STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

PROGRAM REPORT FOR

Pinellas Regional Juvenile Detention Center

"Department of Juvenile Justice"

(State-Operated)

5255 140th Avenue North

Clearwater, Florida 33760

Review Date(s): August 14-17, 2018

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:

Paul Sheffer, Office of Program Accountability, Lead Reviewer (Standard One)
Teresa Andersen, Office of Program Accountability, Deputy Supervisor (Standard 3)
Donna Connors, Office of Program Accountability, Regional Monitor (Standard 4)
Toni DelRegno, Office of Program Accountability, Regional Monitor (Standard 5)
Jennifer Jones, Pasco Regional Juvenile Detention Center, Juvenile Justice Detention Officer Supervisor (Standard 2)
Joey Nice, Office of Education, Education Coordinator (Standard 2)

Program Name: Pinellas Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: Pinellas County / Circuit 6
Review Date(s): August 14-17, 2018

MQI Program Code: 364
Contract Number: n/a
Number of Beds: 100
Lead Reviewer Code: 118

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
- **3** # Clinical Staff
- **2** # Food Service Personnel
- **2** # Healthcare Staff
- **2** # Maintenance Personnel
- **4** # Program Supervisors
- **4** # Other (listed by title): **Regional Clinical Supervisor for Camelot, Regional Nursing Director for Maxim, both assistant superintendents**

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
- **13** # Health Records
- **16** # MH/SA Records
- **13** # Personnel Records
- **18** # Training Records/CORE
- **3** # Youth Records (Closed)
- **9** # Youth Records (Open)
- _____ # Other: _____

Surveys

- **9** # Youth
- **9** # Direct Care Staff
- _____ # Other: _____

Observations During Review

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

Comments

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

Standard 1: Management Accountability
Detention Rating Profile

Indicator Ratings

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

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

Standard 2: Youth Management
Detention Rating Profile

Indicator Ratings

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

* 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	Satisfactory
3.12	* Suicide Prevention Training	Failed
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	Failed
5.03	Census Counts and Tracking	Limited
5.04	Logbook Maintenance	Failed
5.05	Logbook Reviews	Limited
5.06	Key Control	Limited
5.07	Vehicles and Maintenance	Satisfactory
5.08	Tool Inventory and Management	Limited
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	Limited
5.12	* Access to all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.13	Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.14	Confinement Under Twenty-Four Hours	Limited
5.15	Confinement Over Twenty-Four Hours	Failed
5.16	Continuity of Operations Planning (COOP) Drills	Limited
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).

Overall Rating Summary for Standard 5

This standard has received a standard-level rating of Failed, a follow-up review of the program shall be conducted within six (6) months of publication of the program report.

Strengths and Innovative Approaches

- A local Judge Conducts Boys (Build Optimal Youth Success) Court, where eight male youth recently had an opportunity to listen to guest speakers who emphasized using forgiveness to overcoming obstacles. When the youth returned from this engagement, the intake supervisor conducted an activity which showed youth the value of forgiveness. This was followed by a sweet treat for all eight of the youth who participated.

- In early August 2018, the Facility Training Coordinator held a team building event for all of the juvenile justice detention officers (JJDO). She coordinated a barbeque lunch and JJDOs had a great time getting better acquainted and strengthening their bonds.

- The center has developed a relationship with a local attorney who presents a program called, “Youthful Flow.” This is a volunteer study with a goal to provide incarcerated, at-risk youth with an alternative method to discover their own self-awareness through the practice of yoga and mindfulness. The facilitator was certified by the “Pose by Pose” organization to deliver this program.

- Volunteers come to the center after school to present the HYPE program (Helping YOUR People Excel). This program helps youth work on employment readiness through “character” development. The areas of focus are: life skills, communication skills, personal finance, entrepreneurial skills, and preparing for the next steps. Youth who complete the program earn a certificate which is shared with their juvenile probation officer (JPO) and the court.

- Another volunteer organization, Family Soaring, Inc., offered employability training for youth in the center. The group met with a group of youth Monday-Thursday for three weeks. The youth were educated on employment and relatable skills, self-interests, independent living, taxes, dressing for success, work ethic, and much more. The youth earned community service hours for their participation. The center also held a graduation ceremony for those youth who completed the program.

Standard 1: Management Accountability

Overview

Pinellas Regional Juvenile Detention Center is located in Clearwater, Florida and is a 100-bed, hardware-secure facility operated by the Department. The center serves male and female youth from Pinellas County. The center provides a safe environment for youth detained with pending adjudication, disposition, or pending placement in a residential commitment facility. There were fifty-five youth in the center during the annual compliance review. Medical services for youth are provided through a contract with Maxim Healthcare Services, Inc, and all mental health services are provided through a contract with Camelot Community Care, Inc. Education services are provided to youth by the Department of Education through the Pinellas County Public School District. During the annual compliance review, the center had vacancies for two juvenile justice detention officer (JJDO) I positions and three JJDO II positions. A tour of the center by the annual compliance review team found all areas to be clean.

1.01 Initial Background Screening (Critical)	Satisfactory Compliance
Background screening is conducted for all Department employees, contracted provider and grant recipient employees, volunteers, mentors, and interns with access to youth. The background screening process is completed prior to hiring an employee or utilizing the services of a volunteer, mentor, or intern. An Annual Affidavit of Compliance with Level 2 Screening Standards is completed annually.	

The center has a written policy and procedures addressing background screening procedures for all employees, contracted staff, and volunteers/interns. Background screenings were reviewed for twenty-eight applicable center staff who were hired during the annual compliance review period. Each was found to have been screened, with a rating of eligible or eligible with charges, prior to their date of hire. There were also six new volunteers who began supporting youth in the center during this annual compliance review period, and each of them had a background screening completed appropriately. Each was screened prior to contact with youth at the center and each had an eligible rating. A review of staff records also revealed each of the reviewed staff members passed a Department assessment as part of their hiring process. The Annual Affidavit of Compliance with Level Two Screening Standards was completed and submitted to the Department's Background Screening Unit (BSU) on January 26, 2018, and the Annual Affidavit of Compliance with Level Two Screening Standards for School Board Teachers was completed and submitted to the BSU on January 22, 2018, thus meeting the annual requirement. This was confirmed through a review of documentation, and an interview with the administrative assistant.

1.02 Five-Year Rescreening	Satisfactory Compliance
Background screening is conducted for all Department employees, contracted provider and grant recipient employees, volunteers, mentors, and interns with access to youth. Employees and volunteers are rescreened every five years from the initial date of employment.	

The center has a written policy and procedures addressing the background procedures for all employees, contracted staff, and volunteers/interns. There were three staff eligible for a five-year rescreening during the annual compliance review period. Two of the three staff had their five-year rescreening conducted prior to the anniversary of their hire date. One was submitted

on April 16, 2018, which was thirteen days after their anniversary date. Two volunteers required a five-year rescreening during this annual compliance review period. Each were screened within the required timeframe. The new administrative assistant has a tracking log for each staff and volunteer, which shows their date of hire/start and the due dates for when their five-year rescreening's are required.

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 written policy and procedures regarding the staff code of conduct. A review of thirteen personnel records were conducted during the annual compliance review. Four of the thirteen reviewed records indicated staff violated the code of conduct and received disciplinary action. Three staff records had documentation reflecting each staff received an oral reprimand. The fourth staff member resigned after allegations and an investigation was completed by the Department's Office of the Inspector General. A review of these four staff, and nine newly hired staff, found each signed a receipt for the code of conduct and/or a statement of personal responsibility acknowledging the code of conduct staff must adhere to while working for the Department. Three additional records were provided for staff who were recognized by the center during the past six months. Two of the staff were recognized as the central region's employee of the month, and one was recognized as the central region's employee of the second quarter of 2018.

Nine youth and nine staff were interviewed. One youth indicated he had been allowed to call the Florida Abuse Hotline when he made the request, and the other eight youth indicated they never had a reason to call. Each of the nine interviewed staff shared each youth would be provided a call to the Florida Abuse Hotline when requested. They indicated they notify the supervisor, who will help if they cannot break away to allow the youth to get on the phone at the moment. The supervisor on duty is also told so they can determine if the Central Communications Center (CCC) should also be contacted, or if another follow-up needs to occur. All reported this call would be given as soon as possible, depending on staffing and safety concerns. Each of the nine interviewed youth reported staff are respectful when speaking with them. Three indicated they have never heard staff curse, two indicated they have heard a staff member curse once, and four stated they have heard staff curse occasionally. When questioned further, they relayed

this was never used in a derogatory way and was more out of frustration or just a slip in conversation. Nine staff also responded to the same question. Six reported never hearing a co-worker use profanity, and three said occasionally. This was reported to be used out of frustration or just part of conversation. A member of the annual compliance review team heard two staff using profanity while they were supervising line movement. The superintendent indicated this was addressed with the staff in question. All nine interviewed youth reported never having heard staff threaten a youth. Each of the nine staff reported never having heard another staff use threats or intimidation towards a youth. All nine youth reported feeling safe in the center. An interview was conducted with the superintendent, which indicated the center will call the Florida Abuse Hotline, CCC, and parent/guardian of the youth if an incident occurs. They will begin an internal investigation and will remove staff immediately from contact with youth. Based on any findings, staff may be disciplined, with consequences up to, and including, dismissal or criminal charges. A review of the four applicable personnel records confirmed this practice.

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 written policy and procedures regarding incident reporting.
The center had twenty-nine incidents reported to the Department's Central Communications Center (CCC) during the six months prior to the annual compliance review. A sample of five CCC reports were reviewed to establish the center's compliance with reporting procedures. All five reports were called in to the CCC within the two-hour reporting timeframe. Interviews with the superintendent and a supervisor clarified the procedures for incidents reported to the CCC. They explained staff will notify the supervisor on shift whenever a reportable incident occurs. The supervisor will then ensure a call is made to the CCC within two hours of the incident. The supervisor will also follow-up with the superintendent to make them aware of what has occurred. Updates will also be made to the CCC, as applicable.

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 written policy and procedures regarding Protective Action Response (PAR).
The center had 246 Protective Action Response (PAR) reports during the last six months. Twenty-five of the PAR reports were selected for review. All twenty-five of the reports were completed by the end of the staff member's workday and included statements from each of the involved staff. None of the reports indicated injuries to staff or youth. Additionally, none of the reviewed reports documented the use of mechanical restraints or any allegations of abuse by the involved youth. Each of the reports were reviewed by the supervisor on shift and a PAR-certified supervisor to determine if the use of force was consistent with policy. Each of the supervisor and PAR-certified supervisor reviews were conducted within the seventy-two-hour review/processing requirement. Each of the reports reflected a post-PAR interview was completed with each youth within thirty minutes of each incident by the supervisor on shift. Three of the reports had the initial PAR-certified supervisor review completed by the supervisor

on shift, who was also involved in the PAR incident. The superintendent indicated they tried to avoid this; however, their goal was to get all PAR reports processed during the same shift as the incident. None of the youth reported any injuries; therefore, none required a post-PAR medical review. All twenty-five reports were found to have been reviewed by the superintendent or designee; however, three of them were after the seventy-two-hour timeframe. These were two days, three days, and seven days late respectively. Two additional reports were reviewed by the superintendent/designee prior to other required supervisor reviews. Information from the superintendent indicated these supervisors who missed a review were told to complete this when it was found not have been completed. It was also represented these were just missed as an oversight.

All PAR reports are maintained electronically in the Department's Juvenile Justice Information System (JJIS). A review of internal incident reports and the youth grievances did not reveal any other PAR incidents which should have been documented. The center had a PAR rate of 14.94 for the fourth quarter, which is higher than the statewide detention PAR rate of 9.29. A review of information from the Department's Facility Management System indicates their PAR incidents have had a slight decrease. The number from the six-month period from February 13, 2017 through August 14, 2017 found the center had 258 PAR incidents compared to 246 during the same six-month period in 2018. Interviews were conducted with nine staff, and each indicated staff tries talking with youth prior to using physical restraints. An interview with the superintendent revealed the center makes every effort to process the PAR report within twenty-four hours to ensure PAR was used correctly. He also reported any issues or concerns are also addressed by regionally and at headquarters.

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 a written policy and procedures regarding the training of all new staff. Twenty-eight new staff were hired during this annual compliance review period. Nine training records were selected for review. Seven reviewed staff completed all of the requirements for pre-service certification within 180 days of hire. The remaining two staff are almost done with phase one training. Once this is complete, they will attend the next academy. Each of these staff were hired in July 2018 and are still within their initial 180-day period to get certified. The seven certified staff completed the required essential skills training prior to contact with any youth. These essential skill topics include first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), mental health and substance abuse services, suicide prevention, safety, security, and supervision, and the center's facility operating procedures (FOP). Each of the seven certified staff completed forty-hours of Protective Action Response (PAR) training within ninety days of hire. Each completed training was delivered by a qualified trainer and all were documented in the Department's Learning Management System (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 follows the statewide detention in-service training plan for staff and maintains a training calendar which is updated as changes occur. A review of nine staff training records was conducted for training during the calendar year of 2017. The current field training coordinator (FTC) began this role in August of 2017. Six of the nine staff were found to have completed all required trainings. Three of the staff did not complete the required six hours of suicide prevention training. Two were missing the four hours of instructor led training, and the other had not completed the four hours of instructor-led training, in addition to the two hours of suicide prevention found on the Department's Learning Management System (SkillPro). The same staff member who did not complete any suicide prevention training also failed to complete training in professionalism and ethics, and only had twelve hours of training for 2017. The other eight staff exceeded the twenty-hour hours of required training. Four supervisory staff were included in the sample. Three of the supervisors completed at least eight hours of training in the areas of management, leadership, personal accountability, communication skills, and employee relations. The center could only provide documentation reflecting the remaining supervisor completed three and a half hours of supervisory training. All training was documented in SkillPro, with a few minor exceptions. The superintendent indicated ongoing training is offered to staff through SkillPro and instructor-led sessions. Documentation was presented to reflect regular communications sent to staff regarding the training topics for the month to help ensure staff stay on track.

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.

The center has a written policy and procedures in place regarding the sharing of alert information. Interviews were conducted with nine staff. These staff indicated alert information for youth is shared through shift briefings and pass-on alert reports from the Department's Juvenile Justice Information System (JJIS). They also indicated some basic alert information can also be found on the youth's conduct cards. Attendance and observations of two shift briefings confirmed alerts and any changes made were reviewed with staff during the briefing. The outgoing shift supervisor briefed the oncoming shift on any pertinent information from their shift. The interviewed staff also stated they will debrief with outgoing staff when they report to their assigned living module. A review of five random days of shift briefing reports also found the alerts were included in the daily shift briefings. Additionally, the dining hall reviews the pass-on alert report before breakfast, lunch, and dinner to ensure youth are not provided with any foods they may be allergic to.

Nine youth's JJIS alerts were checked to confirm the appropriate entry and closure. Each of these youth were found to have one or more alerts entered into JJIS. Each applicable alert entered at the center was based on the youth's risk factors or identified needs. Four of the reviewed alerts were applicable for closure, and each was closed appropriately within JJIS. Supervisors and management staff are responsible for updating and downgrading JJIS security alerts. All medical and mental health alerts were entered or updated by the appropriate Department representative.

Standard 2: Assessment and Performance Plan

Overview

The center's intake and release department is responsible for the admission and release of all youth into and from the center. The center's intake and release department is headed by a juvenile justice detention officer supervisor (JJDOS) and several juvenile justice detention officers (JJDO). The JJDOs use the Department's Juvenile Justice Information System detention admission and release wizard to complete the admission and release process. The JJDOs search each youth upon their admission and review all information provided to them by the admitting source. Each youth's personal property is inventoried, collected, and secured in a locked filing cabinet or a locked property room. The center has a contractual agreement with the Hillsborough County School Board to provide educational services to the youth held in the center. The center conducts a weekly secure and non-secure detention audit, with various community partners every Thursday afternoon, to verify youth's progress, potential release dates, and commitment placement dates. The center uses a three-tiered behavior management system to promote a positive environment, health, and well-being of the youth in the center.

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.*

Any youth identified as at risk of suicide shall be placed on Precautionary Observation until evaluated by the licensed mental health provider.

The center has a written policy and procedures regarding the initial screening and admission process of youth taken into custody. The juvenile justice detention officers (JJDO) start the initial screening process upon the youth's arrival to the center. The intake area is separate from the other areas of the center, and the youth are placed on a living module after being classified by intake staff. A review of nine active youth records was conducted to verify the admission documentation. Each record contained a copy of the arrest affidavit custody order, a Detention Risk Assessment Instrument (DRAI), and a Suicide Risk Screening Instrument (SRSI). This review also confirmed the JJDO conducting admissions reviewed these documents during the intake process. The reviewed records indicated the intake admission wizard was completed in the Department's Juvenile Justice Information System (JJIS) for each youth. Each reviewed intake wizard indicated frisk, electronic, and strip searches were conduct by a JJDO of the same gender as the youth. The nine active records also had documentation indicating each youth

acknowledged a meal would be offered during the admission process. The documentation reflected each of the youth received a meal during the admission process. Documentation to support each youth was screened for medical, mental health, and substance abuse needs was in each of the records. All nine youth were also provided a phone call to their parent/guardian during the intake admission process. Each of the reviewed records also contained a Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) screening which was completed by the JJDO. Six of the nine youth arrived at the center on precautionary observation and remained on these precautions until youth were evaluated by a qualified mental health clinician.

A youth admission was able to be observed during the annual compliance review. The admission was completed by a JJDO of the same gender as the youth. The JJDO was observed explaining the process to the youth prior to conducting the electronic and frisk searches in the vestibule area, and the full-body visual search in the intake shower room area along with a body chart. Once the searches were completed and the intake shower was administered, the youth was issued detention clothing. The JJDO then made the youth aware of rules and activities. Additionally, upcoming court dates were discussed. The JJDO reviewed the initial admission paperwork, as indicated the JJDO's initials or signatures in appropriate places. Observations included a review of the VSAB, admission wizard, the SRSI, and the Massachusetts Youth Screening instrument- Second Version (MAYSI) by the intake staff. The JJDO reviewed the mental health and medical substance abuse history with the youth. During the completion of the SRSI, a message was left with the youth's assigned juvenile probation officer (JPO). The youth was observed making his intake telephone call and the JJDO speaking with the legal guardian to confirm the youth's mental health, medical, and substance abuse history. The youth was given lunch tray since it was within the two-hour time frame for lunch.

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 policy and procedures implemented by this center include the instructions for orientation of newly admitted youth. The juvenile justice detention officer (JJDO) will review all the of the admission paperwork as a part of the standardized orientation to the center. The interactive dialog between the JJDO and youth is reflected by a review and signature of the orientation checklist review form. The orientation checklist form reviews the center's behavior expectations, related consequences, possible law violations, and the rules and regulations. The orientation checklist also included the review of visitation hours, telephone calls, medical, mental health services, access to the Florida Abuse Hotline number, Prison Elimination Act, and the youth's rights. During observations of an admission, the youth was provided a brochure with the key

topics which were discussed by the JJDO, so the youth could follow along with the information which was discussed. A review of nine records found each contained a signed orientation checklist, which acknowledged the information was presented verbally and in writing. This form also indicated the youth's understanding of the information provided to them. Informal interviews with two youth confirmed staff provided the orientation brochure and the orientation checklist during their admission process. Formal interviews were conducted with nine youth. Seven of the nine youth indicated someone provided them with information regarding center rules and regulations, daily schedule, education services, visitation, abuse reporting, and the behavior management system when they were admitted. The other two youth stated this was not done when they entered the center. One of these youth indicated they have been here before and did not need to go over the same information.

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

The center has a policy and procedures regarding classification of youth during the admission process. The policy requires significant information to be considered before a youth is assigned to a room. The youth's age, physical characteristics such as body stature of height and weight, any physical developmental disabilities or challenges the youth may face in general population of their age group, the youth's known history of aggression, violent behavior, criminal behavior, types of offenses, including sexual offenses or hate crimes, their vulnerability to victimization, and potential suicide risk are to be considered during the classification process. During an observation of a youth intake, information was gathered during the review of available documentation, including court documents reflecting the youth's charges, medical records, and the Vulnerability to Victimization Sexual Aggressive Behavior (VSAB) form. The intake officer also evaluated which living module assignment would prevent the youth from having conflict with other gangs. When the center's census reaches full occupancy, a juvenile justice detention officer supervisor (JJDOS) will review the active records to assign two youth to a room. A review of nine records found the classification documents were reviewed prior to making a room assignment. The policy indicates the center can reclassify at any time for center needs. All nine intake records contained a completed and reviewed VSAB and an admission wizard documenting a review of all required topics considered in making an appropriate room assignment for each youth.

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. *Each facility shall identify a staff person to serve as a gang representative who shall review identified youth for suspected gang involvement or gang activity.*	

The center has a policy and procedures regarding classification of gang members or gang affiliated youth. Nine youth records were reviewed, and each youth was screened for gang affiliation and/or membership during the admission and orientation process. Four of the nine reviewed records were for youth who were identified during the screening process as having gang affiliation or membership. The information was updated in the Department's Juvenile Justice Information System (JJIS) and was also shared through the internal alert system.

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 regarding notification of juvenile probation officer (JPO) circuit gang representative to communicate suspected gang activitiy. The intake department is responsible communicating the information about gangs to appropriate parties. The center was able to provide documentation reflecting the JPO circuit gang representative was contacted for each of the four applicable youth records which were reviewed. Each of these youths had an alert in the Department's Juvenile Justice Information System (JJIS). The email correspondence was maintained to reflect notification of the proper representatives.

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 regarding the handling of youth personal property. The inventory information is gathered while intake staff conduct searches of the new admissions. Items collected by the intake officer include anything which appears to be of value such as electronics, jewelry, money, and clothing. The items are itemized on the property receipt, with the assistance the youth, prior to being secured in a locker. Any valuables (i.e. jewelry and electronics) will be secured in a tamper proof bag, the tag will be signed by both youth and staff, and then the bag will be secured in the drop safe. During the admission process, each youth signs an acknowledgement letter of personal property and what happens to the stored property when not claimed after thirty days. A review of the nine detention admission wizards indicated

two of the youth entered the center with valuable property. Both records contained a property receipt form indicating the youth had valuable property in the safe. All property receipts were signed by the youth and the staff who collected the property.

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 regarding the safe and secure storage of a youth's personal property. Observations during the admission and the release process revealed valuable property is maintained in a drop safe which is in camera view. Prior to these items being stored in a locked cabinet, the property is removed from the drop safe and logged in the valuable property logbook. All youth clothing is kept separate for each youth and maintained in a numerically designated locker with a copy of their signed property receipt. The juvenile justice detention officer supervisors (JJDOS) are the only assigned designees appointed by the superintendent to have access. During the observation of admissions and releases, the property safe was seen under camera observation. The intake hallway has all of the property lockers which are utilized for the youth. The center did not have any incidents reported to the Central Communications Center (CCC) regarding missing or lost personal property during the annual compliance review period. An interview with the superintendent confirmed the observed practices.

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

The center has a policy and procedures regarding youth release. The policy requires the releasing officer to verify the court's authorization to release the youth and must confirm this with a juvenile justice detention officer supervisor (JJDOS). The intake officer utilizes a chronological checklist which documents youth release procedure. The intake officer prepares the release wizard after verifying the court authorization to release. Once the release wizard from the Department's Juvenile Justice Information System (JJIS) is completed, the property receipt is printed for the youth to sign to acknowledge receiving all of their property. Once the release paperwork is successfully completed, the JJDOS will document their review by writing their initials on the second page of the release wizard. A review of nine records for released

youth reflected each release was approved by the JJDOS prior to the youth's release from the center. Three of the releases were for youth placed on the interstate transportation network (ITN) to another center for a court appearance. The other six youth were released to a parent/guardian. All nine records reflected the youth's identification and the identification of the parent/guardian or transporter were verified prior to release. Each of the records reflected all parties signed all applicable release forms, and the release date in the Department's Juvenile Justice Information System (JJIS) reflected the youth's correct release date. Two releases were observed during the annual compliance review. After all required forms were signed and reviewed by the JJDOS, the youth were removed from the center's census count. One was escorted to ITN staff for transport and the other was released to their parent/guardian.

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 regarding the release of youth personal property upon their release from the center. A review of nine closed records confirmed each contained a property sheet completed by the intake officer. Each form was signed by youth and the parent/guardian, indicating all of the youth's personal property was returned to the youth upon release from the center. Observations during the annual compliance review found each property sheet documented the assigned locker where each youth's individual belongings are stored. The youth was provided their personal clothing to change into prior to release. The juvenile justice detention officer (JJDO) reviewed the youth's personal property with them prior to releasing the items to them. During the observation of the release, the JJDO supervisor reviewed the property sheet along with the tamper-free personal property bag, verified the youth's name and identification number, and released the property to the parent/guardian after the signatures was completed on the property receipt form. The valuables logbook was reviewed to observe how the JJDOS signs out the valuables upon a youth's release. The records for two released youth were found to match the reviewed documentation in the logbook. The intake supervisor provided examples of the process for disposing of unclaimed property, and how they itemized clothing items or monetary donations. An interview with the superintendent indicated when a youth does not claim their property, a letter is sent notifying them to come and claim their property within thirty days. If the youth and/or parent/guardian does not retrieve the property within the designated time frame, the property is inventoried and donated, or disposed.

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 policy and procedures regarding the release of prescribed medications. A review of three applicable closed records indicated the center uses Department form HS 053 entitled 'Medication Receipts, Transfer, and Disposition' form to document the release of youth prescriptions. Each of the records contained a signed form HS 053, which was completed appropriately. The form lists the youths name, identification number of the youth, the name of the medication which is prescribed, along with the quantity of each medication to be returned to the parent/guardian. Each reviewed form was signed by the parent/guardian who took custody

of the youth upon their release. Any applicable aftercare instructions were also provided, when applicable.

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

The center has a policy and procedures indicating the detention review officer conducts a facility detention review on a weekly basis to address every youth reflected on the census for both secure and home detention. During the observation of the weekly detention review meetings, the attendees were all present for the conference call for youth residing in surrounding counties. The sign-in roster reflected the assistant chief probation officer, the transportation coordinator, the superintendent, the transportation supervisor, the medical staff, the mental health, and a representative of education department participated in the reviews. All department entities who are on-site and provide services to the youth at the center signed the roster and were given a detention review packet. During the annual compliance review, an observation of the detention reviews found they were conducted at differing times due to youth in the center being from different circuits. Each youth name was called from the review sheet, and the projected release or bed availability was provided by the commitment manager or the juvenile probation officer (JPO) who is representing the case load. The detention review also covered all home detention youth on the list after the youth in secure detention placement were completed for each circuit. Minutes were recorded and information was added to the detention report in the Department's Juvenile Justice Information System (JJIS) by the detention review officer. A review of the documentation from the previous six months found this process was consistently followed. An interview with the superintendent confirmed this practice.

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 policy and procedures regarding the daily activity schedule. The daily activity schedule coordinates different program settings for weekdays and holidays/weekends. The schedule outlines the days of the week and scheduled times for activities. The schedule reflects time for wake-up, hygiene, meals, visitation, volunteer activities, life skills group, snacks, education, small recreation activity, and large recreation activities. The center provides gender-specific programming for the youth. Yoga is offered to female youth by a public defender, and Boy's Court is held once a month under the guidance of a local judge. During a tour of the center, the schedule was observed to be posted in common areas on each living module and in the intake area. All nine interviewed youth indicated the center has a daily schedule, and each confirmed the center works to follow it. All nine staff also indicated the center's daily schedule is followed. A few commented it is tough, but they do their best to stay on track.

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

The center has a policy and procedures regarding adherence to the daily schedule. A review of logbook documentation found entries reflecting youth movement to breakfast and adjourning for preparation for school at scheduled times. During morning preparation and clean up, the juvenile justice detention officer (JJDO) assigned to assist with medical or mental health services escorts the youth to the designated areas to be assessed. The transition movement to school begins according to the logbooks which were reviewed for the six one-hour school blocks held each day school is in session. Documentation was found in the master control logbook indicating small or large recreation activities taking place, as scheduled. The logbook reflected an after school snack and enrichment program are also conducted. Documentation for the last six months also reflected curriculum regarding restorative justice has taken place. This was confirmed through a review of group notes in the Department's Facility Management System (FMS) within the Department's Juvenile Justice Information System (JJIS). All nine interviewed staff indicated the daily schedule is followed. Each of the nine interviewed youth were aware of the center's posted schedule. All nine indicated the schedule is followed closely.

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.	

This center integrates education instruction, both career and technical education, as well as academic instruction, into the daily schedule in such a way to ensure the integrity of required instructional time. The Pinellas County School Board schedule for the center, as well as the daily schedule, support the required 250 days of instruction for the year and 300 minutes of instruction a day. Youth enrolled in the educational program can earn course credit and credit recovery through the online platform APEX, as well as direct instruction. A review of the center's daily schedule and logbook ensures minimal interference of educational instruction. Disruptions for safety and security are minimal and are documented in the logbook. An interview with the district personnel supported these findings. A review of the youth interviews fully supported these findings. The district has implemented a system of communication through One Note which allows student goals and academic progress to be fully communicated and monitored by the district. Additionally, one of the teachers has been involved with two separate national organizations to allow his students to compete in academic challenges. One youth had poetry published as part of a competition. Another group working with this educator had a reading they recorded featured on a national literacy website.

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

The center provides career education programming based on the youth's age, assessed educational abilities, the goals of the youth, and the typical length of stay to which each youth is assigned. The center provides a Type 1 career education program, integrating personal accountability skills and behaviors leading to maintaining employment and living standards. Career education programming includes communication, interpersonal, and decision-making 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 a policy and procedures regarding the implementation of a behavior management system (BMS) to meet the needs of the youth and the center. The BMS at the center promotes good health and wellbeing in a positive environment. The center utilizes conduct cards to assist in maintaining a log of each youth's positive or negative behavior. The level system consists of three level-tiers to promote positive reinforcement for positive behavior between the youth, as well as staff involvement. Negative reinforcement would include the juvenile justice detention officer (JJDO) informing the youth an infraction, or some type of notation of negative behavior, has been notated on the youth's conduct card. The center's use of the conduct card is to track the youth's behavior during their duration residing at the center. Youth are rewarded with extra phone calls, later bedtimes, movies, and occasional food rewards depending on their level. A review of nine closed records found the center maintains the conduct cards after their discharge. Each unit had postings explaining the center's BMS, which defined expectations, rewards for meeting them, and negative consequences if not followed.

A review of youth conduct cards indicated the center utilizes the cards to track each youth's level. There was documentation on the conduct cards indicating each youth's current level and when a youth's level was dropped, there was also a reason for the level drop, if applicable. Nine interviewed youth were asked how they would rate the center's BMS and two indicated the system was very good, four indicated the system was good, and three indicated it was fair. The youth stated the reason they rated it fair was due to occasional favoritism and their wish for more incentives.

An interview with nine staff indicated seven believe the BMS is effective, while two indicated the system is not effective. The two staff indicated the BMS was not effective because of issues with accountability and consistency. Some youth do not care at all, and this makes it hard to work with the other youth. All nine of the staff indicated they speak with youth about the consequences imposed for their negative behaviors while in the center and youth are given an opportunity to explain their behavior and alternative acceptable behaviors are discussed. All of

the interviewed staff indicated the only consequence given to youth was a drop in their level. Each of the staff indicated they receive feedback from their supervisor regarding how they implement the BMS. They also indicated this can happen at others time, including on their yearly evaluation.

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

The Office of Detention Services has a written policy and procedures applicable to this center, which is to be adhered to statewide, prohibiting the use of unauthorized forms of punishment. This includes corporal punishment, the use of drugs to control a youth's behavior, group punishment, as well as never allowing youth to impose discipline or sanctions on other youth. The center's behavior management system (BMS) gives acceptable consequences for a youth's negative behaviors. The center uses counseling and verbal redirection to encourage youth to change their negative behaviors. Observations during the annual compliance review week found no instances of unauthorized punishment being used by the center.

Nine interviewed youth indicated they have never been allowed to punish other youth at the center. Four of the nine interviewed youth indicated they had been sent to their room for punishment. They indicated this was for confinement due to inappropriate behaviors. Each reported their door being locked for confinement placement. Nine interviewed staff indicated they have never seen a coworker take meals, snacks, clothing, education, or medical care from a youth as a consequence for negative behavior. They all reported the only thing which can be taken from a youth is their level when they do not follow the center's rules. All nine staff also indicated they have never seen a coworker 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 a written policy and procedures regarding the youth grievance process. This process encourages the staff to treat all youth fairly, respectfully, and without discrimination. Youth are informed of their rights and the center's grievance process during their admission, as evidenced by a review of the signed orientation brochures and orientation checklists in the nine reviewed youth records. The grievance process consists of three phases. The center's grievance policy indicates the informal phase is when the juvenile justice detention officer (JJDO) who receives the grievance attempts to resolve the complaint or condition with the youth using effective communication skills. The second phase of the grievance process is the formal phase, when the youth submits a written grievance which is then handled by the on-duty JJDO supervisor (JJDOS) by the end of shift or within twenty-four hours of the grievance being filed. The center's final grievance phase is the appeal phase, where the grievance is reviewed by the center's superintendent or designee within seventy-two hours of receipt, excluding weekends and holidays.

Six grievances were selected for review from the previous six months for compliance with the grievance process. One of the six grievances was handled informally, three were handled at the formal phase with a JJDOS, and two were appealed to the superintendent/designee. Each were handled within the appropriate time frames and completed on the Department's electronic grievance form in the Facility Management System (FMS). All nine interviewed staff were able to explain their role in the process and how they help youth in starting the process. None of the nine formally interviewed youth reported having filled out a grievance. Random youth were asked if they were aware of the grievance process and the youth were able to explain the process, as well reference the postings on the living modules in reference to the process.

2.19 Trauma-Informed Care	Satisfactory Compliance

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

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

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

The center has a policy and procedures regarding trauma-informed care which establishes how the center implements these practices in their daily activities, and the role it plays between staff and youth in the center. The policy indicates staff will receive trauma-informed care training when hired, and annually thereafter. A review of nine pre-service training records found each of the staff received initial training in trauma-informed care. A review of nine in-service training records found seven of the nine staff successfully completed the trauma-informed care training requirement in 2017. The center has interventions which are designated specifically to address the consequences and healing in the youth. The mental health staff provide individual treatment services to the help them better understand trauma and symptoms/triggers of trauma. Mental health staff provides individual treatment and interventions to help educate youth on how trauma effects the youth's body, emotions, and brain functions. The center assists the youth in understanding and supports them for healing purposes. The healing can consist of support with childhood experiences, child needs and assessments, journal writing, and/or behavioral therapy. Other services provided, such as soft therapeutic colored environments, a love seat in the soft room, grief groups, and painted murals are found throughout the center. The soft room, which is located on the girls living module is described as a quiet room to help with de-escalating youth, youth with special needs, or situations which need discretion. Interviews with nine staff revealed the staff also pass on information regarding a youth's triggers at shift briefing to ensure all staff are aware and can avoid triggering a youth. An interview with the superintendent revealed the center works to provide an environment where the youth can feel comfortable to open up to staff, and work towards becoming successful. He also indicated they work on celebrating the positive more than the negative. It is their job to seek understanding of the youth and find out the why to their hurt, so they can assist them.

Standard 3: Mental Health and Substance Abuse Services

Overview

Pinellas Regional Juvenile Detention Center provides comprehensive mental health services to youth in the center. The center contracts with Camelot Community Care, Inc, to provide mental health and substance abuse services. Camelot's licensed mental health counselor (LMHC) is the center's designated mental health clinician authority (DMHCA), who is on-site forty hours a week and on-call twenty-four hours a day, seven days a week. The DMHCA oversees all clinical and administrative operations of the center, to include supervision of two full-time LMHCs, one pro re nata (PRN) LMHC, two PRN licensed clinical social workers (LCSW), and one registered mental health counselor intern (RMHCI). Camelot Community Care Inc. contracts with a licensed psychiatrist who is on-site three hours a week to provide psychiatric services to the youth.

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.	

A review was conducted of the license for the designated mental health clinician authority (DMHCA), which is clear and active and expires March 31, 2019. The DMHCA is a licensed mental health counselor and employed by the contract provider Camelot Community Care, Inc. The DMHCA oversees all clinical and administrative operations of the center to ensure the clinical integrity and quality is maintained. The DMHCA provides clinical services in the form of assessments, development of treatment plans, individual and group counseling sessions, and discharge planning. The DMHCA is contracted to be on-site forty hours a week and is on site Monday – Friday 8am-4pm. A review of the contract provider logbook/sign-in sheet validated the DMHCA was on-site weekly for forty hours most weeks, with the exception of two weeks in June 2018, when she was out for a family emergency. While she was out, the on-site licensed mental health counselor (LMHC) and licensed clinical social worker (LCSW) provided coverage. There were additional weeks where the DMHCA was not on-site forty hours, where she was on sick or annual leave, and an LMHC and/or LCSW provided coverage. Through interview with the DMHCA and review of the provider contract and DMHCA job description, it was determined the DMHCA is providing the appropriate services and responsibilities while on-site.

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 contracts with Camelot Community Care Inc., to provide licensed mental health staff. The center has two full-time licensed mental health counselors (LMHC), one pro re nata (PRN) LMHC, two PRN licensed clinical social workers (LCSW), and one licensed psychiatrist. All

contracted mental health staff have a clear and active license, and each provide services according to their 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 utilizes one registered mental health counselor intern (RMHCI), who has a clear and active license, which expires March 31, 2022. The designated mental health clinician authority (DMHCA) provided the transcript and copy of the RMHCI's master's degree, which is in the field of counseling. A review of the Direct Supervision Logs, for the RMHCI, for the weeks dating February 4, 2018 through August 5, 2018 validated clinical supervision was conducted weekly. Direct supervision was provided by the DMHCA on all occasions with the exception of two, when a licensed mental health counselor (LMHC) on staff completed the direct supervision. Each log documented the exact time of the session, with each reflecting the required one hour of supervision. Each log also documented the date, time, supervisor's name, non-licensed staff name, signatures for both, and details of the supervision session. For the weeks reviewed, the week of June 10, 2018, direct supervision was not documented. Mental health staff indicated this was due to the DMHCA being off-site for a family emergency and the intern assisting at a different center during this same week. Licensed mental health staff review each assessment and evaluation completed by non-licensed staff. A review of training documentation found the RMHCI received the twenty hours of suicide risk training, which included the completion of five supervised Assessments of Suicide Risk (ASR).

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 facility operating procedures implementing a standardized admission process. A review of nine records validated detention staff reviewed the Positive Achievement Change Tool (PACT) Prescreen, Massachusetts Youth Screening Instrument-Second Version (MAYSI-2), Suicide Risk Screening Instrument (SRSI), and Victimization and Sexually Aggressive Behavior (VSAB) screening during each youth's intake process. The MAYSI-2 and SRSI were completed in JJIS for each of the nine records. In each record, the nurse and/or mental health staff completed the SRSI and completed the screening results section for each. Five of the nine records documented a need for further assessment. Each record contained an Assessment of Suicide Risk (ASR) which was completed due to the prescreen forms documenting a need for further assessment and each youth was placed on precautionary observation. Of these five, each documented the superintendent was notified.

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

A review of nine records validated six youth were referred for further evaluation. Of the six, two were on-site longer than thirty days, allowing for their comprehensive mental health evaluations to be reviewed or completed. A third record was requested for review. The comprehensive mental health evaluations were completed for all three youth by community providers, prior to each youth's admission, and all were completed within the last six months. Each evaluation was reviewed by the center's mental health staff prior to the youth's thirtieth day in the center. Mental health has a system in place to track each youth who is approaching their fourteenth day on-site. Once a youth is on-site ten days, the mental health staff send an email to the juvenile probation officer requesting a status of each youth's comprehensive mental health evaluation.

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.*	

A review of nine records confirmed all youth were screened for mental health and substance abuse services. Of the nine, three were assigned a mini-treatment team and each had a treatment team meeting. Each meeting consisted of nursing staff, the designated mental health clinician authority (DMHCA), the licensed psychiatrist, and the youth. Two of the youth were receiving mental health services through individual and group counseling, and the third youth was on psychotropic medication. Each of the three youth's records contained a signed and valid Authorization for Evaluation and Treatment (AET). All treatment notes are maintained on the treatment therapy progress notes form (MH 018). Of the three youth, only one attended mental health treatment group. A review of the group session sign-in sheet for the group documented there were nine youth in the session. The center does not have a substance abuse mental health professional on staff; therefore, does not provide substance abuse treatment. Through interview with the DMHCA, it was indicated the youth are offered individual and group counseling, as well as medication management. Nine youth were asked how they rated the mental health services. Of the nine, five rated the services as very good and four indicated they did not receive mental health services.

3.07 Treatment and Discharge Planning [Contract Provider]	Satisfactory Compliance
The superintendent and DMHCA or mental health and substance abuse clinical staff are responsible for ensuring the development and review of an initial and/or individualized mental health/substance abuse treatment plan for each youth receiving mental health and/or substance abuse treatment in the facility. *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.*	

A review of nine records documented three youth received mental health services. Of the three, two were eligible for initial treatment plans. Each were completed within the required seven days and by a licensed mental health professional. The third youth was not on medication; therefore, did not require the initial treatment plan. All three youth were at the center for a period of time allowing for their individualized treatment plan to be completed; with one of the three requiring an individual treatment plan review. Each individualized treatment plan was completed within the required thirty days. The individualized treatment plan review was completed within thirty days of the creation of the individualized treatment plan. Each treatment plan contained all of the required elements. Each treatment plan was signed by the youth, mental health professional, and nursing staff, with the exception of one youth's plan, which was printed for review during the annual compliance review and not the original. Each were completed and signed by the licensed mental health staff within ten days. The center does not maintain the originals, as they are transferred with the youth. The parents/guardians are not contacted during the treatment team meetings, as they are contacted prior to, if need be, or during the treatment team meeting if requiring consent for medication. Three treatment team meetings were observed during the annual compliance review. Each was the initial treatment team meeting. The youth, designated mental health clinician authority, psychiatrist, and the nursing supervisor was present for the treatment team meeting. During one of the treatment team meetings, the youth was prescribed medication; therefore, the parent/guardian was contacted during the meeting to obtain consent, which was provided. A review of three mental health treatment discharge summaries documented all were completed on the appropriate form (MH/SA 011). It was documented each were provided to the youth and parent/guardian by mail and the juvenile probation officer by e-mail. The information pertaining to the summary and copies provided to the appropriate people were documented on the mental health chronological note.

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.	

All psychiatric services are provided by the licensed psychiatrist, who is contracted through Camelot Community Care, Inc. A review of the psychiatrist's license validated it was clear and active. The psychiatrist is on-site three hours a week, which is in accordance with the psychiatric service contract reviewed. A review of nine records documented three youth received psychiatric services. Each of the three youth received a psychiatric interview within fourteen days. The initial psychiatric interview contained all required elements. Out of the three youth, only one was at the center long enough allowing for the in-depth psychiatric evaluation.

The in-depth evaluation contained all required elements. All psychiatric interviews and psychiatric evaluations were completed on the HS006 form. All three of the youth were prescribed medication. Mental health staff obtained verbal consent for the prescribed medication for each of the youth; however, one youth's parent did not provide verbal consent to the medication until twenty-one days later. Each record contained a valid Authorization for Evaluation and Treatment (AET). Parental consent was documented on the Clinical Psychotropic Progress Note (CPPN) form for all three youth and all three documented verbal consent with a follow-up consent form sent by certified mail. None of the youth were in foster care or eighteen years of age.

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.	

A review of the center's Suicide Prevention Plan documented the plan contains each of the required elements. The plan includes identification and assessment of youth at-risk of suicide, referral, communication, immediate staff response, notification, levels of supervision, suicide precautions, staff training, documentation, and review process. The plan was approved and signed by the center's superintendent and designated mental health clinician authority on July 31, 2018.

3.10 Suicide Prevention Services [Detention Staff/Contract Provider] (Critical)	**Satisfactory Compliance**
Suicide Precautions are the methods utilized for supervising, observing, monitoring, and housing youth identified through screenings as having suicide risk factors or identified through assessment as a potential suicide risk. *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.*	

A review of nine youth records documented five youth were placed on precautionary observation (PO) at intake as a result of the prescreening documents. Each of the five youth received an Assessment of Suicide Risk (ASR) within twenty-four hours of the mental health referral. Each had an alert entered into the Department's Juvenile Justice Information System (JJIS) upon placement on PO and when each youth was stepped down from PO. Each ASR was completed on the Department's required form. Each PO log was completed in its entirety and each documented a safe-housing area. Each ASR was completed by a licensed mental health professional with the exception of one, which was completed by the registered mental health counselor intern. Of the five youth placed on PO, all were documented in the logbooks when each youth was stepped down and the discontinuance of PO; however, three were not documented in the logbook when the youth was placed on PO. One youth was released to the mod on PO during third shift and this was not documented in the logbook, nor in the shift report. Two youth were admitted to the center, at which point were on standard; however, it was not documented in the logbook when each youth was placed on PO during intake to the center. Both youth were identified with heightened risk when they were screened at the juvenile

assessment center (JAC); however, they were not found at risk when screened by a clinician during their intake to the center.

A review of three secure observations validated the designated mental health clinician authority (DMHCA) and superintendent/designee were notified in each instance and authorized the placement. A health status checklist was completed for each youth. Each PO was completed in its entirety. Of the three, each documented the ASR was completed within eight hours of placement on secure observation. Each ASR documented the parent/guardian was contacted by telephone and two documented the juvenile probation officer (JPO) was contacted by e-mail after hours and one JPO was contacted by phone during business hours. Of the three, one youth was Baker Acted within an hour of being placed on secure observation and, upon return, was placed on constant supervision. One youth was stepped down to constant supervision within twenty-four hours of placement. The youth was released from the center twenty-five and half hours after placement; however, mental health staff checked on the youth two times during the evening hours when the youth was asleep and met with the youth within twenty hours but did not step the youth down at this time. An additional ASR was completed within twenty-five hours and the youth was stepped down to close supervision. Each of the three instances were noted in the logbook for the secure observation, both placed on and stepped down. The superintendent has an established review process of every serious suicide attempt and a mortality review for completed suicides. The review is part of the suicide prevention plan and includes the required elements. Nine staff were interviewed, and all indicated if youth express suicidal thoughts, they are to notify mental health staff, search the youth and his/her room, document supervision, and provide constant sight and sound. One staff indicated they would place the youth in a locked room. Nine youth were interviewed and four indicated they had been placed on PO and three indicated they were watched by staff the entire time; one youth indicated staff did not watch them the entire time.

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

Nine youth mental health records were reviewed. Of the nine, five documented precautionary observation (PO) logs on the MHSA 006 form. All of the records documented 30-minute checks, with the exception of one, which documented a missed check on August 13, 2018. The PO log documented a check was conducted at 4:31 a.m. and the next one at 5:30 a.m. Of the five, three were not documented in real time, one was, and one only required one 30-minute check before being stepped down to standard after the Assessment of Suicide Risk was completed. None of the records documented warning signs and all documented safe housing on the PO logs. Each log was reviewed and signed by each shift supervisor on each shift and reviewed and signed by mental health clinical staff daily.

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

A review of documented suicide drills and sign-in sheets, validated a drill was completed on each shift for the following quarters: January – March 2018 and July – September 2018. There

was no drill documented for third shirt for the quarter of October – December 2017; nor was there documentation of a drill for first shift for the quarter of April – June 2018. A review of suicide drill documentation, indicated thirty-one of the eighty staff participated in at least two drills semi-annually and twenty-eight of the eighty staff have not been employed with the center a full year; however, of the twenty-eight, nineteen have completed at least one drill. Four staff had no drills documented within the last four quarters, eleven staff had one documented drill, and five staff only had two documented drills in one quarter. Nine staff training records were reviewed for the required six hours of suicide prevention training. Six records documented completion of the required suicide prevention training, one staff did not have any documented suicide prevention training, one completed the two hours of web-based training in the Department's Learning Management System (SkillPro), and one had two hours of SkillPro training and two hours of webinar/instructor led training. Nine staff were interviewed, and each indicated the suicide response kit was located in master control and eight indicated there was also one located in medical and one in each staff bathroom on each of the mods.

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.	

A review of the center's Mental Health Crisis Intervention Plan documented the plan contains each of the required elements. It addresses the notification and alert system, means of referral to include youth self-referral, communication, supervision levels, documentation, and review, as required. The plan was approved and signed by the center's superintendent and designated mental health clinician authority on July 31, 2018. The center has both a combined Emergency Services Plan and a Crisis Intervention Plan in the facility operating procedures.

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.	

A review of the center's Emergency Care Plan documented the plan contains each of the required elements. It addresses immediate staff response, notifications, communication, supervision of youth, authorization to transport for emergency services, transportation for emergency mental health and/or substance abuse evaluation and treatment, documentation, training, and review. The plan was approved and signed by the center's superintendent and designated mental health clinician authority on July 31, 2018. The plan was last revised on July 1, 2017. The plan is located in the superintendent's office, medical clinic, mental health office, master control, and all mods. The plan is also located on the center's central database and is accessible to all staff.

3.15 Crisis Assessments [Contract Provider] (Critical)	Satisfactory Compliance
A Crisis Assessment is a detailed evaluation of a youth demonstrating acute psychological distress (e.g., anxiety, fear, panic, paranoia, agitation, impulsivity, rage) conducted by a licensed mental health professional, 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 not had any crisis assessments in the last six months. The center has a Mental Health Crisis Intervention Plan which indicates a crisis assessment is utilized only when a youth's acute emotional or psychological distress or crisis is not associated with a suicide risk factor. The plan indicates the crisis assessment must be completed by licensed mental health professional or non-licensed mental health professional working under the direct supervision of a licensed mental health professional. The plan further indicates the crisis assessment must be completed on form MHSA 023 in the Office of Health Services (OHS) electronic medical record (EMR) and must contain the required elements. If the youth does not respond to the staff's intervention, the youth should be places on mental health alert and mental health professional is required to complete a crisis assessment and an alert should be entered into the Department's Juvenile Justice Information System.

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

None of the youth records reviewed were for youth who were Baker or Marchman Acted. Mental health staff provided three additional records documenting a Baker Act. In each of the three records, the youth were placed on constant supervision upon return to the center from the Baker Act facility. Each documented a completed medical status examination in the Assessment of Suicide Risk (ASR). Each youth was maintained on constant supervision until an ASR was completed by mental health. Of the three records reviewed, one youth record documented an ASR was completed and the youth stepped down to close supervision. The following day, this youth received an additional ASR and was stepped down to standard. The second youth was released from the center on constant supervision and the parent/guardian was provided a Detention Suicide Risk Notification to Parent/Guardian noting the youth's current suicide risk. The third youth was released on close supervision and the parent/guardian was provided a Detention Suicide Risk Notification to Parent/Guardian noting the youth's current suicide risk. Upon review of the Department's Juvenile Justice Information System (JJIS), each youth's record documented an alert was initiated when the youth was Baker Acted, returned, and placed on constant supervision, and when the youth was stepped down. A review of the logbook for each Baker Act documented when the youth left the center to address the Baker Act and returned from the Baker Act, and documented each youth placed on constant supervision upon return. Upon review of the center's facility operating procedures (FOP), it was validated each documented Baker Act was completed following their FOPs.

Standard 4: Health Services

Overview

Through a written agreement with Maxim Healthcare Services, the center provides medical services for the youth. There is a licensed physician to serve as the designated heath authority (DHA); there is also an agreement with an advanced registered nurse practitioner (ARNP). The program has identified a medical doctor who serves as the DHA's designee when the DHA is on approved leave. In addition to the DHA and ARNP, the on-site medical staff includes one full-time registered nurse (RN), and three full-time licensed practical nurses (LPN). The schedules for the nursing staff are staggered, to allow for nursing staff to provide sick call and other medical services to the youth. There is one full-time medical records clerk.
The center also provides healthcare services through a contract with a psychiatrist; the psychiatrist visits the center weekly to conduct psychiatric evaluations, prescribe psychiatric medications, and monitor youth on psychotropic medications. The psychiatrist is on-call twenty-four hours a day, seven days a week. The center has a medical clinic which includes areas for medication administration, sick call, and storage of youth records and a space for nursing-related administrative functions.

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 a licensed medical doctor to serve as the DHA. The DHA maintains an active, unrestricted license in the state of Florida. The DHA's responsibilities include providing oversight of medical care and reviewing and signing the health-related facility operating procedures and nursing protocols. The contract includes provisions for a doctor to cover 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 and was cleared by the Department's Background Screening Unit. The DHA is required to be on-site on a weekly basis, 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 the DHA or the back-up physician were on-site weekly for the past six months. The DHA was interviewed; she reported completing comprehensive physical assessments, evaluating youth, and being on-call twenty-four hours a day, seven days a week. The DHA reported being concerned at the turnover of the nursing staff, however this has improved; she also reported the non-medical staff need to be informed of who to call after hours.

The contract provides an advanced registered nurse practitioner (ARNP) to provide medical treatment for the youth. The ARNP has a clear and active license, and there is a collaborative practice protocol in place. There is a clear supervisory relationship between the DHA and ARNP. The ARNP completes physical assessments, conducts periodic evaluations on applicable youth, and conducts examinations on youth who have been referred by the nursing staff. The ARNP visits the center twenty hours a week, and is available twenty-four hours a day, seven days a week for consultation with the center staff. The sign-in logs for medical staff were reviewed; there was documentation to support the ARNP was on-site weekly for the past six months.

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 written policies and procedures for health-related protocols. The health-related policies and procedures were reviewed and signed by the designated health authority (DHA) and the superintendent on July 5, 2018. The polices include services related to psychiatric services and psychotropic medication monitoring; this policy was signed by the psychiatrist on August 16, 2018. 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 in July 2018. There are protocols for non-healthcare staff, which provide instructions to juvenile justice detention officers for youth require medical attention when nursing staff are not on-site. There was one nurse hired in the last six months; there was documentation to support the nurse received an orientation on the medical policies and protocols. The orientation was provided by Maxim's regional clinical director, and 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.	

The center has a written policy and procedures to address parental consent. Nine healthcare records were reviewed. Eight records contained either a current Authority for Evaluation and Treatment (AET) or a copy of the valid AET. One youth was also served by the Department of Children and Families and had a court order allowing for the provision of routine medical treatment for the youth included in the record. There were copies of parental notifications located behind the AET in each applicable record.

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

The center has a written policy and procedures to address parental notification, which provides requirements for parental notification and consent when there are changes in the youth's condition and/or treatment. A list of over-the-counter (OTC) medications approved by the designated health authority is sent to all parent/guardians. This form is to be signed and returned to the program, to provide their consent for the medications. Nine healthcare records were reviewed. Each record contained a health-related parental notification which included the list of approved OTC medications, with instructions for the parent/guardian to sign and return the form to the center. The center's nurses sent parental notifications for new prescription medications and changes to medications the youth entered the center with. None of the youth presented at sick call with the same medical complaint three times within two weeks, nor did any of the youth require an immunization. The healthcare records for two youth who were taken off-site for treatment were reviewed. One youth required treatment for on-going ear issues which resulted in the removal of impacted cerumen; the second youth had a tooth extracted. There was no documentation to support the parents/guardians were notified of the procedures

to provide consent. There was documentation in each record of the center sending the parent/guardian notification of the procedure on the day the procedure was completed. All telephone calls and/or attempts were witnessed by a staff member.

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

The center has a written policy and procedures to address the provision of psychotropic medications. Nine healthcare records were reviewed, of which only one was admitted to the center with psychotropic medication. Another youth was subsequently prescribed psychotropic medication while in the center and the center provided a third applicable record for review. A Clinical Psychotropic Progress Note was completed for all three youth. The medications were continued for all three youth. There was a nurse's progress note in each record documenting an attempt telephone to the youth's parent/guardian. There was documentation to support a CPPN and Acknowledgement of Receipt of Clinical Psychotropic Progress Note was sent to all applicable parents/guardians. When applicable for new medication, the CPPNs were sent by certified mail, as required. One youth was in the custody of the Department of Children and Families; however, this youth was not prescribed psychotropic medication.

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

The center has a written policy and procedures to address the verification of a youth's immunization status, which requires a nurse to verify the immunizations upon the youth's admission, to determine whether any immunizations are needed. The center's practice is for a nurse to review the youth's immunization records using the on-line tracking system, 'Florida Shots,' and document the results in the Department's Immunization Tracking Record healthcare record checklist. Nine healthcare records were reviewed and each record contained the youth's immunization record. Each record documented the immunization record was reviewed; the records documented a review for the youth's current admission to the center. All immunizations were documented on the Department's immunization tracking record. None of the youth required any immunizations; therefore, parental notification was not required.

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

The center has a written policy and procedures to address healthcare admission screening. The policy requires the completion of a Facility Entry Physical Health Screening (FEPHS) form on day of the youth's admission to the center. Nine healthcare records were reviewed and each record contained a completed FEPHS form. Each form was completed by a juvenile justice detention officer, on the date of the youth's admission to the center. Each FEPHS form was

reviewed by a licensed nurse within twenty-four hours of the completion of the form. An interview with the superintendent confirmed the observed practice.

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 has a written policy and procedures to address the placement of youth on medical alerts. The center's nursing staff places and discontinues alerts for youth in the Department's Juvenile Justice Information System (JJIS), as well as the internal alert system, as needed. The nurse completing the admission chronological progress note documents completion and verification of alerts. Nine healthcare records were reviewed, of which six youth were applicable for placement on the medical alert for allergies, chronic conditions, pregnancy, or for taking psychotropic medications. The youth were placed on and removed from JJIS alerts as required, with one exception. One youth was placed on a psychotropic medication following his admission to the center; this was not listed JJIS. The superintendent was interviewed; he described the center's alert process as having the nursing staff, juvenile justice detention officers, and juvenile assessment center staff place alerts as needed, and a review daily during shift briefings. Nine were interviewed and eight staff reported learning of youth's medical alerts through the logbook, and shift briefings and seven staff reported through the alert form. Six staff reported this was a very good system, two reported this was a good system, and one staff reported it was a fair system.

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.	

The center has a written policy and procedures to address the screening of youth at risk for suicide, requiring youth to be administered a Suicide Risk Screening Instrument (SRSI) upon admission to the center. There is a section of the SRSI which is to be completed by a medical or mental health provider; the SRSIs are to be completed within twenty-four hours of the youth's admission to the center. Completed SRSI forms are to be maintained in the youth's healthcare record. The nurse completing the admission chronological progress note documents whether the SRSI was completed. Nine healthcare records were reviewed and each contained a completed SRSI. The required sections were completed by a nurse or mental health clinician within twenty-four hours of each youth's admission to the center. All of the SRSIs were maintained in 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.	

The center has a written policy and procedures to address the provision of healthcare orientation to the youth. Upon admission to the program, a comprehensive orientation to the center's medical services is provided by a licensed nurse. The nurse completing the admission chronological progress note documents the completion of orientation to healthcare to the youth. The nurses maintain a binder which includes an outline of the orientation information provided to the youth. Nine healthcare records were reviewed. The admission progress notes for each

youth documented the provision of orientation to healthcare services. The orientation covered the following required elements: how to access sick call, what constitutes an emergency, how medications are administered, to notify staff immediately upon having medication side effects, the right to refuse medical care, what to do in the event of actual or attempted sexual assault, and the non-disciplinary role of healthcare providers. The orientation was also documented in each youth's Health Education Record. The orientation was provided within twenty-four hours of the youth's admission to the center for eight youth. The orientation for one youth was completed forty-eight hours after the youth was admitted.

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

The center has a written policy and procedures to address notification of the designated health authority (DHA), which requires notification to the DHA upon a youth's admission to the center if the youth has a chronic medical condition or there is a medical emergency. The center's practice is to notify the DHA upon each youth's admission, regardless of the youth's medical history or condition at admission. Nine healthcare records were reviewed and each contained an admission chronological progress note which documented notification of the DHA. None of the youth were admitted with an emergent medical issue. Three youth were admitted with a chronic condition, and one youth was pregnant upon her admission to the center, and the DHA was immediately notified of the applicable youth's admissions. The center maintains a list, which is completed each day, listing the names of the youth who had been admitted to the center. The list includes any medical issue, medications, and allergies of the youth and is sent daily to the DHA and the psychiatrist.

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 written policy and procedures to address healthcare rescreening. The policy requires a screening to be completed on youth who have been out of the physical custody of the center for longer than twenty-four hours. The screenings are required to be completed within twenty-four hours of the youth's return to the center. One of the nine healthcare records reviewed was applicable for a rescreening; therefore, two additional applicable records were provided for review. The three youth were temporarily transferred to another center and returned. There was a new Facility Entry Physical Health Screen (FEPHS) form completed for each youth which were completed by a nurse. Each rescreening was completed on the day of the youth's return to the center.

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

The center has a written policy and procedures to address the completion of a Health-Related History (HRH) form. The policy requires the completion of an HRH form within seven days of a youth's admission to the center. Nine healthcare records were reviewed and each record contained either a new or updated HRH on the most recent Department form. Each HRH form

was completed by a licensed nurse, on the day of the youth's current admission to the center. The HRH forms were consistently completed or updated prior to the completion of each youth's Comprehensive Physical Assessment (CPA). There was documentation to support each HRH form was reviewed by the advanced registered nurse practitioner at the time the CPA was completed. The admission chronological note in each record documented the date the HRH was scheduled and/or completed.

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

The center has a written policy and procedures to address the completion of a Comprehensive Physical Assessment (CPA) within seven days of the youth's admission to the center. The nurse completing the admission chronological progress note documents the date each youth is scheduled for a CPA or focused examination. Five of the nine healthcare records reviewed contained a new CPA. Each CPA had been completed by the advanced registered nurse practitioner (ARNP) within seven days of the youth's admission to the center. Each reviewed CPA was completed as required, with a check of the youth's visual acuity, body mass index, scalp, head, cardiovascular and medical grade. Each CPA contained portions of the evaluation which had been deferred by the clinician. In the remaining four records, the CPA was current at the time of the youth's admission to the center. There was a focused evaluation completed by the ARNP within seven days of admission in each of the four records. The applicable youth's Department Problem Lists were updated following the completion of the CPA.

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

The center has a written policy and procedures to address the provision of female-specific evaluations. The standing admission order from the designated health authority requires the nurse to perform a pregnancy test on all female youth upon admission. Three of the nine healthcare records reviewed were applicable for female-specific evaluations. One youth was eight months pregnant at the time of her admission to the center and a pregnancy test was conducted for the remaining two youth. Both youth provided consent for the pregnancy test. None of the youth were provided gynecological examinations during their Comprehensive Physical Assessments (CPAs). Nine youth were interviewed, of which two were female. One youth reported receiving gynecological services while in the center and the other reported not needing any services.

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

The center has a written policy and procedures to address the completion of a tuberculosis screening for each youth admitted to the center. The standing admission order from the designated health authority (DHA) requires an update of the youth's tuberculin skin test (TST). If a youth's TST is not current at their admission to the center, the nurse completing the admission process conducts a TST. If the screening is positive, the youth is not to be placed in general

population until medically assessed by the DHA. Six of the nine healthcare records reviewed contained a current TST. The nurse completed a TST for the other three youth who required one at the time of admission. The results of the current TSTs were documented on each youth's Infectious and Communicable Disease form, and on their Comprehensive Physical Assessment. There was documentation on each reviewed Facility Entry Physical Health Screening form to support the Tier I tuberculosis screening section was completed upon the youth's admission to the center within seventy-two hours of admission. None of the youth required further evaluation for tuberculosis.

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

The center has a written policy and procedures to address sexually transmitted infection (STI) screening. The policy requires the screening of youth upon admission to the center. The designated health authority (DHA) or advanced registered nurse practitioner (ARNP) review the screening form and determine whether the youth requires STI testing and completes an order for testing. Upon the completion of the STI test, the results will be documented, and any required treatment started for the youth. All nine reviewed records contained documentation to support the nurse completed the STI screening form on the date of the youth's admission to the center. Each form was reviewed by the ARNP. Three of the nine youth were applicable for further testing. There was documentation to support STI testing was completed for each applicable youth. The results were documented on two youth's Infectious and Communicable Diseases form and the lab results were filed in the appropriate section of both youth's healthcare records. The test for one youth was sent to the laboratory while the annual compliance review team was on-site. One youth required treatment, which was provided.

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

The center has a written policy and procedures address testing for the Human Immunodeficiency Virus (HIV) for youth in the center. The program has entered into a contract with a local community agency, Metro Wellness, to provide HIV testing and counseling services for the youth and there was documentation confirming the counselor is certified to provide HIV testing services. During the healthcare admission process, an HIV risk assessment is completed by the youth, which is signed by the youth and the nurse conducting the assessment. The youth are presented with the Department's HIV consent form, which allows the youth to consent or refuse an HIV test in writing. Youth who request to be tested are placed on an HIV testing log. The log is a pre-printed form in which the youth's name, the youth's Department identification number, the date the youth was tested, and whether pre and post-test counseling was conducted are to be documented. The youth consenting to be tested will be seen when the counselor next visits the program. The youth are provided the results of the test verbally. Youth receive pre and post-test counseling on the day of testing.

Nine healthcare records were reviewed and there was documentation to support each youth completed the HIV risk assessment. Two youth consented, in writing, to be tested and the remaining seven youth refused in writing. One youth consented for the HIV test while the annual compliance review team was on-site; this youth was placed on the HIV testing log, to be seen

when the HIV counselor is next on-site. The center provided two additional applicable records for review. There was documentation to support all three youth were tested and contained documentation of pre and post-test counseling. The center does not maintain HIV test results in the youth's healthcare record. The youth are provided the results verbally, by the HIV counselor. The youth are provided a business card with the telephone number of the testing agency, to receive further information upon their release from the center. The HIV consent form signed by the youth contains information the youth will receive test results in person. One youth was pregnant and refused the HIV test in writing. Nine youth were interviewed and all nine reported being able to request 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.	

The center has a written policy and procedures to address the provision of sick call. The nurses conduct sick call seven days a week, following medication administration. There are blank sick call request forms placed in the youths' living area. The forms then entered into the Department's Facility Management System and a list of youth to be seen is electronically generated, with the youth's name, date of request, the name of the juvenile justice detention officer who entered the information, and the youth's medical complaint. Upon conducting sick call, the nurse completes the remainder of the sick call form. Completed forms are filed within the progress notes section of the applicable youth's healthcare record. The youth signs the sick call list while being evaluated by the nurse. A referral to the designated health authority (DHA) is required when a youth presents a serious health issue or complains of the same issue three times during a two-week period.

A review of nine healthcare records found six youth submitted ten sick call requests. None of the youth presented with the same complaint three or more times in a two-week period, nor did any of the youth present with severe pain for which the nurse was unfamiliar. None of the youth had a medical issue which was considered an emergency. The sick call documentation was completed by the nurses in the Subjective, Objective Assessment and Plan (SOAP) format. Nine youth were interviewed; one youth reported being seen immediately upon submitting a sick call request and eight youth reported being seen within one day.

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

The center has a written policy and procedures to address the provision of sick call. During their admission to the center, youth receive an orientation to the healthcare process, which includes information on the sick call process. The forms are completed electronically and a list of youth to be seen is electronically generated, with the youth's name, date of request, the name of the juvenile justice detention officer (JJDO) who entered the information, and the youth's medical complaint. If a licensed practical nurse (LPN) conducts sick call, the sick call is to be reviewed by a registered nurse (RN) within twenty-four hours.

A review of nine youth records found six of the youth submitted ten sick call requests. All of the sick call complaints were handled by an RN. Youth submitted sick call complaints for headaches, knee pain, ear pain, back pain, athlete's foot, stomach ache, and tooth pain. All of

the reviewed sick call forms documented the youth's vital signs and were completed in the Subjective, Objective, Assessment and Plan (SOAP) format. One youth submitted two sick call forms; however, the youth refused to be seen for both sick calls, therefore the sick call list was not signed by the youth. The youth signed the sick call log to document being seen for sick call in seven of the remaining eight sick call events. Each call event was documented on the applicable youth's sick call index.

During the annual compliance review, sick call was observed for two youth. Both of the youth provided verbal permission for the observation. The sick call was conducted by an RN, in the medical clinic. The youth were escorted to and from the clinic by a JJDO who remained in the room during the examination of the youth. The youth were asked about his symptoms, vital signs were taken and documented on the sick call complaint form. Youth were provided treatment as permitted by the nursing protocols. One youth was also evaluated by the advanced registered nurse practitioner. Both youth were comfortable with the process. Nine staff were interviewed and all reported the nurses conduct sick call. Nine youth were interviewed and two youth reported never having a sick call. Seven 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 written policy and procedures to address access to medical care, which includes requirements for youth placed in restricted housing of any kind. The policy requires the supervisor on each shift to question the youth placed in confinement regarding medical related issues. The supervisors are to notify medical personnel staff of the placement of youth into restricted housing. The nursing staff are required to make a daily visit and complete a narrative entry in the chronological notes of the youth's healthcare record. Nine healthcare records were reviewed, of which three indicated the youth had been placed in confinement for less than twenty-four hours. There was a case note in each applicable record to document the youth was seen by a nurse while placed in confinement. One of the youth was taking prescribed medication and there was documentation to support the youth was provided medication while in confinement. There were two youth who were placed in medical confinement due to having lice.

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 written policy and procedures to address episodic and first aid care for the youth. A roster is utilized to document when youth require episodic care or first aid treatment. The designated health authority approved the items placed in the first aid kits. There are seventeen first aid kits located throughout the facility. Three first kits (one transport van, master control, and one living mod) were opened to review contents. All of the kits were sealed and each kit contained all of the required items. The saline solution in two kits had expired and was removed and replaced in the kits. The first aid kits were inventoried monthly by the center's registered nurse which were documented on a log. It was noted there were no items in the first aid kits which were sensitive to extreme heat.

Nine healthcare records were reviewed and indicated five youth required episodic or first aid treatment, for a total of eight events. The youth received treatment for pregnancy-related

medical issues, ear pain, placement in confinement, and a hand sprain. Each instance of episodic care was treated by a licensed nurse and was documented as a progress note in the applicable youth's healthcare record. The charting narrative was in the Subjective, Objective Assessment and Plan (SOAP) format. Seven of the eight instances of episodic treatment were documented on the center's episodic care log. The center did not have any examples of episodic/first aid treatment being rendered by a non-healthcare staff.

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

The center has a written policy and procedures to address emergency care for the youth. The policy requires all staff to contact 9-1-1 in the event of a potentially life-threatening situation involving a youth. The program's policy requires medical emergency drills be conducted quarterly on each shift. The staff are required to maintain certifications in first aid, cardiopulmonary resuscitation (CPR), and automated external defibrillator (AED). The training records for eighteen 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 and 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. All of the center's nurses had current first aid and CPR certifications. There is a list of emergency telephone numbers, including poison control, posted in the medical office.

There was documentation to support the center conducted monthly medical drills on each shift for the past six months. The drill documentation was reviewed and found there were drills completed for shortness of breath, Protective Action Response (PAR) injury, non-responsive staff, convulsions, chocking, seizure, tightness in chest, youth hanging, and abdominal pain. Two drills demonstrated the use of CPR. The drill forms consistently included the date of the drill, the time the drill was called and completed, the shift, the nature of the incident, the persons involved and their actions, and the type of drill. One drill did not contain a scenario, rather contained instructions of what staff should do. Seven drills documented the response time of the medical staff. Thirteen drill forms documented recommendations for improved emergency response. corrective action. The forms were signed by the staff responding to the drill.

There are three AEDs at the center. The AEDs are located in in master control, the medical clinic, and on one living mod. There was documentation to support the AEDs were checked monthly to ensure the devices remain charged and operable. The center's registered nurse documented the monthly checks on the AED maintenance and inspection log. During the annual compliance review, all three AEDs were checked. All devices have voice procedures, to prompt the user in how to use it. Each AED was noted to be operational. 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. The battery in the AED on the youth living mod expires in January 2021; the pads expire in October 2018. Nine staff were interviewed and each 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 written policy and procedures to address the provision of off-site treatment to youth. The policy requires the completion of the Summary of Off-Site Care for all youth transported off-site for medical treatment. The policy also requires the designated health authority (DHA) or advanced registered nurse practitioner (ARNP) to review and initial all orders sent back with the youth to the center. None of the nine healthcare records reviewed were applicable for off-site medical treatment; therefore, the center provided three additional applicable records for review. The three youth were taken off-site: one pregnant youth was taken to a community health center, one youth was taken to an Ear, Nose, and Throat specialist for ear issues, and one youth was taken to a dentist for a tooth extraction. The DHA was notified when each youth was taken off-site. There was not a Summary of Off-Site Care form for one youth. There was applicable discharge paperwork presented for all three youth which the DHA or their designee initialed to document their review of discharge instructions for one youth. Two youth required follow-up treatment for the treatment received. One youth was released prior to the follow-up appointment; however, the information was provided to the youth's parent/guardian. The second youth was placed in a residential program prior to the follow-up appointment and the information was provided to the residential program staff. All three instances of off-site treatment were documented on the center's episodic log. In an interview, the ARNP reported youth who are sent off-site for treatment are tracked on the episodic log. The ARNP further reported she or the DHA reviews all orders to determine whether the orders are to be continued.

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

The center has a written policy and procedures to address monitoring youth with a chronic illness. During the healthcare admission to the center, a nurse completes the admission chronological note, which documents any chronic condition the youth may have. All youth are placed on a list to be seen by the designated health authority (DHA) or advanced registered nurse practitioner (ARNP) on their next visit to the center. The list includes a column to document a youth's chronic condition and any prescribed medication. The policy requires youth with chronic medical conditions to be evaluated at least every ninety days. The center's practice is to evaluate all youth who have been in the center at least every ninety days, regardless of the youth's medical history.

Nine healthcare records were reviewed and found three youth were applicable for placement on the chronic conditions roster for asthma and abnormal body mass index. Each youth was placed on the chronic roster. Two of the three youth had been in the center long enough to have a periodic evaluation completed; therefore, the center provided an additional record for review. All three youth received a periodic evaluation by the ARNP. A treatment plan was developed for two youth. The center provided the healthcare records for three youth who were taking psychotropic medication; however, none of the youth had been in the center long enough to have medication management conducted by the psychiatrist.

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

The center has a written policy and procedures to address medication verification requirements. If a youth is admitted to the center taking prescription medications, the medication regime is required to be verified by the nurse conducting the healthcare admission process. The center only accepts medications from a licensed pharmacy, with a current, patient-specific label on the original medication container. Nine healthcare records were reviewed, of which only one was applicable for medication verification. One youth, who was pregnant, was taking several medications while at home, which were brought by the youth's parent/guardian to the center. The medication receipt completed when the youth was admitted listed pre-natal vitamins, folic acid, a prescription medication, and an inhaler. There was no further documentation of the prescription medication in the youth's healthcare record and the medication receipt completed when she was released did not document the prescription medication. The center nursing staff reported the prescription medication was returned to the youth's parent/guardian on the day the medication was brought in however she neglected to revise the receipt. None of the remaining eight youth entered the center with medication; however, the center was able to provide two additional applicable healthcare records for review. There was documentation indicating the medication was verified. All medications the youth entered the center with were documented on the admission progress note in the applicable youth's healthcare record. The records documented notification to the designated health authority (DHA) and the psychiatrist of the medication for all three youth. There was documentation to support a verbal order to continue the medications for each youth.

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

The center has a written policy and procedures to address medication management, which requires all medications to be given pursuant to a current prescription or physician order. Nine healthcare records were reviewed. One of the nine youth was admitted to the center with prescription medications; therefore, the center provided two additional applicable records for review. The medications for each youth were ordered to be continued by the designated health authority or psychiatrist. Two youth were prescribed medications subsequent to their admission; each medication was provided with a current, valid order. Any changes to medications were provided with a valid order. Two youth were provided over-the-counter (OTC) medications not listed on the Authorization for Evaluation and Treatment (AET); however, the medications were consistently provided in accordance with approved protocols. There was documentation on each youth's Medication Administration Record to support the youth received all medication as prescribed.

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 written policy and procedures to address the storage of medication and items defined as sharps. The policy includes a process for the destruction and disposal of applicable

medications. There is a medical clinic in the administration area of the center and is always locked. All medications, including prescription and over-the counter (OTC) medications are maintained in the clinic. All current prescription medications for the youth, and a working supply of over-the-counter medications are maintained in the locked medication cart. The medication cart, which has separate drawers in which various types of medications are stored, is always kept in the locked clinic. Each youth's medications are maintained separately. There are bulk OTC medications stored in locked cabinets in the clinic. All medications are inaccessible to youth. The narcotics and controlled medications are on the medication cart, behind two separate locks. There is a locked refrigerator in the clinic for medications and medical supplies requiring refrigeration. Observations of the medication refrigerator found it was locked and contained only medical supplies. The temperature of the refrigerator was checked and documented daily. All sharps are securely maintained in the clinic. There was documentation to support the program followed their policy regarding the disposal of medications.

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 written policy and procedures to address the storage of medication and items defined as sharps, which includes procedures to follow in the event of any discrepancies in the counts. There is a clinic in the administrative area of center which is locked at all times. There is locked medication cart which contains a working supply of over-the-counter (OTC) medications, as well as the prescription medications for the youth. The center securely maintains 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 and found the inventories were completed as required. During the annual compliance review, the counts of three sharps, including suture removal kits, Kelley forceps, and insulin syringes were matched against the current inventory; all counts matched the inventory. Three OTC medications including ear wax removal, cough syrup, and lidocaine injection were counted and the counts of all three items matched the current inventory. Three youth specific prescription medications were counted and 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 written policy and procedures to address the management of controlled medications, including procedures for conducting shift-to-shift counts. There is locked medication cart which contains a working supply of over-the-counter (OTC) medications, as well as the prescription medications for the youth. The controlled medications are stored behind a second lock on the medication cart. There was one youth currently taking one controlled medication. The center documented a perpetual count of the controlled medication on the applicable youth's Controlled Medication Inventory Record. The controlled medication was counted; the number matched the youth's Medication Administration Record. The nurses consistently conducted a shift-to-shift count of the medication. A shift-to-shift count of controlled medications was not observed during the annual compliance review.

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

The center has a written policy and procedures to address medication administration. The center utilizes pre-printed pharmacy Medication Administration Records (MAR). Nine healthcare records were reviewed; four youth did not have any prescription or over-the-counter (OTC) medications. One youth entered the center with medications; therefore, the center provided two additional applicable records for youth who entered the center with medications for review. There was a completed MAR documenting administration of OTC medications, as well as prescription medications for seven youth. This included five youth who were prescribed medication during the stay, plus the two additional records provided for youth entering the center on medications. Each reviewed MAR contained the youth's name, Department identification number, date of birth, allergies, side effects, medical grade, precautions, and medical alerts. The start/stop dates and monitoring of side effects were consistently recorded on the MARs. There is a photograph of each youth with the active MARs, to assist in the medication administration process. The active MARs are placed in a binder on the medication cart. A review of the applicable MARs documented each youth received medications, as ordered. The nurses provide medication to the youth every day; however, trained supervisory staff are authorized to administer medication when licensed medical staff are not on-site.

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 written policy and procedures to address their medication administration process. The nurses have been scheduled to allow for medical coverage between 7:00 a.m. - 7:00 p.m., seven days a week. The nurses provide medication to the youth each day. There were no youth requiring the administration of parenteral medications. During the annual compliance review, the medication administration process by a licensed nurse was observed for four youth. Each youth provided verbal consent for the observation of the medication administration. The youth were escorted to the clinic by a juvenile justice detention officer (JJDO). There is counter in the clinic; the youth and the JJDO stood on one side of the counter, with the nurse on the other side, with the medication cart. The youth were asked their name, the medication they were taking, and whether they were having any issues. The nurse's sole responsibility was to provide the medication, as the JJDO supervised the youth. The youth were provided a cup of water and were handed the medication in a small paper container. After the youth swallowed the medication, the nurse had the youth open their mouth and cough, to verify the youth swallowed the medication. The nurse and each youth initialed the Medication Administration Record. In this annual compliance review period, the center had one incident reported to the Central Communications Center (CCC) involving medication. On March 24, 2018, one youth was not provided two dosages of medications; one dosage should have been administered by a licensed nurse. The report was closed, as there was no evidence of grave harm. Nine youth were interviewed and five youth reported not taking medication and four youth reported nurses provided medication.

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

The center has a written policy and procedures to address the medication administration process. There are trained non-healthcare staff available to assist youth in the self-administration of medication when licensed healthcare staff are not on-site. The center has a list of supervisory staff, identified by name and title, who are authorized access to medications. The medication administration process by non-licensed staff was not observed during the annual compliance review, as non-healthcare staff rarely provide medication to the youth.

Nine healthcare records were reviewed; however, there were no examples in which non-medical staff provided over-the-counter (OTC) medications to the youth. On March 28, 2018, the nurse was unable to be at the center in time for the youth to receive their morning medication, therefore a juvenile justice detention officer supervisor (JJDOS) provided the medication for seven youth. The medication administration records (MAR) for the seven youth documented each youth received medication. Each youth and the JJDOS initialed the MAR to document receipt of the medication. During this annual compliance review period, the center had one incident reported to the Central Communications Center (CCC) involving medication. On March 24, 2018, one youth was not provided two dosages of medications; one dose should have been provided by a non-healthcare staff. The report was closed, as there was no evidence of grave harm. All nine interviewed staff reported they did not give medication to the youth. Five of the nine interviewed youth reported not taking medication and four youth reported nurses provided medication. Two youth also reported receiving medication from non-healthcare staff.

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

The center has a written policy and procedures to address monitoring youth taking psychotropic medications. The procedures did not include standing orders for psychotropic medications nor for the provision of emergency treatment orders for psychotropic medications. Upon admission to the center, notification is provided to the designated health authority (DHA) for all youth. For youth taking psychotropic medication upon admission, the DHA and the psychiatrist are to be notified. The psychiatrist determines whether the medication should be continued until an evaluation can be completed. Nine healthcare records were reviewed. One record indicated the youth was taking psychotropic medication while at home and documentation showed the psychiatrist was notified. A psychiatric evaluation was completed on the youth within the required timeframe and medication was ordered upon receiving consent from the youth's parent/guardian. The center provided two additional records of youth who entered the center with psychotropic medication for review. The psychiatrist was notified upon admission for both youth. A psychiatric evaluation was completed for both youth within the required timeframe and medications were continued for both youth following the evaluation. Each psychiatric evaluation was completed using the Clinical Psychiatric Progress Note (CPPN) and contained all required information, including the identifying data, diagnosis, target symptoms of each medication, evaluation, and description of the effect of prescribed medication, dosage and quantity of

prescribed psychotic medication, side effects, youth's adherence to the medication regime, and vital signs, when appropriate. The evaluations were signed and dated by the psychiatrist. None of the youth were applicable for medication monitoring. The center did not have any youth who had been in the center long enough to have medication management conducted. None of the youth required Tardive Dyskinesia screening.

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, with one exception. The plan did not contain information regarding tuberculosis, as there is a separate policy which address tuberculosis control and screening. The medical provider has separate instructions staff are to follow for needle stick claims. The infection control plan was reviewed and signed by the designated health authority and the superintendent on July 5, 2018. The plan addresses requirements for staff training, hepatitis B vaccination, and post-exposure follow-up. The center offers hepatitis B vaccinations to all staff. During pre-service training, staff are provided information regarding hepatitis B immunizations. There have been no reportable incidents to the local county health department and/or Centers for Disease Control and Prevention 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.	

The center's infection control plan contains requirements for the provision of infection control training for staff and youth. The healthcare records of nine youth were reviewed. Each record contained documentation infection control education was provided within seven days of the youth's admission to the center. All required elements, including hand washing, standard precautions, the prevention of communicable diseases, vaccinations, and the Centers for Disease Control and Prevention guidelines were included. The education was documented on the Health Education Record in each youth's healthcare record. The training records of nine staff were reviewed for the receipt of in-service training. Six records documented training on the center's exposure control/infection control plan and blood borne pathogens. There was no documentation to support three staff received the training in 2017. The training was provided annually as in-service, and as part of the center's pre-service training; the training was facilitated by a nurse.

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 a combined infection control and exposure control plan. The plan includes all required elements, including risk assessment and methods of compliance. The exposure control plan is available for the staff in the clinic. The plan was reviewed on July 5, 2018 by the designated health authority and the superintendent. There is training on the center's exposure control plan provided annually by the center's registered nurse. There is also a copy of the exposure control plan in a separate binder in the staff room, for easy access when needed.

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 written policy and procedures to address the care of pregnant youth. Only one of the nine youth healthcare records reviewed was applicable for prenatal care; therefore, the center provided two additional applicable records for review. There was a pregnancy test provided for two youth upon their admission. The remaining youth was eight months pregnant upon her admission to the center. The designated health authority (DHA) was notified for all three youth and prenatal care began immediately for all three youth. The DHA ordered folic acid and pre-natal vitamins for all three youth, which were started immediately for all three youth. The Medication Administration Records for each youth documented the youth received the vitamins and supplements daily during their stay in the center. During the daily administration of vitamins, the youth were monitored for danger signs of pregnancy complications which was documented as a progress note for each monitoring. One youth was released to home detention within two days of being placed in secure detention and the remaining two youth were in the center for less than two weeks. One youth was taken off-site for an evaluation by an obstetrician.

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 written policy and procedures to address the care of pregnant youth. The center has a binder of education topics related to pregnancy, to be presented to pregnant youth. Nine healthcare records were reviewed, of which, only one was applicable. The center provided two additional applicable records for review. There was documentation in each youth's record 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 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 written policy and procedures to address the care of pregnant youth, which includes training requirements. The training records of nine staff were reviewed for the receipt of in-service training. There was documentation to support six staff received training on monitoring, observation, and emergency care of the youth; three staff did not receive this training in 2017.

Standard 5: Safety and Security

Overview

The primary responsibility of all staff at the Pinellas Regional Juvenile Detention Center is the safety of the youth in the Department's custody and the security of the center by ensuring staffing patterns and staff compliance with the center's Facility Operating Procedures (FOP) consistently provides for effective supervision of the youth during all center activities. The four-building center has five living modules for housing youth; however, during the annual compliance review, only four of the units were populated, allowing for the vacant module (Charlie) to be refurbished. One module (Echo), is designated for females and the three remaining modules (Alpha, Bravo, and Delta) house the males. Capable of appropriately maintaining a census of 100 youth, there were eighty-one youth detained at the center on the first day of the annual compliance review. Trained juvenile justice detention officers are responsible for the direct supervision of the youth through each of three daily eight-hour shifts. JJDOs supervise wake-up and hygiene activities, school and recreational activities, mealtimes, visitation, the application of the behavior management system and off-site transports. All common areas of the center are monitored using a video surveillance system which utilizes 112 cameras and seven digital video recorders. The recorders store footage for thirty days. During the annual compliance review, it was observed ten of the cameras were not operable and an additional sixteen camera views were either obstructed or blurry. Maintenance is reportedly addressing the camera issues, however, the superintendent further indicated, because of duplication in camera angles, all common areas of the facility are under surveillance. The center uses a wand monitoring system to document the JJDO's visual checks of all youth when placed in their rooms. Additionally, the program maintains a chronological record of the youth counts, events, incidents, and center activities in logbooks in master control and each living module.

The center's current maintenance mechanic has been on-site approximately two weeks, having transferred from another nearby center. Amongst their many responsibilities, the administrative staff provide and oversee the center has an effective key control system, the staff are appropriately trained to provide supervision to the youth and to respond to emergency situations, and they conduct walk through checks during each shift to ensure the security of the center. The maintenance mechanic is responsible for facility safety ensuring all necessary repairs to the facility, grounds, and transport vehicles are completed in a timely manner, and all flammable, toxic, and poisonous items, as well as, all potentially dangerous tools used at the center are inventoried, maintained, and disposed of, as needed, while being consistently inaccessible to the youth.

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 primary focus of the center's Facility Operating Procedures (FOP) is to provide guidelines to ensure all detained youth are afforded effective supervision in a safe and secure environment. These guidelines seek to ensure the center implements appropriate staffing patterns, activity scheduling, and supervision techniques to consistently promote the safety of the youth and the staff at the center while minimizing potential risks to safety or security. During the annual compliance review, the review team observed and documented the staff practice of active supervision during each of the four days the team was on-site. The team was able to observe staff supervision of youth engaged in a variety of activities including meals, line movements, medication pass, school, recreation, and treatment team meetings. There were observations of youth/staff interactions, youth movements and counts, youth behavioral compliance with center rules, and staff application of the behavior management system. Additionally, the review team members conducted interviews with various staff and to determine if officers are aware of how many youth they were supervising. Master control and module logbooks were reviewed to verify regular youth counts were conducted, staff were aware of youth alerts/special needs to provide appropriate supervision, and staff were documenting their observations to communicate with staff on other shifts. Overall, staff supervision of youth was observed to be appropriate and conscientious. Staff were often seen positioning themselves to ensure their vantage point provided direct supervision of as many youth as possible. Youth are directly supervised by staff in the module and are observable by master control staff in all areas of the facility through video surveillance. Master control is situated so it faces the main recreation yard, enabling additional staff to observe youth directly when the youth are engaged in recreation activities. All youth movement is authorized by the master control operator prior to the movement and documented in the appropriate master control logbook. During movement, youth are always escorted by juvenile justice detention officers who carry two-way radios to communicate with master control. Typically, one officer walks behind the group to monitor the movement of the youth ahead of them. During the annual compliance review, movement was observed directly and through camera surveillance. A review of camera footage and direct observation confirmed active supervision of youth in the dormitories and classrooms, and at all other times and locations, including in the classroom, on the recreation field, and during sleeping hours. At no time during the annual compliance review, was any youth observed to be

without staff supervision. Ten-minute checks were observed to be conducted on the youth in confinement and documented on the Visual Observation Report. The reviewer approached four different JJDOs and asked them to state how many youths they were supervising at the time and each time, the JJDO correctly stated how many. Two of the JJDOs subsequently commented youth are never removed from an area by another staff, such as a nurse or mental health clinician, without notification of the JJDO assigned to supervise the youth. There were no observances or reports of instances when a youth was permitted to supervise or discipline another youth. All observed staff and youth interactions appeared appropriate and positive, and there were instances when it was clear to the reviewer the staff and youth had formed a healthy rapport. Accordingly, a review of the additional comments seven of nine youth made during the interview process indicated the youth perceive the staff as caring and supportive. Nine randomly selected staff, representing at least one staff from each of the three shifts, were interviewed. Seven of nine staff indicated there are sufficient staff to provide for the safety and security of the youth and staff at the center. The two staff who responded negatively reported frequent holdovers.

5.02 Ten-Minute Checks (Critical)	**Failed 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's Facility Operating Procedures (FOP) clearly address the requirements regarding the consistent visual observations of youth when they are placed in their rooms for to prepare for showers, due to illness or placement on confinement/room restriction, or to sleep. The requirement is for staff to conduct visual observations of each youth on standard supervision at least every ten minutes until they are no longer in their room. If a juvenile justice detention officer (JJDO) is unable for any reason to observe the youth or any part of the youth's body, the officer is to request the assistance of another officer and open the door of the youth's room to confirm the youth is present and safe. Each youth room has a vertical window inserted into the door to facilitate the observation of a youth when in their room. During the facility tour, it was observed some of these windows have numerous etchings/scratches, on the surface; however, none of the markings were significant enough to inhibit the completion of the visual observations. Neither were any other items (stickers, photographs, clothing) observed obstructing the view into the youth rooms during the tour.

The center conducts and records ten-minute checks while youth are in their rooms sleeping, utilizing camera surveillance and the Brooklyn Computer Systems (BCS) silver-guard monitoring system. Staff utilize the electronic BCS wand by tapping it on the checkpoint sensors on the

outside of each youth's room. A review video footage verified staff visually observe each youth in a manner consistent with the FOP. Each morning, the data from each wand is downloaded to ensure the data recorded and print outs of the data can be provided to administration for review. A review of video footage from July 23, 2018 through August 4, 2018 was conducted encompassing four different dates, all four modules, and all three shifts. Two of the dates were weekends and two of the dates were weekdays. The review of a Sunday morning occurred during hygiene time when not all youth were in their rooms, therefore not all required room checks. Ultimately, the review offered forty-one check opportunities and found, with two minor exceptions, checks were completed consistently within the ten-minute time frame. Two consecutive checks of one youth were observed to occur three and then fifteen minutes late. Upon request of the wand data sheets, the reviewer was informed due to a downloading glitch occurring at least six weeks prior, the wand reports were unavailable. To substantiate their claim, the center provided a copy of a work order to repair the problem. Though aware the wand information could not be accessed, the center did not implement the use of written Visual Observation Reports (VOR) to document the completion of ten-minute checks. Aware documentation of the room checks was needed, the administrative staff produced numerous print outs of wand information for review; however, these print outs lack any clarity as to the modules and room numbers the data represented. Ultimately, the center was unable to provide written documentation verifying room checks were conducted, as stipulated in the FOP. Neither was the center able to provide documentation recording the required completion of forty-eight-hour superintendent reviews of the wand check documents.

Center practice regarding documentation of ten-minute checks on youth in confinement during daytime hours is the completion of a VOR. Seeking to confirm these checks are completed appropriately, a review of camera footage of three different youth in confinement, on three different dates, in three different modules was attempted. While observations of staff conducting three ten-minute checks of a youth in the Delta dormitory was completed, it was difficult to discern whether checks were effectively completed in the other two instances because more than one youth was in confinement at the time and the youth's room number was unknown to the annual compliance review team member. When asked to provide the VORs for the three randomly selected confinements, including the confinement which was just observed on videotape, the program was unable to do so. All nine of the interviewed staff confirmed their awareness room checks are to be conducted every ten minutes when a (non-suicidal) youth was in their room sleeping or for non-punishment reasons.

5.03 Census, Counts, and Tracking	Limited 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 kmdue 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).

A review of the center's Facility Operating Procedures (FOP) requires the center to ensure the exact number and location of all youth under their supervision are known to staff at all times. Direct observations, an interview with the master control operator, and a review of the master control logbooks indicated the center reliably tracks the youth census through the process of repeatedly conducting routine and randomized head counts during each shift. A review of random sections of four master control logbooks dated from February to mid-June noted consistency in youth head counts occurring at the beginning and end of each shift, after each group movement from one area of the facility to another, whenever a new admission or a release occurred, and a minimum of at least once randomly during the shift. Additionally, the annual compliance review team member observed instances in the master control logbook where youth head counts occurring after a program code had been called and after a power outage were documented. The counts are documented by module, listing each module and the count. Observations of several entries, documented, almost daily on weekdays, groups of youth were transported off-site, typically to court, and often out of county. However, during their absence, when counts were conducted, the counts were consistently documented only by module and included the youth who were off-site, ensuring the total count was equal to the center's full census. Each of the reviewed counts included all youth on the Department's Juvenile Justice Information System's (JJIS) census for the center, even those youth who were off-site at the time the count was taken. There was no documentation found of counts specifically indicating there were youth off-site. This practice is contrary to the FOP, which articulates staff should not include youth in the count who are not physically present with the staff person at the time of the count. A review of documentation indicates staff must keep track of how many youth are assigned to the module they are supervising and how many are off-site, so they can provide the information to master control when counts are conducted. This practice could result in confusion for the officer regarding how many youth they are supervising on-site at any given time. However, four randomly selected direct care staff who were actively supervising youth were asked how many youth they were supervising at the time and each was able to state the correct number. Each of these staff were also able to report the correct procedures to employ in a count cannot be immediately reconciled. Each of the nine additional staff interviewed during the annual compliance review indicated emergency counts are to be conducted whenever a youth is believed to be missing, visibility is hindered, such as during a power outage and after a major disturbance.

5.04 Logbook Maintenance	Failed 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.*	

Consistent with the requirements stipulated in the Facility Operating Procedures (FOP), the center maintains several logbooks to document a chronological record of events, incidents, and activities which occur in the facility. While the master control and individual logbooks are the primary logbooks utilized by the center to document ongoing events, there are also other logbooks focused on the documentation of specific events/information including transports and vehicle mileage, fire drills, equipment maintenance, key control, as well as, youth personal property maintained by the center. A review of four master control and four module logbooks, from February through June 2018, found the logbooks to be bound journals with numbered, lined pages. Though somewhat worn, none of the reviewed logbooks were missing pages or remarkably damaged. The master control logbooks were consistently dated at the top of each page and the time was stated in the left margin of the page before the entry was written. However, the documentation of dates was inconsistent in the reviewed module logbooks where some pages were not dated and at least two pages were dated with the wrong month referenced for all of the entries on the page. All entries were completed in either black or blue ink, as required, with blue ink seemingly reserved for administrative reviews. Contrary to the FOP, which states errors must be crossed out with a single line and initialed, the reviewed logbooks suggested staff practice is to attempt to write over errors. This practice was particularly observed when the error was a number. While the FOP requires staff initial each entry, there were many entries observed in the logbooks reviewed where staff initials were absent. Highlighting of specific information impacting youth safety and facility security was observed, though the practice seemed inconsistent with information highlighted by one staff and the same type of information not highlighted by another staff.

The reviewed logbooks documented emergency situations and significant incidents, safety drills, mental health/medical alerts, group movements, youth admission and release information, youth transports, youth counts, and specific times youth were placed in/removed from confinement or precautionary observations. During the annual compliance review, exceptions to the FOP were observed in the documentation of the youth's name in an entry. One youth admission on June 5, 2018 was not documented in the master control logbook. Often the word "youth" is documented as a generic term such as, "Youth escorted to medical" or in another instance, when it was documented a youth had a special visit occurring at 11:00 p.m. and lasting until midnight, without stating the youth's name, as required. Documentation was not consistent regarding a youth's placement on suicide precautions, particularly upon admission and when a youth was stepped down by Camelot staff was not consistently stated. A review of confinement reports

indicated there were ten youth released from confinement from June 26 to July 3, 2018; however, there was no documentation in the master control log book regarding these releases. Additionally, there were, two specific incidents when the times of confinement were clearly incorrect when compared to the Department's Juvenile Justice Information System's (JJIS) confinement reports. Two COOP drills and one fire drill were not documented in the master control logbook. Furthermore, the annual compliance review team member was often unable to discern if the activity schedule was being followed, particularly when school has begun or when the youth are in small recreation area, based upon review of module logbooks.

5.05 Logbook Reviews	**Limited 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's Facility Operating Procedures (FOP) requires logbook reviews by administrative staff on a weekly basis and the review of the logbooks by supervisory and juvenile justice detention officers (JJDO) each day they assume responsibility for supervision of youth. A review of four master control and four module logbooks from February through June 2018, verified the superintendent or his designee, reviews the master control and module logbooks weekly. The purpose of the review is to ensure the logbook entries are appropriately documented and accurate. Though there are entries documenting their review of the logbooks, none of the entries offered a critique or feedback, positive or negative, regarding the logbook entries.
The JJDO supervisors (JJDOS) are also to review the master control logbook and document their review and acceptance of responsibility for each shift they manage. The reviewed logbooks, however, did not consistently document the supervisor's review of the master control logbook, particularly during the first and second shifts. Specifically, one reviewed logbook sample, which included twenty-one opportunities for staff to document their review of the master control logbook, indicated JJDOS staff on day shift documented their review of the master control logbook when assuming facility responsibility three of seven times, evening shift staff documented the required review four of seven times, and night shift documented six out of seven times. Additionally, the JJDOS is required to document their review of each module logbook on each shift to ensure all entries completed by staff since the last logbook review, are complete and accurate. A review of four module logbooks found while the JJDOS documents a visit to the module on each shift in the logbook, indicating the logbook is in their possession, they don't consistently document their review of the logbook when making their entry about the visit or at any other time during the shift.

The FOP further requires the JJDOs to document acceptance of responsibility for the living area and to review the logbook maintained in the youth living area of the module where they have been assigned every time they begin a shift. The purpose of their review of the previous shift entries is to ensure they are aware of the alerts, security risks, and other pertinent issues regarding the youth they are supervising. Though much of this information has been shared during the shift briefing, the staff are required to document their review of the module logbook. A

review of module logbooks substantiated the JJDOs are regularly accepting responsibility for their shift in the logbook; however, they are not consistently documenting their review of the logbook. It should be noted, however, when documenting their acceptance of responsibility, they write a rather extensive entry listing the youth in the module, any special alerts or needs the youth may have, and their room assignment.

5.06 Key Control	Limited 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 Facility Operating Procedures (FOP) document the policies and procedures for the center to ensure the proper usage, storage, and general security of all facility keys, as well as, the personal keys of all staff and visitors. A review of the FOP indicates it is the superintendent's responsibility to develop a system of key control in the facility to address issuance of keys, assignment of staff keys, inventory and tracking of keys, storage of keys when not in use, restricted keys, key markings and identifiers, key rings used in the facility, procedures for missing or lost keys, the reporting and replacement of damaged keys and other general procedures and prohibitions regarding keys within the facility. Since his arrival to the center in June 2018, the superintendent has implemented a modified key control system. The superintendent was interviewed to determine current center practice regarding key assignment, key inventory, key storage, and key security. During the interview, the superintendent demonstrated how the system works through the observance of some of the processes, including the collection of visitor keys, the issuing of center keys to staff, and the inventory of facility keys located in the superintendent's office. The newly placed, lockable key control box in master control and the key log book, the recently developed key control sheet utilized each shift, and the facility key inventory, were also reviewed to determine center compliance with Department requirements regarding key control. The center has a master key inventory of all facility keys, including keys used by staff and unused keys which are maintained in a secure box attached to the superintendent's office wall. The master inventory documents all facility key ring numbers, the number of keys on each ring, the capability of each key on the ring, and to whom or where the keys are issued. Emergency keys, restricted keys, and permanently issued keys are also listed on the inventory. A review of the master key inventory, which tracks all permanent and temporary keys, for the month of July 2018 and found it to be accurate without exception. All non-issued keys are kept in the secure key box in the superintendent's office. The center has a protocol addressing damaged, lost, or stolen keys. All damaged keys are reported to the staff's immediate supervisor, who then completes a request for replacement. The replacement key will have identical markings to the damaged key, the damaged key will be destroyed, and replacement of damaged keys will be documented in the maintenance log. Lost

or missing keys shall be immediately and confidentially reported to the supervisor on duty. The supervisor then orders all youth movement to cease. The superintendent is notified, and a search of the facility and the youth is initiated immediately. There were no reports to the Central Communications Center (CCC) for lost keys during the last six months. There was no documentation indicating any officer keys had been taken out of the facility when an officer completed his shift, but an interview with a master control officer indicated she recalled one such event and indicated the officer returned the keys to the facility within two hours.

In addition to the key inventory maintained by the superintendent, an inventory of keys and all keys used regularly by staff but not currently in use are maintained by master control. Located in master control is a set of emergency keys, allowing access through exterior doors. These keys are stored in a conspicuous, sealed, red box on the wall inside master control. Restricted keys providing access to the medical rooms and storage, mental health offices and records, education offices and case management offices where youth records are stored, the kitchen, and youth property area are issued from master control to the appropriate staff member, upon request, and appropriate documentation in the key log. Restricted key rings are numbered and assigned to a specific staff member who signs them out at the beginning of each shift and then signs them in before they leave the facility. While there are four sets of permanently issued keys provided to each of the three administrators and the maintenance mechanic, all other facility keys are issued on an as-needed basis to various groups of staff such as a juvenile justice detention officers (JJDO), JJDO supervisors, teachers, mental health staff, and medical staff rather than assigning a specific ring to a specific person. It was observed all regularly used facility keys are on tamper-proof key rings, so keys cannot be removed or added. All key rings are tagged with a specifically colored hub relating to the specific job responsibilities and a control number for identification and inventory. A random review of six key rings confirmed all of the key rings matched the facility and master control inventory information, including number of keys and capability of each key. When various non-detention staff arrive to the center, they are issued their keys from the master control key box, where keys are stored based on the staff's position at the center. The master control operator documents the issuance of keys on the key control sheet and the staff signs in acknowledging receipt of the keys in the appropriate staff sign in logbook. When JJDOs and supervisors arrive to the center, they access keys in one of three ways including issuance by master control upon arrival, issuance during shift briefing, or by accessing the key from the officer leaving his shift. They sign for the keys in the key log and each key ring transfer is to be documented in the key log, as well, as the key control log sheet. It was not clear where the information was documented during shift briefing; however, the key logbook is maintained in master control. The key rings issued to each officer are to be signed out in the key log once surrendered. However, a review of the key log showed numerous instances when the keys are not documented as returned. While the center completes a reconciliation of key count at the end of each shift and does not permit the supervisor to leave the facility without reconciling the key count for his/her shift, it was observed information required in the FOP is not consistently documented. Specifically, the required time of key return and the name of the staff issuing the key ring is not readily available for each key use. Though the JJDOs and supervisors are to document the time they access the keys and when they return them, a review of the key log showed blank spaces where time-in should have been documented for about half of the entries on each page of the log. Neither is the staff issuing the keys regularly identified in reviewed documentation. Though the key control sheet does list the master control officers working during the shift, and the shift reports indicate what staff was assigned what key, neither form documents which staff issued the keys or what time the keys were issued. Nor is there any documentation elsewhere if the JJDO accesses his keys from a shift supervisor or another officer.

All visitors to the center must surrender their personal keys to master control. Upon surrender, the visitor receives receipt in the form of a numbered chit. The number corresponds to the hook the keys are placed on in the secure key box in master control. During the four days of the annual compliance review, the review team observed/experienced this practice each day upon entry and exit of the facility.

All nine interviewed staff correctly listed restricted keys as those providing access to medical or mental health, case management records, youth property, and the kitchen. Each staff also demonstrated the ability to discuss the center's daily process of tracking keys/key control. Observations during the annual compliance review found none of the staff were carrying personal keys into the secure area and staff always had facility keys on their person during their shift. Consistent with comments by all nine interviewed staff, at no time during the annual compliance review did it appear youth had access to facility 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.*	

A review of the center's Facility Operating Procedures (FOP) found there are numerous policies and procedures in place to ensure the safe transportation of youth, a component of which is the proper maintenance and operation of vehicles used for transports. Presently, the center maintains a fleet of nine full-size, multi-passenger vans ranging from one to twelve years old. At the time of the annual compliance review, all vehicles were operational and in use, though the oldest van was in the shop for maintenance and unavailable for inspection; therefore, an inspection of eight vehicles was conducted. Each of the vehicles was observed parked in the front of the center, locked when not in use, and secured with an anti-theft device on the steering wheel. Most of the vans were plain white in color, though a few had specialized markings identifying the vehicle as owned by the Department. Each inspected van was observed to be equipped with a metal security screen between the driver and the passengers, the appropriate number of securely anchored seat belts, a recently charged (all were dated as being inspected in June 2018) fire extinguisher, an approved first aid kit, and a vehicle hazard kit which included a flashlight, a warning triangle and jumper cables, among other required items. One van was noted to be missing the combination window punch/seat belt cutter tool upon inspection. This tool was immediately replaced once the discrepancy was noted. There was no evidence of tobacco usage by the youth or driver in any of the vehicles. All of the vans appeared clean externally; however, four of the vans were observed in need of cleaning, particularly in the driver's compartment.

There was documentation each van was visually inspected weekly by the facility maintenance mechanic to ensure all fluids are at sufficient levels, the emergency equipment is present and in working order, and the brakes and horn are operable. An inspection of the internal and external cleanliness of each vehicle is also documented weekly. Documentation of monthly vehicle inspections was also reviewed and indicated the facility mechanic checks tires, conducts a battery test, examines the windshield and wipers, and looks for damage to the body, windows, and mirrors. The supervisor in charge of the vehicle fleet provided maintenance information including receipts from the automobile shop regarding each vehicle. It was evident the vehicles

had regularly scheduled oil changes and preventative maintenance, when needed, every five months or every 5,000 miles, whichever comes first, in accordance with the 2018 FOP. Documentation of annual safety inspections found all inspections were conducted by a licensed mechanic for eight of the nine vehicles. The remaining vehicle is too new for an annual inspection to have been conducted.

A member of the annual compliance review team observed staff preparing to transporting several youth out of the county. The youth were searched, handcuffed and shackled, and were waiting to board the van upon the annual compliance review team member's arrival. The driver demonstrated center practice of inspecting the vehicle for contraband, looking under and between seats and throughout the passenger compartment. He also examined the safety screen and ensured each seatbelt was securely anchored. He also voiced he had ensured the vehicle had sufficient gasoline for the trip and had checked out a mobile telephone from the transport office to ensure contact could be maintained with the center during the transport. The driver then documented the witnessed inspection in the vehicle log book. A review of the vehicle folder and found it contained all required items, (gas card, restraint keys, vehicle registration, and vehicle mileage logs) with one exception. Missing was the required copy of the current transportation procedures. The youth were then brought out to the sally port area and frisk-searched before entering the vehicle. It was observed each youth was buckled into the vehicle and the driver and other JJDO also wore seatbelts as the van left the sally port. It was also observed the driver was alone in the front of the vehicle and the other JJDO sat in the back with the youth. All of the youth and the JJDOs were males. Interviewed later, the transportation team supervisor reported upon return to the center, each vehicle and youth is searched for contraband and then the vehicle is parked, the security device is applied, and then the van is locked.

5.08 Tool Inventory and Management	**Limited 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. The center ensures all tools and equipment related to maintenance are properly maintained, stored, and inventoried. Inspections of tool control areas are conducted monthly, and the results of these inspections are required to be submitted to the superintendent or designee for their review. Tools are stored in a shed and a small garage area outside of the main building, which is locked when not in use, and no youth have access to any of the tools nor the area. This area is off-limits to detention staff as well, with only the maintenance mechanic and center administrators having authorized access to the area. The maintenance mechanic reported any broken or defective tools would be removed for repair or replacement. Tool replacements are noted in writing and verified by the superintendent or designee. Immediately following repairs, tools are returned to the appropriate storage area and properly secured. Tools were inspected during the annual compliance review and all were found to be marked with an identification code identifying the tool as Department Property. The center has had no lost or missing tools within the annual compliance review period. An observation during the annual compliance review found the small garage for lawn tools open. Concerns were shared separately with the superintendent and regional maintenance director. Further observations found this corrected. While the monthly tool inventory was completed by the maintenance mechanic, there is no evidence to show these inventories were reviewed by the superintendent during the past six months. The center was not able to locate daily tool inventories from February through March 2018. There were also no daily inventories for the month of July 2018, even though

maintenance staff were on-site during this time. The new maintenance mechanic put a check-out system in place on the second day of the annual compliance review to make it easier to identify which tools are signed out. This system uses easily identifiable tags which are placed in the spot the tool is kept. The tags indicate when the item was checked out, and who has it.

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.*	

A review of the Facility Operating Procedures (FOP) substantiates there is a written policy and procedures in place addressing the inventory and storage of kitchen knives and other sharp or hazardous culinary tools. Observations conducted during the annual compliance review confirmed all kitchen knives and utensils not being used were securely locked in a cabinet along a back wall of the kitchen, which is inaccessible to the youth. The cabinet was observed to be locked upon approach and upon opening, a shadow board outlining each specific tool which serves to ensure a missing tool would be conspicuous upon looking at the board. The cabinet also contained an inventory list of each of the items posted on the shadow board and a review of this inventory was found to match the items in the cabinet. The center maintains a perpetual inventory by placing name tags on the spot on the shadow board where a tool which has been removed for use and then replacing the tag with item when the tool is no longer needed. All kitchen tools are inventoried in the morning before food preparation begins and again, prior to the departure of the kitchen staff. According an interviewed kitchen staff, there have been no lost or misplaced tools during this annual compliance review period, and if an inventory indicates a tool is missing, the discrepancy must be immediately communicated to the superintendent or assistant superintendent. Additionally, any broken tool or tool in need of replacement is to be properly disposed of and the superintendent/assistant superintendent is to be notified in writing of the disposal. Nine direct care staff (juvenile justice detention officers) were interviewed during the annual compliance review. Each of the staff reported youth are never allowed access to a kitchen knife. Accordingly, all nine interviewed youth responded negatively when asked if they were permitted access to kitchen knives while at the center.

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 Facility Operating Procedures (FOP) clearly states, “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.” During the annual compliance review, observations of youth assisting in the clean-up of their modules

indicated the youth are afforded access to brooms, as well as mop buckets and mops. Each time a youth was observed engaged in a clean-up activity, the staff were observed providing direct supervision within a few feet of the youth. These clean-up tools were seen stored in the locked closet on the module when not in use. All other tools are locked away out of access to the youth including maintenance, medical, and kitchen tools. All nine interviewed youth acknowledged they were permitted to use mops and brooms in the center and have either utilized them or witnessed other youth using these items under staff supervision. The youth unanimously denied access to other types of cleaning tools such as scrub brushes and construction tools including hammers and/or screwdrivers, as well as, garden tools such as axes and rakes. Each of the nine interviewed staff responded the only tools the youth have access to in the center are brooms and mops (with associated mop buckets) and only under direct supervision of staff.

5.11 Inventory of all Flammable, Toxic, Caustic, and Poisonous Items	**Limited 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 written policy and procedures to address the inventory of flammable, toxic, caustic, and poisonous items. A review of the inventory for flammable, toxic, caustic, and poisonous items was found to be accurate. Cleaning chemicals are stored in a locked shed outside of the main building, but within the center's perimeter. The flammable items are kept in three easily identifiable yellow flammable item cabinets. All flammable, toxic, caustic, and poisonous items have the Safety Date Sheets (SDS) on hand in the center, with one exception; however, the center was able to produce the missing SDS for weed killer for the review team, and updated the binder. The SDS binders are maintained near the chemicals and are accessible to staff for reference. Chemical inventory and storage is maintained by maintenance staff, and access to this shed is limited according to the center administration staff. The chemical storage shed was organized and free from clutter. The center did not have any inventories for the flammable, toxic, caustic, and poisonous items for the months of February and March 2018. The inventories for April, June, and July 2018 were not signed by the maintenance mechanic or the superintendent. The inventory for May 2018 was signed by the maintenance mechanic, but not by the superintendent/designee. An observation during the annual compliance review found two of the flammable item storage cabinets standing wide open. Concerns were shared separately with the superintendent and regional maintenance director. Further observations found this corrected.

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 reviewed Facility Operating Procedures (FOP) stipulates, "Youth may participate in cleaning activities but shall not be permitted to directly handle dangerous or hazardous chemicals." Observations during the facility walk through and other tours/visits of the facility during the annual compliance review week indicated none of the chemicals were stored in an area accessible to youth. Upon request, the center's maintenance manager provided a tour of the area where the most potentially dangerous chemicals are stored, including flammable, toxic, and poisonous items, such as gasoline, bleach, and other cleaning agents, as well as, paints and paint thinner. All of the hazardous chemicals are maintained in a fenced in/secured area behind the kitchen where the youth have no access. Key access to the maintenance area and storage cabinets is restricted to maintenance and supervisory staff only. The superintendent provided a tour and presentation to show the newly implemented chemical dispensing system on the modules which provides staff access to cleaning agents. The superintendent also demonstrated how laundry soap is introduced to each laundry load without youth contact/access to the chemicals. Nine interviewed youth were asked if they were able to access chemicals while detained at the center or if they cleaned with any type of cleaning agent such as bleach, laundry soap, window, or toilet cleaners. Each of the nine youth responded affirmatively, but added the staff always handles the cleaning agent and will spray the chemical on the surface to be cleaned and they wipe the surface clean under staff supervision. Two youth added staff have provided the youth with latex gloves to wear when cleaning to reduce their exposure to the cleaning agent. Accordingly, each of the nine interviewed staff substantiated youth reports of never handling the cleaning agents, only wiping the chemicals once sprayed by the staff who is directly supervision the youth during clean-up activities.

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's Facility Operating Procedures (FOP) address the approved methods of disposal of all flammable, toxic, caustic, and poisonous chemicals and requires all handling and disposal of hazardous waste be in accordance with the Occupational Safety and Health Administration (OSHA) Standard 29. During a tour of the maintenance area, the center's newly assigned maintenance mechanic indicated the facility has not disposed of any kind of hazardous waste during this annual compliance review period. Aware the disposal options must be in accordance with OSHA standards utilizing one of the following methods: compaction, evaporation, flushing, incineration, or using a bio-hazardous waste contractor, the maintenance mechanic indicated the center uses a contractor. Elaborating, he reported as the only staff authorized to dispose of hazardous waste, if needed, he would contact EnviroLight, a waste disposal company to ensure appropriate disposal of any hazardous waste. The maintenance mechanic further stated

flammable, toxic, caustic, and poisonous chemicals requiring disposal are never stored at the center while awaiting disposal. Rather, they are immediately removed from the center to ensure they cannot pose a risk to the youth in the facility. During the tour, it was observed five sealed barrels of non-flammable paint in the secure maintenance area awaiting pick-up by a paint recycling company. The maintenance mechanic explained less hazardous waste such as non-oil-based paints and some cleaning solvents are disposed of in accordance with the recommendation on the safety data sheet corresponding to the item, or if appropriate, a recycling center.

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

The specific supervision and documentation requirements of youth confinements under twenty-four hours are stated in the center's Facility Operating Procedures (FOP). During the last annual compliance review conducted in September 2017, the center was assigned a minor deficiency related to confinements under twenty-four hours. The deficiency was escalated to a major deficiency in December, requiring the completion of an outcome-based corrective action plan (OBCAP), and verification of the action steps on the OBCAP were satisfactorily achieved. The OBCAP was closed on March 28, 2018. Therefore, the sample of nine confinements under twenty-four hours during this annual compliance review period were randomly selected from the 388 applicable confinements occurring at the center from March 29, 2018 to August 14, 2018. The reviewed sample confinement times ranged from 5.28 hours to 19.48 hours. Since the center does not have any designated confinement rooms, all of the youth were placed in confinement in their own room. Eight of the nine reviewed confinement reports reflected the staff searched the room prior to placing the youth, as required. The exception was a room not searched due to youth aggression at the time of placement. The review confirmed staff are consistently documenting an incident report in the Facility Management System (FMS) within the one-hour time frame after an incident, with the observance on one report which was documented twenty minutes late. All nine reviewed confinement reports reflected a supervisor completed a review for fairness and appropriateness within the two-hour requirement; however, three of these reviews documented no reason the confinement was appropriate. The FOP for Detention Services asserts confinement is to be a temporary response to behavior which threatens immediate harm to the youth or others; however, four of the confinement reports indicated the youth was placed in confinement referencing their status in the behavioral management system, and one youth who had engaged in horseplay was placed in confinement, "to deter youth from such behavior in the future." One youth was placed in confinement for aggressive behavior exhibited the night prior though she was not demonstrating any kind of threatening behavior at the time of confinement. While all nine reviewed confinement reports documented supervisory interactions with the youth during the confinement, four of the reviewed reports indicated the supervisor was late in completing the required three-hour supervisor checks throughout the course of the youth's confinement. The observed lapses ranged from fifteen minutes to ninety minutes. The FOP for Detention Services requires each of these supervisory checks to include a reason for continued confinement. Rationales justifying continued confinement include severity of rule violation, past disciplinary history, and behavior while in confinement, and the rationale must be documented. The review found two instances when the rationales for continued confinement was deterrence and another was safety and security in relation to a youth who wrote on the wall of his room a non-specific threat to cause a fight because he was to be released later in the day. One reviewed report stated, "youth was

counseled about his behavior and is resuming the program at this time," however, there is a subsequent entry documented ninety minutes later stating, "Youth is now out of confinement," suggesting a youth remained confined after it was determined and documented confinement was no longer appropriate. All nine interviewed staff indicated they are to complete a report, conduct a room search and document ten-minute checks when youth are placed in confinement. Observations made of youth while in confinement found youth are afforded living conditions approximate to youth in general population. However, none of the reviewed confinement reports documented youth access to showers, hygiene products, or participation in large muscle exercise. Neither was there documentation of youth access to educational materials for four of the five youth who were confined during school hours. The FOP also requires the superintendent/designee shall review all confinement reports within twenty-four hours excluding weekends and holidays. Furthermore, the determination of whether the confinement was appropriate is to be made at this time. One of the nine reviewed confinement reports indicated a supervisory review due on a Friday evening did not occur until mid-morning the following Monday, and two other administrative reviews were not completed.

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

The specific requirements of youth confinements over twenty-four hours are stated in the center's Facility Operating Procedures (FOP). During the last annual compliance review conducted in September 2017, the center was assigned a minor deficiency related to confinements over twenty-four hours. The deficiency was escalated to a major deficiency in December 2017, requiring the completion of an outcome-based corrective action plan (OBCAP), and verification the plan was satisfactorily executed. The OBCAP was closed on March 28, 2018; therefore, the nine confinements over twenty-four hours during this annual compliance review period were selected from the twenty-two applicable confinements occurring at the center from March 29, 2018 to August 14, 2018, the first day of the annual compliance review. There were three incidents which resulted in the confinement of multiple youth and nineteen of the twenty-two confinements. The average length of time a youth was confined when confined over twenty-four hours was just over forty-six hours. Notably, because the center does not have specialized rooms to place youth in confinement, all youth were confined to their assigned room. Nine confinement reports were reviewed for appropriate documentation of the confinement. The confinements in this sample ranged from 25.67 hours to 79.20 hours. All nine reviewed confinement reports documented a staff search of the youth's room prior to placing the youth in confinement. Additionally, each of the nine reviewed confinement reports documented

administrative approval of the confinement. The 2018 FOP requires the superintendent to approve confinements extended beyond twenty-four hours and every twenty-four hours afterwards. Additionally, permission to extend a confinement beyond twenty-four hours must be obtained by the regional director of detention services or designee and this permission must be obtained again every subsequent twenty-four hours. Five of the nine reviewed confinement reports reflected youth who were confined for at least two twenty-four-hour periods. One youth was confined over three twenty-four-hour periods. Each of the nine reviewed reports documented one of the assistant superintendents approved the confinements during the first twenty-four-hour period; however, only five of nine reviewed confinement reports documented contact and approval from the regional director of detention services regarding extended confinement over twenty-four hours. The remaining four applicable confinement reports did not. Furthermore, there is no documentation the regional director was ever contacted regarding subsequent extensions beyond twenty-four hours for any of the nine youth including the four youth who were confined for more than forty-eight hours and one youth who was confined for more than seventy-two hours.

Each of the three-hour checks for each youth were observed to have at least one lapse in supervision over the course of confinement totaling ten lapses. These lapses ranged from eleven minutes to over three hours and nine minutes. Additionally, the supervisors did not document actual observation or interactive contact with the youth during the three-hour checks during waking hours, but rather notes such as “Due to the youth’s major disturbance, confinement will continue,” in thirty-seven reviewed entries. The center’s FOP requires the checks to include a reason for continued confinement. Factors for justification include severity of rule violation, past disciplinary history, and behavior while in confinement. These must be clearly documented in the confinement report. Appropriate justifications were stated upon the initial confinement in only four of the nine reports. Typically, the first entry would simply state, “Room confinement warranted.” The remaining checks conducted during non-sleeping hours, with a few minor exceptions, did document an acceptable reason for continued confinement. The exceptions included an three entries stating the youth was calm and then confinement will continue, another stating “confinement to continue if behavior warrants.” Though the FOP clearly states no youth is to be on confined more than seventy-two hours (three days) without a hearing and determination the youth would present as a risk to safety/security. One youth was in confinement for 79.2 hours and there was no documentation of a hearing to determine the need for extended confinement.

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

A review was conducted of the center’s Continuity of Operations Plan (COOP), which was developed to ensure the center has a planned and comprehensive approach to effectively manage emergencies and disaster events, including full evacuation events. Such events require the center to relocate the youth and staff, while maintaining operations, safety, and security. A review of the center’s COOP found it contains all required elements, annexes, and appendices. The 2018 Statewide Facility Operating Procedures for Detention Services requires the annual completion of, a minimum of, two COOP drills, at least one of which is to be conducted prior to the first day of June, the start of hurricane season. The center provided documentation of two COOP drills occurring thus far in 2018, including a tornado drill in January 2018 and another drill in April 2018 centered around the scenario of a manufactured Hurricane Coleman. Both COOP drills occurred before the start of the hurricane season. The reviewed documentation included

detailed scenarios of the drills, as well as, the dates and times of the drills. The documentation of the January drill included a staff meeting agenda dated the following day indicating the COOP drill was addressed. There were also signed rosters of fifty-five staff who participated in the drill provided for review. Interviews with nine staff revealed five of the nine staff recall participation in weather-related drills in the past six months, suggesting their participation in the hurricane drill in April 2017. Neither of the drills were documented on the Emergency Drill Reporting Form; therefore, there was an absence of information regarding the specific events comprising the drills, any detailed information on problems or concerns during the drills, or any kind of critique or specific recommendations for an improved emergency response. A review of the logbooks revealed neither of the COOP drills were documented, as required, in the master control or module logbooks.

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 utilized the Department's established policies and procedures, as outlined in their Facility Operating Procedures (FOP), to ensure the center is prepared to appropriately respond to escapes and to develop an escape prevention and escape response plan. Integral to this plan is staff participation in training regarding youth behaviors which could indicate a potential escape incident and instruction regarding center policies relating to attempted and/or completed escapes. Additionally, quarterly unannounced escape drills on each shift would serve to reinforce appropriate response from staff. Accordingly, the FOP requires all staff to be trained annually regarding escape prevention. A review of nine staff in-service training records in SkillPro, the Department's Learning Management System, documented six staff completed training in the FOP addressing escapes and escape prevention. The FOP also requires the center to conduct and document quarterly escape drills on each shift to provide the staff with practice of the appropriate response to an escape. A review of escape drill reports provided by the center indicated escape drills were conducted quarterly, on each shift, as required during the first and second quarters of the 2018 calendar year with one exception. The center provided documentation of three escape drills, one occurring on each shift, during the quarter from January 2018 through March 2018. However, during the second quarter April 2018 through to June 2018, there were only two escape drills conducted, with one drill missed for the first shift. Additionally, the center provided documentation of two escape drills for the incomplete third quarter beginning July 2018. Each drill was documented on a drill report, providing details and a critique about the drill. Each drill report was reviewed and signed by an administrative staff. All seven of the completed drills were fully documented in the master control logbook on the date and time the drill occurred. Seven of the nine interviewed staff stated they participated in an at least one escape drill during 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.*	

Consistent with the requirements of their Facility Operating Procedures (FOP), the center has documented the completion of twenty-one fire drills, specifically, one fire drill occurring on each shift, monthly, since January 2018. These unannounced fire drills occur at different times during the shift, on different days, and when the youth are engaged in various activities. The scenarios described different origins of the simulated fire, and the different modules in the center responded as they would if the fire were actually occurring. Documentation of the fire drills included the dates and times of the drills, the narratives of a mock scenarios, any observed problems during the drills, and recommendations for an improved emergency response. However, it was noted recommendations for improvement were seldom offered and with the exception of a few admonitions about remaining cautious and aware, this section of the drill form was blank. All drill forms were observed to have been reviewed and signed by an administrative staff. Twenty of the twenty-one fire drills were documented in the master control logbook on the dates and times the drills took place.

The center's Continuity of Operations Plan (COOP) has incorporated a fire prevention and safety plan to ensure the safety of youth and staff. In addition to monthly fire drills, components of this plan include the prohibition of smoking, the requirement all exits are clearly marked, and designation of key staff roles and responsibilities in case a fire occurs. Additionally, the center is to have conspicuously placed egress plans throughout the facility which clearly outline the exit routes and depict the location of first aid and fire safety equipment in the various buildings of the facility. Another part of the fire safety plan is the involvement of a State Fire Marshall to conduct annual inspections of the fire safety equipment and facility, and to review the center's polices and fire drill procedures. The center provided documentation indicating fire inspections were conducted on-site annually. An inspection occurring May 30, 2018 resulted in four required corrections. Each of the corrections was made in a timely manner prior to the follow-up fire inspection, which occurred on July 7, 2018. During this second inspection, the fire inspector verified all corrections were completed. Another component of the fire safety plan is to ensure staff and youth know what to do in case of a fire. All nine interviewed staff indicated fire drills take place at the center at least monthly and each indicated they have participated in at least one fire drill in the past six months. Seven of the nine interviewed youth indicated they had been instructed what to do in case of a fire at the center. Two youth stated they do not recall such instruction. A review of intake procedures and documentation indicate site-specific information regarding what to do in case of a fire is addressed during the intake of every youth.

Program Name: Pinellas Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: Pinellas County / Circuit 6
Review Date(s): August 14-17, 2018

MQI Program Code: 364
Contract Number: n/a
Number of Beds: 100
Lead Reviewer Code: 118

Overall Rating Summary

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

Limited Ratings	Failed Ratings
5.03 Census Counts and Tracking	3.12 Suicide Prevention Training
5.05 Logbook Reviews	5.02 * Ten-Minute Checks
5.06 Key Control	5.04 Logbook Maintenance
5.08 Tool Inventory and Management	5.15 Confinement Over Twenty-Four Hours
5.11 Inventory of all Flammable, Toxic, Caustic, and Poisonous Items	
5.14 Confinement Under Twenty-Four Hours	
5.16 Continuity of Operations Planning (COOP) Drills	

Overall Rating Summary for Standard 5

This standard has received a standard-level rating of Failed, a follow-up review of the program shall be conducted within six (6) months of publication of the program report.