twenty-four hours were reviewed. All five reflected the room was searched prior to placement and the confinement was approved by the superintendent or designee. Two of the five confinements were approved every twenty-four hours. The juvenile justice detention officer supervisor (JJDOS) documented the three hour evaluation and conversation in a timely manner in four of five reports. The JJDOS conducted the three hour evaluation and conversation late on four occasions for one youth (six hours, ten minutes, forty-five minutes, one hour fifteen minutes). Documentation did not support the confinement of three youth over twenty-four hours was approved by the Regional Director. Two confinement reports did not contain documentation the youth was seen by a mental health professional while in confinement; however, documentation in the mental health chronological notes reflects staff did see the youth. A mental health professional reviewed the status of the youth in confinement in two of the five reports reviewed on the confinement report documentation. Two reports didn't document the mental health professional's review and one youth's confinement report contained a note entered by mental health staff six days after the youth was released, reflecting the review was late because they were unaware the youth was in confinement.

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

The center's Disaster Preparedness Plan was reviewed. The center has a Continuity of Operations Plan (COOP) to ensure the center is prepared to manage emergency and disasters. The center conducts two COOP drills a year. A hurricane drill was conducted April 30, 2018, prior to the start of hurricane season. The next COOP drill was conducted on October 10, 2018 in response to Hurricane Michael. There was no corrective action noted for either of the COOP drills. Five staff were interviewed and three reported participating in weather drills and one in a bomb threat drill.

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

The center has a policy and procedures related to escape prevention. Documentation reflected the center conducted escape drills on a quarterly basis. A review of five training records reflected staff received escape prevention training annually. Logbooks contained documentation of when escape drills were conducted. Drill documentation was reviewed and reflected the drill report provides details of the drill and a critique of the drill. Four of five interviewed staff stated they participated in an escape drill within the past six months. One interviewed staff did not recall participating in an escape drill in the past six months.

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

The center has a disaster preparedness plan which addresses fire safety and prevention. The center maintains documentation of all fire drills. A review of these drills confirmed the center conducted monthly fire drills on each shift, in accordance with Florida Administrative Code. A review of fire drill reports and staff sign-in sheets showed drills occurred on all shifts, as well as a description of the scenario, and critiques of the staff's performance during the drill.
The center has egress plans which are posted throughout the center showing primary and secondary evacuation routes, location of fire extinguishers, and all exits. The center also provided documentation of the center's fire safety plan which was reviewed and approved by the fire marshal.

Program Name: Pasco Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: Pasco County / Circuit 6
Review Date(s): February 26-March1, 2019

MQI Program Code: 363
Contract Number: N/A
Number of Beds: 36
Lead Reviewer Code: 146

Overall Rating Summary

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

Limited Ratings	Failed Ratings
2.13 Daily Activity Schedule	5.06 Key Control
3.11 Suicide Precaution Observation Logs	
5.15 Confinement Over Twenty-Four Hours	