STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Pinellas Regional Juvenile Detention Center

Department of Juvenile Justice

(State-Operated)

5255 140th Avenue North

Clearwater, Florida 33760

Review Date(s): February 18-21, 2020

Promoting Continuous Improvement and Accountability
in Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Felicia Goldstein, Office of Program Accountability, Lead Reviewer (Standard 1)
Kara Brown, Office of Program Accountability, Regional Monitor (Standard 4)
Jennifer Jones, Detention Services, Government Operations Consultant II (Standard 2)
Tamara Mahl-Adkins, Office of Program Accountability, Regional Monitor (Standard 3)
Gregory MahoumNassar, Office of Program Accountability, Regional Monitor (Staff and Youth Interviews)
Gustavo Mazorra, Office of Program Accountability, Regional Monitor (Standard 3)
Amanda Nelson, Office of Program Accountability, Regional Monitor (Standard 5
Rowena Rose, Office of Education, Education Coordinator (Standard 2)
Paul Sheffer, Office of Program Accountability, Regional Monitor (Standard 5)

Program Name: Pinellas Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: Pinellas County / Circuit 6
Review Date(s): February 18-21, 2020

MQI Program Code: 364
Contract Number: N/A
Number of Beds: 100
Lead Reviewer Code: 146

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.05 Protective Action Response (PAR)	4.01 Designated Health Authority/Designee*
5.04 Logbook Maintenance	5.08 Tool Inventory and Management
5.10 Inventory of all Flammable, Toxic, Caustic, and Poisonous Items	
5.13 Confinement Under Twenty-Four Hours	

Standard 1: Management Accountability
Detention Rating Profile

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

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

Standard 2: Youth Management
Detention Rating Profile

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

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

Indicator Ratings

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

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Standard 4: Health Services
Detention Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Detention Rating Profile

Indicator Ratings

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

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Program Overview

The Pinellas Regional Juvenile Detention Center is a state-owned detention center, operated by the Department, located in Clearwater, Florida. The center serves youth in Pinellas County in Circuit 6. Male and female youth who are detained pending adjudication, disposition, or placement in a residential commitment program are housed in the 100 bed center. Youth are provided services which include youth orientation, behavior management, safety and emergency procedures, transportation, mental health, and healthcare services. The center's educational services are provided by the Pinellas County School Board. The center's management team includes the superintendent, two assistant superintendents, one administrative assistant, seventy-six juvenile justice detention officer positions, and nine juvenile justice detention officer supervisors. Healthcare services and mental health services are provided through the contracted provider, Maxim Healthcare Services and Camelot Community Care. Mental health services are provided by five staff to include: one designated mental health clinician authority (DMHCA), one licensed clinical social worker (LCSW) and three non-licensed master's-level professionals. The DMHCA and LCSW both hold an active license in the State of Florida expiring on March 31, 2021. Clinical services provided by the contracted provider include mental health and substance abuse evaluations, mental health treatment planning, individual, group, and family therapy, mental health crisis intervention services, on-site psychiatric services, and availability for substance abuse services for youth with co-occurring disorders. Healthcare services are provided by two designated health authority positions (one of which serves as a back-up), one advanced practice registered nurse (APRN), one registered nurse, three licensed practical nurses, one psychiatrist, and one medical records clerk. All healthcare staff hold an active and unrestricted license in the State of Florida. The APRN's license expires on April 20, 2021, the RN's license expires April 30, 2021, and all three LPN's licenses expire July 31, 2021. The medical clinic maintains nursing coverage seven days a week from 7:00 a.m. to 7:30 p.m. Food services are provided by Department staff and include menus, meal planning, meal schedules, special diets, nutritional analysis, daily allowance, food preparation, health certifications, food product standards, sanitation, and cleaning. Staff are responsible for the custody and control of youth in their care, providing youth supervision twenty-four hours a day, seven days a week. The center has five living modules for housing youth, which are divided by male and female. During the annual compliance review, three of the units were populated, allowing for the vacant modules to be renovated. The center has a total of 186 cameras, with four cameras being vacant feeds. At the time of the annual compliance review, the program reported four non-essential cameras inoperable. Cameras have a recording capacity of thirty days. The center was clean and free from safety and security issues. A minor amount of graffiti was seen on the center's tour; however, it was only seen on a painted chalkboard square in a few youth sleeping rooms. Inappropriate items on the chalkboard are erased daily by staff during afternoon searches. The center designed a new training area, computer training lab, and staff break area. At the time of the annual compliance review, the center had eleven vacancies, which included nine juvenile justice detention officers, one juvenile justice detention officer supervisor, and one food service worker.

Standard 1: Management Accountability

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

The center has a policy and procedures outlining the required background screening process. A review of documentation verified the center conducts background screenings on all new staff, volunteers, mentors, and interns who will have access to the youth and/or their confidential information. The center uses the Department's Background Screening Unit (BSU) for center staff and volunteers. The screening of contracted staff with Maxim Healthcare and Camelot Community Care Inc. is completed by the provider and all screenings are completed through the Clearinghouse. Since the center's last annual compliance review, the center has hired thirty-five new staff and six volunteers. A review of background screenings found all forty-one individuals had a screening completed prior to the staff's/volunteer's hire/start date with no exceptions. Since the last annual compliance review, Maxim and Camelot each hired three new staff (three nurses and three mental health clinicians). Each of the six contracted staff had a screening completed prior to the staff's hire date or center start date. All reviewed documentation of new newly hired staff indicated each received an eligible, or eligible with charges rating during the background screening process and none required an exemption. Twenty-one of the twenty-three applicable direct care staff completed a pre-employment assessment tool, prior to their hire date, and received a passing score. Two of the direct care staff did not receive a passing score on the pre-assessment tool; however, both staff had an approved score exemption form documented in their personnel record. Each staff's personnel record contained a copy of the completed assessment. Each of the applicable staff were added to the Clearinghouse employee roster, as required. Teachers at the center are staff of the Pinellas County School Board. The Affidavit of Compliance with Level 2 Screening Standards for the center and school board were submitted to the BSU on January 24, 2020 and January 31, 2020, respectively. The contracted providers for mental health and medical services submitted their Annual Affidavit of Compliance with Level 2 Screening Standards to the BSU January 29, 2020.

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

The center has a policy and procedures for conducting a background rescreening for all applicable staff, volunteers, mentors, and interns every five years from the date of hire. A review of the center's staff and volunteer roster revealed seven center staff and no volunteers were eligible for a five-year rescreening during the annual compliance review period. All rescreenings conducted on the center's staff were completed at least four months prior to the individual's anniversary date with one exception. One staff member had a five-year rescreening due July 8, 2019; however, the rescreening was not submitted until this annual compliance review. The rescreening was completed on February 20, 2020 and resulted in an eligible rating. All reviewed five-year rescreenings yielded eligible ratings. None of the contracted staff were applicable for a five-year rescreening.

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

The center has a policy and procedures regarding the staff code of conduct. The center utilizes the Department's employee handbook, and the Code of Ethics Agreement form which is to be signed by each new staff upon hire. Staff acknowledgment of the human resources policy, procedures, and employment information requirements are documented electronically in the Human Resources Employment System (HRES). The center's policy and code of conduct prohibits any form of abuse, intimidation, harassment, or the use of profanity when interacting with a youth. Physical abuse of youth is prohibited by law and a suspicion or knowledge of abuse must be reported to the Florida Abuse Hotline and the Department's Central Communications Center (CCC). The code also states when interacting with youth, officers shall

maintain professional behavior and relationships. Staff are not to engage in or allow “horseplay,” either verbal or physical with and/or between youth or any other staff member. The code mandates officers always maintain youth confidentiality and are not to have personal relationships or discuss any personal information regarding themselves or other staff with the youth. A review of the HRES for seven staff found each of the staff had signed the Code of Conduct form electronically. None of the seven staff had a record of discipline.

Five additional staff records were reviewed for disciplinary practices. The center indicated these five records were the only applicable records available. Each of the five reviewed records found violations of staff conduct, management responded with: one written reprimand, two suspensions, and two terminations. None of the violations were related to abuse towards youth. In addition to addressing disciplinary incidents, documentation provided indicated administrative staff sought opportunities to recognize and show appreciation for staff. The center provided commendation documentation for seven staff. One staff received an award for employee of the month, three staff received a certification of acknowledgement for going above and beyond their job duties, and two of the staff were celebrated as the employee of the month (November and December 2019). The center provided pictures showing the monthly celebrations and staff recognition events. In their interview, the center’s superintendent indicated they have tried to improve staff morale by including more staff recognition awards and staff appreciation events. Photos of these events and meals were provided by the superintendent.

During the annual compliance review, interviews were conducted with seven youth and seven staff. When asked if the youth have ever been stopped from reporting abuse, one youth said yes, three youth said no, and three youth said they’ve never had a reason to call. The one youth who said they were prevented from calling the CCC/Florida Abuse Hotline to report abuse, was offered a call by the annual compliance review team member. The youth declined the call and stated they wanted to call because of not getting their third snack, as required; therefore, they wanted to report it. The youth states they eventually got their snack and no longer wanted to call. All seven youth stated staff are respectful when talking to youth and none of them have heard staff use curse words. All the youth stated they have not heard staff threaten other youth and six of the seven feel safe at this center. One of the seven youth stated they don’t feel safe because too many kids in the center are from his neighborhood and he’s afraid of getting into a fight. This information was provided to the center’s administration. Each of the seven interviewed staff reported they have never observed a co-worker using threats, humiliation, or intimidation with youth. Five of the seven staff indicated they have never observed a co-worker using profanity with youth. Two staff stated they have heard staff in the past use profanity, but this was years ago. All seven staff indicate the working conditions at the center are good or very good.

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

The center has a policy and procedures addressing incident reporting to the Department’s Central Communications Center (CCC) in accordance with Florida Administrative Code. The center had thirty-nine incidents reported to the CCC during the last six months, five of which are pending closure. A review of all CCC reports was conducted to determine accuracy, timeliness, and the completion of follow-up reporting, as applicable. The reported incidents included youth

behavior incidents, complaints against staff, violation of policy/rule, medical and mental health incidents, and use of force. A review of the CCC reports confirmed the center's practice to report incidents to the CCC in a timely manner with no exceptions. None of the incidents were substantiated as late reports. A review of the center's logbooks, incident reports, and youth grievances did not reveal any additional incidents which should have been reported to the CCC. A sample of five CCC reports were reviewed and all five were reported within two hours of staff becoming aware of the incident and each of the reports were documented in the logbook, as required. According to the superintendent, the center complies with the CCC reporting requirements and reports all reportable incidents within two hours of the incident or within two hours of knowledge of said incident.

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

The center has a policy and procedures outlining the use of physical intervention techniques, as indicated under the Department's approved Protective Action Response (PAR) matrix in accordance with Florida Administrative Code. When an incident occurs during the use of a PAR technique, the center's practice is to generate a PAR incident report. There was an increase of incidents with 307 recorded PAR incidents at this center six months prior to the annual compliance review. Last year's annual compliance review report noted the center had 246 incidents prior to the annual compliance review. The annual compliance review team did not find any other incidents when PAR physical intervention techniques were used during a review of the center's logbooks, incident reports, or grievance forms. Thirty PAR incident reports were reviewed for compliance. Fourteen of the thirty reports were not completed as required. Two reports were late and not completed by the end of the staff member's work day. Two reports were missing signatures needed on page two, and two reports were missing written statements from staff involved. Three reports were missing the review and approval of an administrator, which is due within seventy-two business hours of the incident. Three of the reports were approved/signed off by the administrator before all other required parties signed the report. Six of the reviewed reports revealed the person signing as the lead staff member who initiated the PAR was also signing as the PAR instructor/certified staff person who is reviewing the incident for compliance with the PAR rule. All post-PAR youth interviews occurred within thirty minutes with three exceptions (one done ten days late and two were blank on the report). None of the incidents indicated the youth required further medical attention.

All reports were completed in the Facility Management System (FMS), located on the Department's Juvenile Justice Information System (JJIS). None of the reports included the use of mechanical restraints. None of the reports included allegations of abuse, which needed to be reported to the Florida Abuse Hotline. The center's PAR rate during the annual compliance review period was 24.40, which is above the statewide detention PAR rate of 12.00. In an interview, the center's superintendent indicated the number of PAR incidents are starting to go down; however, a few months ago, their center went through a big change in staff and youth culture. Since the summer of 2019, the center has turned over one superintendent, both assistant superintendents, a field training officer, and several staff positions. The superintendent also indicated they repeatedly reinforce the use of verbal interventions with youth when applicable and the administrative team reviews reports and trends on a regular basis. The

center's behavior management system and introduction of weekly restaurant meals for high level youth has helped encouraged the decrease of the youth's physical aggression. The center now has a stable administrative team and the vacancy numbers are decreasing. Seven interviewed staff reported they try to talk to youth prior to using any physical or mechanical restraint.

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

The center has procedures for pre-service and certification training of all new staff. Seven staff training records were reviewed and each record reflected staff were certified within 180 days of hire and received all required essential skills prior to youth contact. All staff completed Protective Action Response (PAR) certification within the first ninety days. Each of the reviewed records indicated the staff completed essential skills trainings to include cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), first aid, mental health and substance abuse, suicide recognition, prevention and intervention, the Prison Rape Elimination Act, human trafficking, safety, security, and youth supervision, as well as, the Department's detention facility operations and procedures. Each staff member had documentation in their records and in the Department's Learning Management System (SkillPro) indicating the successful completion of phase one and phase two academy training.

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

The center has a policy and procedures regarding annual, in-service training for all staff. In-service training begins the calendar year after a staff completes their certification (pre-service) training. The center maintains an annual training calendar to ensure every staff is trained in all mandatory topics, as specified in Florida Administrative Code and the Department's approved training plan. Training opportunities are provided within the Department's Learning Management System (SkillPro), as well as, through attendance and participation in instructor-led courses. Seven staff training records were reviewed for completion of mandatory in-service training. Each record revealed staff obtained more than the required twenty-four hours of training in all mandatory topics with one exception. One staff member did not have training in trauma-informed care documented in 2019. Three in-service training records for supervisory staff were reviewed for compliance with the requirements of supervisory training. All seven supervisors obtained at least sixty hours of supervisory training in the topics of leadership, management, employee relations and communication skills. Additionally, each supervisor received training in medication administration and utilizing an epinephrine auto injector. Training was consistently documented in SkillPro.

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

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

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

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

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

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

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

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

The center has a policy and procedures for entering and sharing youth alerts. The center enters all alerts into the Department's Juvenile Justice Information System (JJIS). Upon completion of the Admission Wizard and intake screenings, the intake officer is to ensure all critical and special alerts are entered in to JJIS. Medical and mental health staff enter, update, and close alerts in JJIS, when appropriate. There was documentation in the center's logbooks and in JJIS identifying youth with medical, mental health, suicide, gang, and security issues. Seven youth medical records, mental health and substance abuse records, and management records were reviewed. Each of the reviewed youth records had alerts documented and/or updated in JJIS by center staff either from the current or previous admissions to the center. All youth were medically graded one through five and had a corresponding alert. Observed alerts included medical restrictions, single room only, gang association, the prescription of medications, and the placement and closure of youth on suicide precautions. The staff reviewed the pass down alert report daily to ensure the accuracy of the information regarding the youth's status in the alerts. Administrative and supervisory staff ensure the alert information is accurate each day. The supervisors then ensure the alerts are dispersed to appropriate staff and effectively addressed. The JJIS pass-on alert list is reviewed with staff at each shift briefing and available to all staff for review during the shift, if needed. A review of documentation and observations, to include shift briefings, support the center's alert practice. Seven staff were interviewed regarding how they are informed of alerts specific to youth. All seven stated they receive alerts through shift briefings, logbooks, and JJIS. Four of the seven staff stated they also look at the alert board in master control, and three stated they hear it verbally from intake staff or supervisors. When all seven interviewed staff were asked how management informs them about issues within the center, six stated through shift briefings, five stated during meetings, and all seven stated by email.

Standard 2: Assessment and Performance Plan

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

The center has a policy and procedures regarding the initial screening and assessment process of youth taken into custody. The juvenile justice detention officers (JJDO) start the initial screening process upon the arrival of a youth to the center. The intake area is separate from other areas of the center. The youth are assigned to a module and sleeping room after being classified by the intake officer. Seven active youth records were reviewed for admission documentation. Each record contained a copy of the Detention Risk Assessment Instrument (DRAI) and the Suicide Risk Screening Instrument (SRSI). Each of the active records contained a copy of the Admission Wizard completed in the Department's Juvenile Justice Information System (JJIS). The Admission Wizard in each record indicated an electronic search, frisk search, and a strip search were conducted by a JJDO of the same gender as the youth. Signatures of the youth and the JJDO reflected each youth was assessed for medical, mental health, and substance abuse needs. Information in all records reflected each youth was offered a telephone call to his/her parent/guardian, and each youth could indicate their refusal in the electronic box which would document a time and date. All records contained a Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) screening completed by the intake admission JJDO. Each record also contained documentation which indicated the youth either accepted or refused the snack or meal offered during the admission process. None of the youth presented to secure detention required emergency medical care, a mental health crisis intervention, or were under the influence of any intoxicant.

The admission process was observed by a member of the annual compliance review team during the annual compliance review. The JJDO greeted the youth and explained the process and what to expect during the admission process. The electronic search, frisk search, and strip search were conducted by a JJDO of the same gender. After the search process, the youth was returned to the intake area and a JJDO continued the intake process in JJIS. The JJDO informed the youth of his/her rights, center rules, regulations, the grievance process, the right to an abuse-free environment, court appearances, and the process of assigning the youth to a module. The observation also included a review and administration of the VSAB, the Admission Wizard, the SRSI, and the Massachusetts Youth Screening Instrument (MAYSI) by the intake officer. The JJDO offered a telephone call to the youth after all documents were reviewed and signed by all parties. The youth was provided a meal within the two-hour timeframe of the next scheduled meal.

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

The policy and procedures implemented by the center includes the instruction for orientation of the new admitted youth. The juvenile justice detention officer (JJDO) reviews all of the admission paperwork and forms as part of the standardized orientation to the center. Signatures of the youth and JJDO reflect the review of the orientation checklist review form. The orientation checklist form reviews the center's behavior management system, expectations, possible law violations, and center rules and regulations. The orientation checklist also includes the review of an orientation brochure which describes visitation hours, telephone calls, medical services, mental health services, expectations for behavior and related consequences, possible new law violations for destruction of property, the Prison Rape Elimination Act, and how to report abuse. The annual compliance review team observed a youth's admission into the center. During the admission process, the youth was given the orientation brochure to read, as well as the opportunity to ask the JJDO questions regarding the key topics which were not understood. The youth was able to follow along with the JJDO as the information was reviewed and discussed. A review of seven active youth records reflected each record contained a signed orientation checklist, which acknowledged the information was presented to the youth by the JJDO both verbally and in writing. This form also indicated the youth's understanding of the information provided to them at the time of admission. Six of the seven interviewed youth indicated someone provided them with information regarding the center's rules and regulations, daily schedule, education services, visitation, abuse reporting, and the behavior management system when they were admitted. One youth stated this was not conducted during his admission upon the entrance to the center.

2.03 Classification	Satisfactory Compliance

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

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

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

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

The center has policy and procedures regarding classification of youth during the admission process and reclassification, when necessary. The policy requires significant information to be considered before a youth is assigned to a room. Considerations include but are not limited to the following: the youth's age, physical characteristics, 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. A review of seven active youth records revealed each youth was classified after considering the youth's history and status. All seven youth were assigned to a room based on their classification. Each admitted youth was screened to determine criminal street gang affiliation. One of the seven youth was applicable for requiring a new or updated alert in the Department's Juvenile Justice Information System and the update was completed as required. Observations of a youth admission during the annual compliance review found the juvenile justice detention officer (JJDO) reviewed the youth's court documents which reflected the youth's charges, as well as the youth's medical records, admission wizard, and the Vulnerability to Victimization Sexual Aggressive Behavior (VSAB) form upon admission. The JJDO also evaluated the modules for proper housing placement to prevent conflict with any youth or gang members. If or when the center reaches full capacity, a juvenile justice detention officer supervisor (JJDOS) will review the active records to assign two youth to a room. In an interview, the superintendent validated the center's process.

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

The center has policy and procedures regarding classification of gang affiliated youth and procedures regarding the notification of the juvenile probation officer (JPO) designated as the circuit's gang liaison of suspected gang activity. Seven active youth records were reviewed, and each youth was screened for gang affiliation and/or membership during the admission and orientation process. One of the seven youth records indicated the youth was identified during the admission screening as having gang affiliation and an alert was created in the Department's Juvenile Justice Information System (JJIS). Two additional records were provided by the center for review. Each of the three applicable youth were identified as having gang affiliation at admission and the center sent notifications to the circuit's JPO gang liaison and law enforcement. The center reported no suspicions of gang activity taking place during the annual compliance review period.

The intake department is responsible for communicating any gang related information upon entry to the center to the JPO liaison and law enforcement. Prior to the annual compliance review, the JPO liaison was reassigned to another JPO in the circuit due to changes within their department. The center's designated gang representative made attempts to contact the JPO liaison in November 2019 to inform them no gang activity was noted or suspected within the center. The center's designated gang representative also made attempts to contact the JPO liaison in December 2019 with a follow-up email notification which included youth in the center with gang affiliations and all updated information. The superintendent was scheduled to attend the local law enforcement's monthly gang task force meeting during the week of this annual compliance review. The meeting occurs monthly and allows for law enforcement and other approved law enforcement agencies to communicate and share local gang information.

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

The center has policy and procedures regarding the handling of youth's personal property. The inventory information is gathered during the admission process after the strip search and intake shower has been completed. Youth items are collected and inventoried by the juvenile justice detention officer (JJDO). Any items of value (i.e. jewelry, electronics, or US currency) are stored in a plastic tamper-proof bag, with the tag signed by both the youth and JJDO. The tamper-proof property bag is then secured in a secure locked safe or cabinet. Valuable items will be secured in a separate location from youth clothing items. The property tag will be stapled to the personal property sheet. During the admission process, each youth signs an acknowledgement letter of personal property describing what happens to the stored property if not claimed at the time of

release. A review of the seven active youth records indicated all records contained an itemized property sheet and a letter of acknowledgement. Three of the youth records reflected valuable property was confiscated from the youth during the admission process and secured in the property safe. The bound logbook for the drop safe documented the date, time, youth's name, Department identification number, printed name of the officer who secured the property, and the officer's initials. All seven youth's personal property was observed in the correct locker, with a copy of their signed property sheets. Observations verified all clothing items stored in the locker were present and accounted for. Observations validated the program's practice. Six of the seven interviewed youth stated the staff checked their personal property upon admission to the center and then had them sign a form stating the property was correct. One of the seven youth could not remember if this process occurred. In an interview, the superintendent described the center's practice and indicated all unclaimed property is purged and given to the fiscal assistants who then creates a spread sheet. Money is combined and generated into a money order with a list of its origin and then forwarded to the central region detention office for further processing. Unclaimed clothing items are taken to Goodwill and the receipts are forwarded to the central region office for further processing.

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

The center has policy and procedures regarding the safe and secure storage of all youth's personal property. Each of the seven reviewed active youth records reflected the youth's property was stored in a numerical locker, under constant camera observation. The personal property and valuable property are noted at the time of admission and secured. The youth personal property is accessible by the juvenile justice detention officer (JJDO) and all valuable property is secured in the drop safe. The valuable property can only be moved by administration or an appointed designee. An admission was observed by the annual compliance review team. During the admission process, the JJDO reviewed and documented the collection of all personal and valuable property. The JJDO and the youth signed the required property form, confirming all items were accounted for by both parties. The valuable property was logged in the valuable property logbook on the date the valuables were moved to a locked cabinet and the non-valuables were assigned a numerical locker to store the youth's property. Observations also verified the property safe was positioned under constant camera surveillance. The center did not have any incidents reported to the Central Communications Center regarding missing or lost personal property during the annual compliance review period. In their interview, the superintendent indicated all valuables are placed in the drop safe during the intake process. The intake supervisor removes the sealed drop safe bag, reviews the property receipt and contents through bag and then secures the bag in a secure cabinet.

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

The center has a policy and procedures regarding youth releases. The policy requires the releasing juvenile justice detention officer (JJDO) to verify the court's authorization to release the youth and to confirm this with a juvenile justice detention officer supervisor (JJDOS). The intake JJDO utilizes the chronological checklist which includes the release procedures. The intake JJDO prepares the Release Wizard in the Department's Juvenile Justice Information System (JJIS) after verifying the court's authorization to release the youth. Once the Release Wizard is complete, the property receipt is printed for the youth to sign and acknowledge all items have been identified and returned. The JJDOS will document their review of all paperwork prior to the youth's release on the court document and Release Wizard. A review of seven inactive youth records indicated each release was reviewed and approved by the JJDOS prior to allowing the youth's departure from secure detention. Two of the seven reviewed inactive records were for youth who were released on the interstate transportation network (ITN) for residential program placement. The remaining five youth were released to their parent/guardian after identification was verified. All seven of the records contained a copy of identification of who was signing for custody of the youth if under the age of eighteen years of age. After the JJDOS confirms all documents are reviewed and correct, the JJDOS will confer with master control to change the center's census count. A review of Central Communications Center reports for the past six months revealed the center had a substantiated violation of policy/unauthorized release. The youth was released when he should have been held in secure detention due to having an active hold from another county. The staff member involved was reprimanded.

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

The center has a policy and procedures regarding the release of youth's personal property upon their release from the center. A review of seven active youth records found each record contained a property sheet generated by the juvenile justice detention officer (JJDO). The forms reflected signatures from the youth, the JJDO, and parents/guardians, indicating all items were returned to the youth. The release process was observed by the annual compliance review

team. The youth's property locker was verified by the number listed on the property sheet with the youth present. The property was removed from the locker and all items were accounted for. The youth confirmed all items were accounted for and then changed into his personal property and out of the detention clothing. The JJDO printed a personal property sheet which reflected all items were returned to the youth. The JJDO completed the Release Wizard in the Department's Juvenile Justice Information System (JJIS) by completing the required information in the JJIS. The JJDO reviewed all court appearances and follow-up information with the youth and parent/guardian. The JJDO explained if the youth had any valuable property, the juvenile justice detention officer supervisor (JJDOS) would be notified to retrieve the valuable property from the locked cabinet and then log it out of the valuable logbook. The transportation supervisor was able to provide examples of the on-going process of disposing property and valuables which have been stored beyond the thirty-day period. During an interview, the superintendent indicated if a youth does not claim their property within a thirty-day period, a notice or letter of acknowledgement is sent to inform the youth and parent belongings which are stored at the center will be disposed of if not claimed. If the property is not claimed in the designated time frame, the items will be discarded.

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

The center has policy and procedures regarding the release of prescribed medications. A review of three inactive youth records reflected two of the youth were released with prescribed medication. A review of two applicable inactive records revealed the center used the Department form titled "Medication Receipt Transfer and Disposition Form" to document the entrance, release, or transfer of youth prescribed medications. The form listed the youth's name, the numerical number assigned to identify the youth, and a section to complete the information of the medication, which has been prescribed by a physician. The form requires the quantity of the medication, the contact information of the physician, and signature lines for medication verification or change in custody of the medication. The review of the two medication aftercare receipts reflects all required information to include the signature of the person who assumed responsibility of the medication upon release or transfer to another center along with discharge instructions. All three records documented the youth and person to whom the youth was released to, were reminded of any pending appointments or court dates.

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

The center has policy and procedures indicating the detention review officer conducts a detention review of all the youth on the center's census weekly. Youth in secure and on home detention are discussed. Participants in the review discuss the legal status of youth for upcoming court dates, releases, and youth pending residential placement. During the annual compliance review, a review team member observed the weekly detention review meeting. The following parties were in attendance: juvenile justice detention officer (JJDO), superintendent, transportation supervisor, medical staff, mental health staff, and the juvenile probation officer (JPO). Each week, all Department participants sign a roster reflecting their attendance. Each youth at the center was discussed and status updates were provided by the juvenile probation

officer (JPO) to update the youth's projected release, and/or transport. A review of meeting documents for the past six months validates the center's process. The superintendent reported the center's intake supervisor/transportation coordinator and the detention review specialist conduct weekly detention case reviews.

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

The center has a policy and procedures regarding the daily activity schedules. Activities include education, visitation, and various programs involving community involvement (i.e. drum circle). The youth also have scheduled activities which incorporate behavior management reward acknowledgement. The schedule reflects times for hygiene, wake up, groups, meal times, yoga, scheduled recreation times, and volunteer activities. The center provides gender-specific programming for the youth. The daily activity schedule was posted in the common area of all modules. Seven youth were interviewed, and all seven youth indicated the activity schedule is followed. Each of the seven interviewed staff indicated the activity schedule is followed to the best of their ability as longs as there is no interference or disruption while moving the youth to their activity.

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

The center has a policy and procedures regarding adherence to the daily schedule. During the review of the logbook documentation, entries were noted for youth movement for wake up, hygiene, and meal movement. Between August and December 2019, the logbook notations did not always notate when school began or ended, except for an entry which indicated "program began/ended." The superintendent revealed an internal audit in December 2019 identified this logbook discrepancy and corrective action was put in place. A review of logbooks since December 2019 show the center has made significant improvements with regards to documenting when school started, ended, and was postponed for lunch. The logbook for the module reflected when teachers entered the classroom for school or when school ended. The logbooks reflect all group movement to and from scheduled activities. If a youth was escorted for medical or mental health services, the logbook indicated individual movement to an assigned area. The group activities are notated in the group notes section in the Facility Management System (FMS) of the Department's Juvenile Justice Information System (JJIS). All seven interviewed youth indicated the activity schedule is followed and each confirmed the daily activity schedule is posted on the modules. All seven interviewed staff indicated the daily activity is followed.

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

The Pinellas County School Board has approved of the daily schedule for the center, and the academic courses support the education program. Youth participate in an educational and career-related program. The schedule provides instruction for 250 days distributed over twelve months; twenty-five hours of instruction weekly equals 300 minutes each day. The education staff uses ten days for teacher planning or professional development. Each youth receives face-to-face instruction for mathematics, social studies, physical education, reading, science, and English/language arts. Youth are receiving academic courses to earn credit and have the opportunity to use the online platform Apex, for credit recovery in grades six to twelve; no credits can be earned for career training experience. Interviews with the lead educator and the superintendent, ensured there is minimal interference with the educational instruction schedule. The lead educator stated there are no reasons for the school day to be canceled at the center. Seven interviewed youth indicated the schedule is followed, and school is in session Monday through Friday. A review of center logbooks for the last six months revealed entries August 2019 through December 2019 do not consistently notate both a start and end time of education activities. The center indicated they identified this issue during an internal review in December and put corrective action in place. A review of logbook entries from December 2019 to February 2020 revealed improvements in the documentation of education start and end times. A random selection of three days on video were reviewed by a member of the review team. Each video review provided evidence classes started and ended as scheduled. Observations made by the review team during the annual compliance review show youth moving to and from educational classes/activities as scheduled.

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

The center provides Type 1 career education programming based on the youth's age, assessed educational abilities, and youth goals during the length of stay assigned. The education teaching staff discuss personal accountability skills and work habits to maintain employment. Career education textbooks are used in the classroom for group discussions and inquiring about career occupation interests. The youth are receiving communication, interpersonal, and decision-making skills in the career education program.

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

The center has a policy and procedures which requires the implementation of a behavior management system (BMS) to meet the needs of the youth and the center. The BMS at the center helps promote wellbeing, character, and a positive environment. The center utilizes a conduct card to track the negative and positive behaviors of the youth in the center. The level system consists of three tiers, requiring the youth to maintain behavior for several days to be promoted to the next level as positive reinforcement. Consequences are enforced by the juvenile justice detention officer (JJDO) by notifying the youth of an infraction, no level raise, or a level drop. The negative infractions are noted on the conduct card. Youth who can maintain good behavior are able to receive rewards such as being housed on the honors module, name brand hygiene items, snacks outside of the scheduled times, later bed times, use of a ping pong table, movies, and extra food rewards. The BMS is posted in the common area of each module. Interviews with seven youth indicated the BMS is effective. One youth indicated the BMS was good and six youth indicated the BMS is very good. All youth stated the consequences they have been given were fair and the only thing taken from them is points and/or their level. Each of the seven interviewed staff indicated the BMS is effective. All seven stated they speak with youth to discuss the consequences imposed in addition to giving the youth an opportunity to explain their behavior.

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

The Office of Detention Services has a policy and procedures, prohibiting the use of unauthorized forms of punishment to include: corporal punishment, group punishment, and drugs, to control the youth's behavior. Additionally, the policy does not allow for youth to impose discipline or sanctions on other youth. The center's behavior management system (BMS) gives acceptable consequences for a youth. The center uses verbal interventions and counseling to

redirect the youth and to prevent negative behavior. Seven youth were interviewed and all youth indicated they have never been punished by another peer. If consequences are given it resulted in deduction in points or a level drop. Three of the seven youth state they have been sent to their room for punishment reasons with the door shut and locked. All youth revealed they have never witnessed handcuffs or leg irons used on out of control youth to prevent them from hurting themselves. All seven interviewed staff indicated they've never witnessed a coworker encouraging a youth to harm another youth.

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

The center has a policy for the procedures of the grievance process. This process encourages the juvenile justice detention officers (JJDO) to treat all youth fairly, respectfully, and without discrimination. The grievance process consists of three phases: informal phase, formal phase, and the appeal phase. In the informal phase, the youth can write down his complaint and give the complaint to the JJDO. The JJDO attempts to resolve the complaint from the youth. If the grievance is not able to be resolved, then the grievance is moved to the formal phase to be reviewed by the supervisor within twenty-four hours of the recorded grievance. In the final phase of appeal, the grievance is reviewed by the administration staff or designee within seventy-two hours of the receipt, excluding weekends and holidays. The center has had no grievances in the last six months and four within the last twelve months. All four grievances were reviewed and in compliance. After the grievances are completed, information will be transposed into the Facility Management System (FMS). Seven staff were interviewed, and each was able to explain the grievance process. Each of the seven interviewed youth revealed they've never submitted a grievance.

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

The center has a policy and procedures regarding trauma-informed care which implements how the center is to perform consistent practices during their daily activities. The policy indicates the juvenile justice detention officer (JJDO) shall receive annual training to understand their role while employed at the center. A review of the seven in-service staff training records indicated six staff completed trauma-informed care trainings in the 2019 calendar year. The center has an area designated for intervention and support. The mental health staff at the center provide individual and group treatment to educate the youth of symptoms and triggers of trauma. The soft room is included on modules to assist in de-escalating youth with needs or situations which require discretion. The JJDO is to assist the youth with understanding and support through the healing process. The healing process can consist of the child's needs and assessment, journal writing on black boards, self-expression art, and grief group. An interview with the superintendent indicates once a youth is identified with trauma or trauma history, the youth will work with the mental health department to find a good solution to help establish ways to cope and implement a safety plan. Trauma alerts or notations may be added to youth record or alerts to assist with youth and their stay in the center.

Standard 3: Mental Health and Substance Abuse Services

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

The center's designated mental health clinician authority (DMHCA) is a licensed mental health counselor (LMHC) who works forty hours a week on-site, ensuring appropriate coordination and implementation of mental health and substance abuse services are taking place. The DMHCA is also available by phone when not on-site and holds an active license in the State of Florida expiring March 31, 2021.

The DMHCA interview indicated she is responsible for working with the administration at the center to ensure services are provided; reviewing all services administered by mental health professionals. She reviews changes in levels of supervision by reviewing and approving the Assessment of Suicide Risks (ASR) administered by unlicensed therapists prior to each youth's change of level. The DMHCA participates in regularly scheduled administrative meetings to stay abreast of changes in policy. Furthermore, the DMHCA works with the senior behavior analyst, who performs an on-site review of services to include evidence of practice through chart audits as well as client and staff interviews every quarter. The senior behavior analyst is also available telephonically and through email for support should questions arise in interpretation of policy compliance. The DMHCA checks the youth population count every day for those youths entering the facility and has daily communication with the nursing staff.

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

In addition to the designated mental health clinician authority, the center has one licensed clinical social worker (LCSW) who assists on an as needed basis. The LCSW holds an active license in the State of Florida expiring March 31, 2021.

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

The center has three non-licensed mental health and substance abuse clinical staff working under a Chapter 397 active license. All three non-licensed staff hold a master-level degree, one in mental health counseling and the other two in social work and they all received the required

on the job training to complete Assessments of Suicide Risk (ASR). The designated mental health clinician authority (DMHCA) provided direct supervision including reviewing and approving comprehensive mental health/substance abuse evaluations, updated comprehensive mental health/substance abuse evaluations, initial mental health/substance abuse treatment plans and individualized mental health/substance abuse treatment plans, prepared by the non-licensed mental health clinical staff within ten calendar days of administration of the instrument. A review of the last six months of weekly one-hour direct supervision documentation for the three non-licensed staff indicated one staff was missing two weeks of supervision and another staff was missing five weeks of supervision; the third had all direct supervision documentation. The center reports supervision during the missing weeks was mistakenly not documented for those staff; however, they indicated it was completed. All direct supervision was documented on the appropriate Department form.

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

In all seven youth records reviewed, the screening documents included the Suicide Risk Screening Instrument (SRSI) and six of the seven records included the Massachusetts Admission Youth Screening Instrument-Second Version (MAYSI-2). The detention staff completed a review of all instruments which were documented in the Department's Juvenile Justice Information System (JJIS). The nurse and/or mental health staff completed the required sections of each SRSI and included the summary and recommendations in the screening results segment. In all seven records, each youth had a positive response on the SRSI and each was placed on suicide precautions. All of the records documented a mental health referral was completed, which documented the need for an Assessment of Suicide Risk (ASR), as well as notification of the superintendent. All screenings were completed by a trained staff. In one of the seven records reviewed, the MAYSI-2 indicated an elevated suicide risk, and in three records, the MAYSI-2 indicated the need for a comprehensive assessment.

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

In two of the seven records reviewed, the youth was identified as needing a referral for further assessment after admission and both youth were referred to the detention provider. One additional example was provided by the center. In the three applicable records, a new comprehensive mental health/substance abuse evaluation was completed by the detention provider within thirty-one days of the referral.

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

In two of the seven records reviewed, the youth required mental health and/or substance abuse treatment; therefore, one additional applicable record was reviewed. In the three applicable records each youth required treatment and was assigned to a mini-treatment team, consisting of mental health clinical staff, a minimum of one staff from a different service area, the youth and when possible, the parent/guardian. All three youth were determined to be in need of mental health treatment, and were receiving group, individual, or family counseling; two of the three youth were in need of substance abuse treatment. Two of the three youth received treatment according to the frequency of their treatment plan, one did not. The staff indicated in the one record, the original plan frequency was adhered to for the first week and then the youth was stepped down and they stopped providing the treatment as often, which would be reflected on the updated treatment plan.

All three youth had a valid Authority for Evaluation and Treatment form maintained in each record, one of the youth had a substance abuse consent and information release as well. All treatment notes were documented on the proper Department form and the youth received the necessary and appropriate mental health and substance abuse treatment and services reflecting diagnosis and treatment needs. Mental health staff had adequate access to each youth to provide the treatment services. A review of the last six months of documentation indicated all mental health group therapy was conducted with ten or fewer youth and substance abuse groups did not consist of more than fifteen youth.

The designated mental health clinician authority indicated the center does not provide specialized services but provides mental health and substance abuse groups. Seven youth interviews indicated two had not received any mental health or substance abuse services while at the center. The remaining five rated the services received as very good or good.

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

Two of the seven reviewed records required an initial treatment plan. One more example was provided by the center staff; a closed record. In the three applicable records, the initial treatment

plan was completed within seven days of treatment initiation and completed on the appropriate Department form. The forms contained the reason for referral for treatment, initial diagnosis/symptoms, initial treatment methods, initial treatment goals, psychiatric services where required, the mental health/substance abuse professional signature, the youth's signature and documentation of the mini-treatment team members involved in the development of the plan. In one record, it could not be determined if the signatures on the plan were captured due to the original record having been sent with the youth.

None of the seven records required an individualized treatment plan; therefore, one open and two closed records were provided by the center staff for review. In the three applicable records the individualized treatment plans were developed by the thirty-first day of the youth's admission into the center and the licensed mental health/substance abuse professional signed the form within ten days of completion. The forms indicated the diagnosis, treatment focused symptoms, treatment goals, strengths/abilities/needs, psychiatric services, and pharmacological interventions, where applicable. One of the youth was at the center long enough to receive services, as stipulated on the treatment plan. In the two closed records, it could not be determined if the signatures on the plan were captured due to the original record having been sent with the youth. In the one record the youth, mental health/substance abuse professional and parent/guardian participation was documented. The center was unable to provide any individual treatment plan reviews for this annual compliance review period.

One of the seven records included psychiatric treatment services; therefore, two more examples were provided. In the three applicable records, the treatment plan included treatment and services provided by a licensed psychiatrist. Three closed records were reviewed, and all contained a mental health/substance abuse treatment discharge summary on the appropriate Department form and the summary was provided to the youth, parent/guardian, and the juvenile probation officer.

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.	

Seven records were reviewed, of which two were applicable for psychiatric services; therefore, one additional applicable record was reviewed. In the three applicable records, the youth entered the center with psychotropic medication or was referred for a psychiatric interview/initial diagnostic interview which was completed within fourteen days of admission. The initial psychiatric interview included the reason for referral, history, mental status examination, diagnosis, treatment recommendations, prescribed medication, explanation of the need for psychotropic medication and frequency of medication monitoring/management. An in-depth psychiatric evaluation was conducted on all three youth within thirty days of admission and included the stated reasons and factors leading to the referral, history, mental status examination, identification of individual, family and/or environmental factors which may influence or ameliorate the youth's difficulties, diagnosis, treatment recommendations and interventions, prescribed medication and frequency of medication monitoring/management, explanation of the need for psychotropic medication related to the youth's diagnosis, target symptoms, potential side effects, risks, and benefits of taking the medication and where needed most recent applicable therapeutic serum drug levels, as well as the signature of the practitioner conducting the psychiatric evaluation. The Clinical Psychotropic Progress Note, page three, was completed

for all three youth. The psychiatric evaluation included all required elements, the date and signature of the psychiatrist, monitoring for Tardive Dyskinesia symptoms, and where needed whether the parent/guardian was contacted telephonically to discuss medication. All three youth had a valid Authority for Evaluation and Treatment maintained in the healthcare record.

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

The center had a written plan detailing suicide prevention procedures, which included identification and assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and a review process.

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

In all seven records reviewed, an alert was entered, updated, and closed in the Department's Juvenile Justice Information System (JJIS), as well as documented in the logbook, as required for all suicide precaution placements. During the admission screening process, all of the seven youth were determined to be at risk and were placed on precautionary observation and a referral was completed for the youth to receive an Assessment of Suicide Risk (ASR). Each of the records contained the Suicide Precaution Observation logs completed in their entirety including safe housing area requirements. In all seven records, the staff documented a consultation with the designated mental health clinician authority on the mental health/substance abuse referral summary, as well as notifying the superintendent/designee immediately of the youth's suicide risk. All seven records documented a referral was made to the mental health professional, the youth was placed on precautionary observation, and the observation was authorized. Each ASR was completed on the Department's form within twenty-four hours of referral and included assessing the youth in real time. None of the youth were released prior to completion of an ASR. Each ASR was completed by a licensed professional or a clinical staff working under the supervision of a licensed professional and all non-licensed staff had received twenty hours of ASR training. Each of the records documented a conference was held with the superintendent and licensed mental health professional to reduce the level of supervision and the youth was stepped down according to the center's suicide prevention plan. The center was unable to provide any secure observation documentation for the annual compliance review period.

The superintendent maintains an established review process for every serious suicide attempt or serious self-inflicted injury and a mortality review for a completed suicide, which is documented in the center's facility operating procedure (FOP). The FOP includes circumstances surrounding the event, facility procedures relevant to the incident, all relevant training received by involved staff, pertinent medical and mental health services involving the victim, possible precipitating factors and recommendations for changes in policy, training, physical plant, medical or mental health services and/or operational procedures.

Seven staff interviews indicated the staff would notify the mental health authority, search the youth and his/her room for sharp objects, document supervision, and place the youth on constant sight and sound supervision. Six of the seven staff stated they would place the youth in a locked room if the youth expressed suicidal thoughts and provide and document supervision. The staff mentioned entering a mental health note, placing a mental health alert in JJIS, and notifying the supervisor. Seven youth interviews indicated all had been placed on suicide watch during this stay or a previous stay and were observed 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 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.	

In all seven records reviewed, the Suicide Precaution Observation Logs were maintained for the duration the youth was on suicide precautions. Each of the entries were documented in real time, not exceeding thirty-minute intervals, and documented safe housing areas; none observed warning signs. Every log was reviewed and signed by each shift supervisor, as well as a mental health clinical staff.

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

Seven staff training records were reviewed. One of the seven staff had switched positions recently and had not yet completed the four hours of suicide prevention and implementation of suicide precautions instructor/web-based training, which is required for the new position. Each of the remaining six records documented all staff completed the two hours of the Department's Learning Management System (SkillPro) and the four hours of instructor/web-based suicide prevention and implementation of suicide precautions training.

A review of mock drills for the last year indicated all staff participated in at least one mock drill quarterly and at least one mock drill annually which included the use of cardiopulmonary resuscitation (CPR). All staff members who are not present during a mock drill can review a drill scenario and procedures to understand the process and to receive the necessary training; this is to be documented on the original drill scenario roster.

Seven staff interviews indicated the suicide response kits were kept in master control, staff bathrooms on the modules, and the clinic.

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

The center had a written mental health crisis intervention plan which detailed crisis intervention procedures and included notification and alert system, means of referral, communication, supervision and documentation, and review process.

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

The center had an emergency care plan which included immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for Baker Act and Marchman Act, documentation, training and review. The plan was updated on January 17, 2020 and approved on January 23, 2020. The plan is in the superintendent's office, clinic, and the mental health office 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 (LMHP), or under the direct supervision of a LMHP, to determine the severity of youth's symptoms, and level of risk to self or others. When staff observations indicate a youth's acute psychological distress is extreme/severe and does not respond to ordinary intervention, the superintendent or designee must be notified of the crisis situation and need for Crisis Assessment. A Crisis Assessment is to be utilized only when the youth's crisis (psychological distress) is not associated with suicide risk factors or suicide risk behaviors. If the youth's behavior or statements indicate possible suicide risk, the youth must receive an Assessment of Suicide Risk (ASR) instead of a Crisis Assessment.	

None of the seven records reviewed were eligible for crisis assessment completion. The center was able to provide one applicable record for the annual compliance review period. In the one record reviewed, the youth was determined to be in crisis and a Crisis Assessment was completed within twenty-four hours, which included the reason for the assessment, mental status, danger to self/others, initial clinical impressions, supervision recommendations, treatment recommendations, and recommendations for follow-up or further evaluation, as well as a Mental Health and Substance Abuse Referral Summary due to the youth being an alleged victim in a Prison Rape Elimination Act event. The youth was eighteen years old; therefore, the

parent/guardian was not required to be notified. The youth was identified by direct care/clinical staff as having acute emotional or behavior problems, or acute psychological distress. The Crisis Assessment was completed by a non-licensed person and was not reviewed until seven days later by a licensed mental health professional.

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 seven records reviewed were eligible for Baker or Marchman Act. The center was able to provide two applicable records for the annual compliance review period. In both records, the youth were placed on suicide precautions upon re-admission from Baker Act status. Each record documented a mental health referral was completed for a Mental Status Examination (MSE), which was completed by or under the direct supervision of a licensed mental health professional. Both youth were maintained on constant supervision until an appropriate assessment was completed and the mental health staff conferred with a licensed supervisor and the superintendent/designee to lower the youth's supervision level. In the two records the youth's suicide risk alert in the Department's Juvenile Justice Information System (JJIS) was updated based on the results of the Assessment of Suicide Risk (ASR).

Standard 4: Health Services

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

The center has a policy and procedures to ensure each youth admitted into the center is provided with clinical services. The center has a contract agreement with Maxim Healthcare Services, Inc. to provide medical services at the center. The designated health authority (DHA) at the center is a licensed medical doctor (MD) and holds an unrestricted, clear and active license in the State of Florida. The DHA's license expires on January 31, 2021. The DHA is contracted to be on-site once a week for a minimum of two hours and is to be available on-call twenty-four hours a day, seven days a week. A review of the center's logbook for the last six months found on November 7, 2019 the DHA was only on-site for one hour and twenty minutes, from 5:10 p.m. to 6:30 p.m. There were three occasions in which nine or more days passed between DHA on-site visits. The DHA was on-site on September 6, 2019 and not again until September 21, 2019, on December 31, 2019 and not again until January 11, 2020, and on January 14, 2020 and not again until January 25, 2020. There was no coverage arranged when the DHA was off-site, although the provider employs a medical doctor who is available as a back-up if needed. During an interview with the DHA, it was confirmed they are scheduled on-site once a week for two hours to provide clinical services, perform comprehensive physical assessments, and see sick or injured youth. The DHA confirmed being available twenty-four hours a day, seven days a week for emergency care and consultation.

The center has an advanced practice registered nurse (APRN), who has experience with pediatrics, and holds an unrestricted, clear and active license in the State of Florida. The APRN's license expires on April 20, 2021. The APRN is scheduled to be on-site twice a week. The APRN has a collaborative practice protocol in place, which is approved by the DHA and maintained on-site.

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

The center has a policy and facility operating procedures (FOPs) addressing the health-related procedures and protocols utilized. A review of the FOPs found they were all signed by the designated health authority (DHA) and the facility superintendent on August 16, 2019. The center's psychiatrist signed all applicable FOPs. Reviewed documentation indicated all nursing staff signed and dated cover pages stating they reviewed all medical FOPs and treatment protocols. All newly employed health care personnel receive a comprehensive clinical orientation to Department's health care policies and procedures given by a registered nurse (RN). There was one nurse hired in the last six months and there was documentation to support the nurse received a comprehensive clinical orientation to the Department's health care policies and procedures from the RN.

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 policy and procedures in place to ensure the completion of the Authority for Evaluation and Treatment (AET) or Limited Consent for Evaluation and Treatment form authorizing specific treatment for youth in the custody of the Department. A review of seven individual healthcare records verified five of the records contained a valid AET signed by the parent/guardian and witnessed by a Department representative. Four of the reviewed AET forms were copies and had the word "copy" stamped on them. One reviewed AET was an original AET. One individual healthcare record contained a Limited Consent for Evaluation and Treatment form along with the AET form. Two youth were eighteen years of age and did not require an AET form. None of the youth in the sample were under the supervision or care of the Department of Children and Families (DCF). Each AET was obtained prior to providing medical services.

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

The center has a policy and procedures addressing parent/guardian notification and consent when a youth is taken off-site for treatment, or when a new medication is prescribed or significantly modified. A total of seven records were reviewed with one pertaining to parental notifications. Two more records were requested. Two of the three applicable records were applicable for off-site treatment. In both instances, the parent/guardian was telephonically contacted and were sent a written Parental Notification form with request for return and signature. One of the records reviewed was for newly prescribed psychotropic medication. The parent/guardian was contacted telephonically, which was documented on the Clinical Psychiatric Progress Note (CPPN), page three, including documentation of a witness to the verbal consent, and written consent was sent to the parent/guardian on the Acknowledgement of Receipt of CPPN form.

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

The center maintains a policy and procedures to ensure each youth is screened for healthcare concerns upon admission to the center. Seven individual healthcare records were reviewed, and each record contained a completed Medical and Mental Health Admission Screening form completed the day of admission. Each screening was completed by a juvenile justice detention officer and reviewed by a licensed practical nurse or higher within twenty-four hours. None of the records reviewed were applicable for rescreening. The center's policy indicates if a youth leaves custody and comes back into custody, they are considered a new admission and the admission process starts over. The center had one example of a youth who was at the center, transferred to another center for court, and returned to the center. The youth was rescreened, and the Health-Related History form was updated, showing the center's process. A review of seven records reflected three were for female youth, where one met the requirements for

pregnancy testing. Additional records were requested. A review of five female individual healthcare records indicated three youth received a qualitative urine pregnancy screening, with their verbal consent, at the time of admission. One youth was not sexually active, and one youth was already aware of her pregnancy. The Medical and Mental Health Admission Screening form for one youth indicates the youth was not pregnant; however, the youth was pregnant and aware of the pregnancy at the time of admission from a pregnancy test at another center she transferred in from.

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

The center maintains a policy and procedures to ensure all youth receive an orientation regarding general healthcare upon admission. A review of seven individual healthcare records reflected six youth received a general healthcare orientation. One youth was not applicable due to transferring in from another center where orientation was previously completed. Five of the six applicable youth received their orientation within twenty-four hours. One orientation was conducted three days after admission. Each reviewed record supported the youth's orientation included the required topics to include: access to medical care, sick call, what constitutes as an "emergency" and when to notify staff, medication process to include side effect monitoring, the right to refuse care and how it is documented, what to do in the case of a sexual assault or attempted sexual assault, and the non-disciplinary role of health care providers.

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

The center maintains a policy and procedures to ensure the designated health authority (DHA) is notified when admitted youth require emergency care or routine notification in accordance with the Department's requirements. The center's policy requires notification to the DHA upon each youth's admission if there is a medical emergency or if a youth has a chronic medical condition. The center's practice is to notify the DHA of all new admissions. A review of seven individual healthcare records indicated none of the youth were identified as in need of emergency care and two youth were admitted with a chronic condition. An additional record was requested. A review of the three individual healthcare records reflected none of the youth were identified as in need of emergency care. three reviewed youth were admitted with a chronic condition. For one of the youth, the box on the admission progress note asking if the youth had a chronic condition was marked no, despite the youth having a chronic condition. The DHA was notified of all three admissions within twelve hours. two of the notifications were documented on the admission chronological progress notes in the individual healthcare records. The other DHA notification was not documented in the youth's individual healthcare record; however, it was documented on the daily intake log, which the center maintains and completes daily. The log lists the names of all youth admitted to the center. The daily intake log includes any chronic illnesses, as well as any allergies or medications. Each applicable youth was referred to the DHA or the advanced practice registered nurse. Two individual healthcare records indicated the youth were on psychotropic medication upon admission into the center. The DHA was notified of both.

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

The center has a policy and procedures indicating the Department Health-Related History (HRH) form shall be completed for all youth admitted into the center within seven days of their admission. A review of seven individual healthcare records validated two records had new HRH forms and five records had updated HRH forms. One HRH form was signed and indicated the form was reviewed with no changes; however, the form indicated the youth was not pregnant when she was. Each form was completed by licensed nursing staff and was done on the Department's most recent HRH form. All applicable HRH forms were completed before the Comprehensive Physical Assessment.

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

The center maintains a policy and procedures to ensure a Comprehensive Physical Assessment (CPA) form is completed for all youth admitted into the center. A review of seven individual healthcare records reflected each youth had a CPA completed on the Department's CPA form in their record. A new CPA was completed for three youth within seven days of admission. Two of the new CPAs were completed by the advanced practice registered nurse (APRN) and one was completed by the designated health authority (DHA). Four youth had a current CPA on file at the time of their admission. Three of the current CPAs were reviewed, initialed, and dated by the APRN within seven days of admission. The fourth youth was not applicable as the youth transferred from another center where the CPA was previously updated. A focused evaluation was present in the record for each youth. The medical grade was listed on each CPA and an alert was generated in the center's alert system for youth assigned a medical grade between two and five. Three CPAs were completed in full and included all elements. The purified protein derivative (PPD) read by box was blank on three CPAs and the PPD placed by box was blank on two CPAs. None of the records indicated the youth refused any part of the exam. The Department's Problem List was updated in all records as required. Four of the records indicated the tuberculosis skin test (TST) was completed within seventy-two hours of admission. Two of the records contained TST results from within the last twelve months. One record indicated the TST was completed six days after admission. The results of this TST were still pending. The results of all other TSTs were documented on each youth's Infectious and Communicable Disease form and on their CPA. None of the reviewed youth required further evaluation.

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

The center maintains a policy and procedures to ensure all youth are evaluated and treated for sexually transmitted infections (STIs). The center screens each youth for STIs upon admission by utilizing the Department's STI Screening form. A review of seven individual healthcare records indicated one youth required further evaluation as a result of their STI screening, so additional records were requested. Three total individual health records were reviewed, and

each record contained a completed STI Screening form. All three of the youth required further evaluation, and all were referred for STI testing. Results had not been received for one youth at the time of the annual compliance review. Results for the other two youth were documented on the Infectious and Communicable Disease form in their individual healthcare record.
The center provides human immunodeficiency virus (HIV) counseling by a certified counselor for youth who consent to HIV testing. The program has a contract with Metro Wellness, a local community agency, to provide HIV testing and counseling services for each youth. Metro Wellness provides a certified counselor to complete all testing and pre/post counseling. A review of seven individual healthcare records indicated two youth consented to HIV testing and none of the youth had received an HIV test. An additional record was requested to look at these items. All three records validated each youth was offered counseling, testing, and treatment for HIV. all three youth records contained a signed consent form refusing testing. Each youth record contained a signed consent form consenting to treatment. Documentation in the three records indicate the youth received pre-test and post-test counseling by a certified HIV counselor. All results are filed in a confidential manner. Seven youth were interviewed and all indicated they can request an HIV test.

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

The center has a policy and procedures in place regarding the sick call process. A notebook with protocols appropriate to the level of provider conducting sick call, approved and signed by the designated health authority, is reviewed and signed by all nursing staff. The nurses conduct sick call seven days a week from 9:00a a.m. to 11:00 a.m. and as needed. Youth who would like to request a sick call inform staff of their complaint and staff will generate a sick call request in the Department's Facility Management System (FMS). A review of seven individual healthcare records indicated two youth had requested a sick call. An additional record was requested for review. A review of three individual healthcare records indicated all requested a sick call. Each of the records contained all sick call forms which documented the nature of the complaint, assessment, and plan to include subjective, objective, assessment, and plan format (SOAP). Two sick calls were conducted by a registered nurse (RN). One sick call was conducted by a licensed practical nurse (LPN) and was reviewed by an RN within twenty-four hours. Each of the reviewed sick calls were documented on the FMS generated sick call log and each youth signed the log to acknowledge they received a sick call. None of the reviewed youth presented with a similar sick call complaint three or more times within a two-week period. There were no situations where the nature and/or severity of a youth's medical condition could not be determined. No youth complained of any severe pain which staff were unfamiliar with.
One sick call was observed during the annual compliance review. The youth provided verbal consent for observation prior to the sick call. The youth was escorted to the clinic by direct care staff. The nurse identified herself and stated why the youth was there. The youth signed the sick call log prior to the exam. The youth was examined in a private area while direct care staff was able to maintain supervision. The youth was interviewed and then examined by nursing staff. Seven youth interviews reflect five youth were seen within one day of requesting a sick call and two youth had never requested a sick call. Six youth reported nursing staff conducts sick call, four youth also report staff conduct sick call, and two youth also report not having made a sick call request. Four youth rate the medical care at the center good, one youth rates it very good,

and two youth report not having received medical services. Seven staff were interviewed and asked who responds to sick calls. One staff reported a nurse responds to sick call. Six staff reported staff/supervisors and responds to sick call. All seven of the interviewed staff reported nursing staff conduct sick calls and two of the seven staff indicated supervisors conduct sick call after hours.

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

The center has emergency care procedures, as well as facility operating policy and procedures, which include the process of conducting emergency medical drills at least quarterly on each shift. Seven healthcare records reviewed and two were applicable for having an episodic/first aid/emergency care event. One additional applicable record was reviewed for a total of three applicable records. In all three records the episodic care event was conducted by a licensed healthcare staff and included the progress note clearly documenting it as an episodic/first aid/emergency care event, with the date and time of the event, the nature of the complaint, the findings of the person rendering care and the treatment rendered. One of the records was applicable for parental notification, which was completed. In all three records the form included the printed name, credentials of the staff, electronic signature of the staff, the name of the Department facility, as well as the nurse utilizing problem-oriented charting to document the event. All three events were documented in the center's episodic care log.

The center's first aid kits and automated external defibrillators (AED) were observed. Three first aid kits (from the kitchen, the B1 module, and the B4 module) were opened and reviewed for contents. All three were stocked and had approved and current contents. A review of the last six months of first aid kit checklists indicated all were monitored monthly. The facility operating procedures indicated the first aid kits are replenished when needed. A review of the last six months of episodic care logs indicated all the events were documented as necessary for the three records reviewed. The center had three AEDs, located in the B4 module, master control and the clinic; all had the procedures/instructions with them. An outside provider checks all AEDs on a regular basis. All AED batteries expire on April 28, 2021.

A review of the last four quarters of medical drills indicated the center conducted at least one medical drill each quarter on each shift and at least one medical drill with demonstration of cardiopulmonary resuscitation (CPR)/AED on each shift annually. The center has a list of emergency numbers posted in the clinic inaccessible to youth and maintains emergency telephone and cell phone numbers accessible to staff. All seven pre-service and seven in-service training records reviewed had documentation the staff completed CPR/AED/first aid certification annually, as well as all nursing staff maintaining current CPR/AED certifications. All seven staff interviews indicated they all can contact 9-1-1 in case of an emergency.

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

The center has a policy and procedures in place to provide timely referrals and coordination of medical services to an off-site healthcare provider. Two of seven reviewed individual healthcare records were applicable for off-site care, so one additional record was reviewed. Three applicable youth had a total of four off-site events. All three youth were taken off-site for routine care, and one youth was taken off-site for emergency care. In three off-sites the Summary of Off-Site Care form was utilized and filed in the individual healthcare records. Nursing staff indicated the fourth form was taken off-site, but not returned to the center. Discharge documentation and instructions were included in the records for three off-sites, the remaining off-site did not require any instructions. The designated health authority (DHA) was notified of the emergency event and the event was logged in the episodic care log. The DHA signed the off-site care findings, instructions, and information for three off-sites. The DHA has not been on-site to sign the information since the fourth off-site took place. Two of the applicable youth required follow-up care. Both follow up appointments were logged on the center's referral tracking log. One of the applicable youth was released prior to the follow up and the other applicable youth's follow up appointment has not yet taken place.

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

One of the seven records reviewed was applicable regarding receipt of a periodic evaluation; the others were not appropriate. The center was unable to provide another example of a youth having received a periodic evaluation in the annual compliance review period. In the one record reviewed the youth received a periodic evaluation due to being identified as pregnant and scoring a classification of medical grade two to five. The medical staff does not utilize a chronic condition list but checks the youth population daily and provides periodic evaluations to all youth staying at the center for ninety days or more. The youth received an evaluation on-site every two to four weeks due to being in her first eight months of pregnancy and the evaluations were documented in the individual health care record (IHCR) chronological progress notes. The treatment orders were written so they were clearly distinguishable for clinical staff to follow and the problem list was updated as required.

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

The center has a policy and procedures ensuring all medication is received, stored, inventoried, and provided in a safe and effective manner. A review of seven youth medical records revealed three youth were admitted into the program on prescribed medications. Documentation in all applicable individual healthcare records verified the designated health authority (DHA) and psychiatrist, when applicable, were contacted for an order to resume the specified medications prescribed prior to admission. Verification of medication is conducted whenever a youth is

admitted with medication or a parent/guardian brings medication to the center. Each verification is logged on the Medication Receipt, Transfer, and Disposition form. All medication was stored in a container intact with the original label and approved medication. Youth who are taking medication while in the care of the center are administered medications by licensed nursing staff. Supervisors are trained in medication administration and administer medication in the absence of the healthcare professionals. A review of training sign-in logs verified nine supervisory staff were trained in medication management.

None of the reviewed youth were in restricted housing. There were no youth requiring over-the-counter medication not listed in the Authorization for Evaluation and Treatment (AET). There were no undocumented explanations for lapses or errors in administered medication in any of the three applicable records. A review of three applicable records verified there were no standing orders of psychotropic medication, no emergency treatment orders for psychotropic medication, and no pro re nata (PRN) orders for psychotropic medication.

A review of three youths' Department's Medication Administration Record (MAR) forms verified medication administrated was documented on the MAR forms. Each MAR form contained the youth's name, Department identification (DJJID) number, date of birth, allergies, precautions, medical grade, medical alerts, a current photo of the youth, start and stop dates, and monitored side effects. Further review of the MARs indicated each youth received the medication as ordered. One youth's Practitioners Order form shows the youth should receive one 150mg tab of their prescribed medication each day. Page three of the youth's Clinical Psychotropic Progress Note (CPPN), signed by the psychiatrist, states the youth is prescribed to take two 150mg tabs a day. The MAR reflects the youth is taking two tabs each day, as noted on page three of the CPPN. Both staff and youth initialed the MARs after the administration of all medication. One youth refused two medications on one occasion. An "R" is documented on the MARs where the youth would have initialed if the medication was administered and a refusal form is signed by the youth for both medications. None of the youth required parenteral medication. Two reviewed youth were on psychotropic medication. Psychotropic medication was continued until a diagnostic psychiatric interview was conducted. The initial diagnostic psychiatric interview for each youth was conducted within fourteen days of admission. Neither youth on psychotropic medications had been in the center over thirty days to receive a review of medication monitoring by the psychiatrist.

An observation of four youth receiving medication indicated the Six Rights of Medication Administration was verified for each youth. Direct care staff escorted each youth to the clinic. Two of the youth were brought into the clinic one at a time; however, the other two youth were brought in together, but approached the counter to take their medication individually. The nurse verified each youth's name and date of birth with each youth and verified all documentation and information on the MAR. One youth was asked if they were experiencing any side effects. The nurse observed each youth swallowing the medication and had each youth cough to ensure they swallowed the medication. The nurse and each youth initialed the MAR to document each youth had received their medication.

None of the medication was pre-poured from the original packaging or placed in another container. Observations of medication storage verified all medications are kept in a separate, locked area designated for storage of medication. All stored medications are separated by type/form. None of the medication is accessible to youth and only medical staff or supervisory staff have access to the medication storage area. Medications requiring refrigeration are stored in a secure refrigerator designated for medication only. Syringes and sharps are secured in a

locked cabinet. The center has a process in place for the disposal and destruction of expired or discontinued medication.

Seven youth interviews were conducted. Four interviewed youth indicated a nurse gives them their medication. Three youth indicated they do not take medications. Seven staff were interviewed. Three staff indicated they give medication to youth and four staff indicated they do not. All three staff who reported giving medication to youth were on the list of supervisory staff trained in medication administration.

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

The center has a policy and procedures to ensure medication and sharps are secured and inventoried by using a perpetual inventory. All medical equipment classified as sharps are secured in a locked cabinet. A perpetual inventory of sharps is conducted, subtracting from the count as a sharp is used. A weekly inventory is also conducted. The center maintains a perpetual daily inventory of medications to include prescribed and over-the-counter (OTC) medications. Documentation of each individual dose of medication administered to a youth is maintained on the youth's Medication Administration Record. The center conducts a weekly inventory for all opened OTC medications. There is a method for detecting and responding to inventory discrepancies which nursing staff receive as part of their training. The center has a process for the destruction and disposal or return of expired or discontinued medications.

Controlled substances are maintained behind two locks. They are kept in a locked box inside the locked medication cart. An inventory of controlled substances, including the number of pills remaining, is completed at the beginning of first shift when nursing staff arrive, and again at the end of second shift when nursing staff leave for the day. Each count is signed off on by two staff. The controlled substance inventories are documented on each youth's individualized Controlled Medication Inventory Record. The center is conducting the required counts, and all proper elements are there; however, they are not documenting them in the proper columns to show when the counts are done. The center is currently utilizing the Controlled Medication Inventory Record form located in the Department's electronic medical records from February 2010; however, there is an updated form located in the Department's forms library, which is from April 2010.

A random count of four sharps, three prescribed medications, three OTC medications, and three controlled medications was conducted. The counts and inventories matched for three of the sharps, three prescribed medications, three OTC medications, and three controlled medications. A sharp count was conducted of nail clippers. There were eight nail clippers on the inventory sheet and seven nail clippers were counted. Nursing staff indicated one nail clipper had been used by a youth and disposed of, as they were instructed to discard them after use due to not being able to sanitize them. By the end of the annual compliance review period, an updated inventory log was provided, reflecting the correct number of nail clippers, and showing a late entry for the one used and discarded nail clipper.

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

The center's operating procedures include the superintendent maintaining a file in cases of employee or youth facility/occupational exposure events to be kept in a confidential manner for a ten-year period. In all seven healthcare records reviewed, the youth received infection control training within seven days of admission, which included hand-washing techniques, universal/standard precautions, prevention/transmission of communicable diseases, vaccinations, and Centers for Disease Control and Prevention (CDC) guidelines for infection control. The center's exposure control plan was written in accordance with the Occupational Safety and Health Administration (OSHA) and included risk assessment and methods of compliance with all underlying requirements. The plan was reviewed and signed by the superintendent on August 16, 2019. The center's infection control procedures included prevention, containment, treatment, and reporting requirements for all required types or categories of diseases, which included common, infectious diseases of childhood, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, tuberculosis, hepatitis A, B, C, and human immunodeficiency virus (HIV) infectious diseases caused by bloodborne pathogens, other outbreaks or epidemics, outbreaks of pediculosis and/or scabies, methicillin-resistant staphylococcus aureus (MRSA) and other antibiotic-resistant micro-organisms, food-borne illnesses, bio-terrorist agents, and chemical exposures in the workplace. The plan also included staff to follow universal precautions, protocols for needle stick post-exposure intervention and treatment, hepatitis B immunizations are made available to staff, and staff having access to protective equipment. The center did not have any incidents, including infectious diseases and sexually transmitted infections reported to the local county health department, the CDC or reports to the Central Communications Center (CCC). A review of seven pre-service and seven in-service staff training records indicated they all had training regarding the center's exposure control plan.

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

One of the seven records reviewed was applicable regarding prenatal care. Two more records were provided by the nursing staff. All three records documented the youth received prenatal care immediately upon determination of the youth's pregnancy status. The prenatal care was provided at recommended intervals which included each youth receiving nutritious food in quantities appropriate for a pregnant youth and routine monitoring of youth's nutritional and weight status. The nursing staff check in with each youth daily when providing prenatal vitamins to monitor for possible complications, as well as for side effects. One of the three records documented the medical doctor conducted a focused medical evaluation at least once every thirty days; the remaining two youth had not been at the center long enough. One of the youth complained of issues relating to her pregnancy, the designated health authority (DHA) was notified and the youth was sent for emergency care. All three youth received education in the topics of alcohol and drug use, smoking, nutrition, sexually transmitted diseases, contraception,

prenatal care, birthing process, postpartum care, basic baby care, child/infant development and parenting skills, documented in the health education record in the healthcare record. A review of seven in-service training records for non-healthcare revealed all had training in girl's healthcare and related education topics.

Standard 5: Safety and Security

5.01 Active Supervision of Youth (Critical)	Satisfactory Compliance
Staff are aware of the location of youth assigned to their supervision at all times. Staff monitor the movement of youth in their direct care from one location to another. *Youth are in sight of at least one juvenile justice detention officer (JJDO) at all times (with the exception of sleeping hours or time secured in rooms).* *Officers are responsible for the care of youth at all times. At no time shall another youth be allowed to exercise control over or provide discipline or care of any type to another youth.* *When a youth leaves the group or program area of the center for any reason, all staff assigned to supervise the youth are informed.* *Master Control authorizes all movement of youth prior to the actual movement, and no movement occurs until cleared by Master Control.* *Staff moves youth from one area of the center to another in accordance with Florida Administrative Code.*	

The center follows the statewide detention policy regarding youth supervision, which is in place to ensure the safety and security of youth. During the annual compliance review, observations confirmed staff were actively supervising youth at all times. Observations confirmed consistent communication between staff and master control using a two-way radio to complete head counts and to receive authorization for all movement within the center. The staff were seen supervising youth on living modules, in the classrooms, during line movement, while eating meals in the dining hall, and during recreation. A review of the program's logbooks for the last six months documented headcounts were conducted on a consistent basis at the beginning and end of each shift and randomly throughout each shift. The logbooks are the center's main tool to keep track of how many youth are in the center. This includes documentation of all trips for youth out of the center (for court, doctors, etc.), in addition to all admissions and releases. Staff in master control also use a dry erase board to track the status of youth in the center, in addition to those out to court or other transports. Interviews were conducted with seven staff during the annual compliance review. All seven staff indicated youth counts are completed at the beginning of the shift, the end of the shift, before and after meals, and before and after school. All seven of the interviewed staff were able to explain the basic procedures which would be followed if a count is not correct. All staff indicated all movement would stop, and an immediate recount would be conducted. All seven interviewed staff indicated there have been enough staff at the center to provide for the safety and security of the youth and staff during recent months. No additional comments were provided from these respondents. Informal interviews with three staff during the review revealed the staff are pleased with the new leadership, and feel things are getting better at the center.

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

The center has a policy and procedures ensuring ten-minute checks are conducted when youth are in their rooms for sleeping or other reasons. The center has a total of 186 cameras with four cameras being vacant feeds. At the time of this review, the program reports four non-essential cameras inoperable. Cameras have a recording capacity of thirty days. The center utilizes the Guard One Plus which is an electronic wand system to document ten-minute checks. Staff utilize the electronic Guard One Plus by tapping the wand on the check point sensor located on the outside of each youth's room door. The data from the wand is downloaded daily to ensure no information is lost.

The juvenile justice detention officer (JJDO) is responsible for pausing at the youth's sleeping room door and observing the youth behind the closed door before the check point sensor is activated with the wand to ensure there are no issues with the youth. The superintendent was interviewed and validated this practice. Observations of youth living modules and rooms confirmed there were no obstructions over the windows and areas in which direct line of sight is needed. Observations of ten-minute room checks via cameras on four different modules, from three different shifts, and six different days and times along with corresponding ten-minute logs downloaded from the wands supported checks were conducted every ten-minutes, or less, and in real time and with fidelity. Seven staff were interviewed, and each staff reported rooms checks are completed at minimum every ten-minutes. Two of the seven staff also stated room checks are done every five minutes for the first hour; and every ten minutes thereafter.

5.03 Census, Counts, and Tracking	Satisfactory Compliance

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

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

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

The center has a policy and procedures ensuring headcounts are conducted as required. Staff must always know the exact number and location of all youth under their supervision. Census counts are taken, called into master control, and documented in the center's master control logbook. Living module counts are recorded in their assigned living module logbook. No youth movement is conducted until master control confirms the counts, reconciles the count, and authorizes the center's activity to resume, if necessary. An interview with the center's master control technician confirmed this practice. A review of the master control logbook for the past six months validated headcounts were documented at the beginning and end of each shift, following any emergency, inclusive of any mock or emergency drills, whenever a population change occurs, prior to any youth movements, and randomly at least once on each shift. Seven staff were interviewed regarding youth counts and each staff responded counts are conducted at the beginning and end of each shift, prior to and following school, and before and after each meal. Each interviewed staff reported emergency counts are conducted when a youth is believed to be missing, when visibility is hindered such as an electrical outage, and after any major disturbance. The interviewed staff did not articulate the process following counts which were unable to be reconciled; therefore, the review team randomly interviewed seven additional direct care staff during observations as to the process for unreconciled counts. All randomly interviewed staff were able to articulate the process to be followed if counts were not able to be reconciled.

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

The center follows the statewide facility operating procedures (FOP) regarding logbooks. The center has a master control area where the assigned staff update and maintain the master control logbook. A review was conducted on the logbooks from the past six months. The logbooks contained a chronological record of events, incidents, and activities occurring in the program. Each logbook was bound with numbered pages and contained entries regarding admissions and releases, emergencies, incidents, head counts, transports, youth movement, documentation of law enforcement presence, and precautionary observation documentation to include placement information with subsequent step-downs, to include when the placement was initiated and ended. Each logbook entry consistently included the date and time of the event, names of staff and youth involved, a very brief description of the event with the initials of the person making the entry, and the date and time of the entry. There were very few entries found obliterated or removed. The logbook review found exceptions regarding confinement reporting for twenty-two of the twenty-seven selected reports. Ten of the reports had no documentation in the master control logbook, five had no beginning time, and seven had no ending time found. The Detention FOP requires all confinements, with beginning and ending times, to be entered in the master control logbook. Additionally, four of the seven reviewed for calls placed to the Central Communications Center and/or the Florida Abuse Hotline were found documented in the logbook. The logbook was found to indicate head counts were conducted, and accurate information was recorded to reflect how many youth were in the physical presence of staff during the count. They documented all youth movement within the master control logbook. The center gathers all pertinent information on a shift report which is maintained with the Facility Management System (FMS) within the Department's Juvenile Justice Information System (JJIS). The review of living module logbooks found all pertinent information regarding occurrences for each module were documented consistently.

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

The center follows the statewide detention facility operating procedures regarding logbook reviews. The center's policy requires the superintendent or designee to review the master control logbook and all living module logbooks at least once a week and document their review of the logbook. The review of master control and living unit logbooks had documentation reflecting consistent reviews conducted by the superintendent or their designee more often than required. A review of nine master control and living unit logbooks reflected staff signed acknowledging their review of the living unit logbook when reporting for duty, in addition to reviewing the logbook entries for the previous seventy-two hours. Additionally, the review found shift supervisors consistently reviewing and signing the master control logbook when they accept responsibility for the center. A review of living unit logbooks confirmed the shift supervisors visit each unit during their shift and enter a review of each living module logbook during their shift.

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

The center maintains a policy and procedures ensuring the inventory and control of all center keys, as well as replacing lost or damaged keys. Center keys are maintained on a tamper-resistant ring with a brass tag identifying the ring number and the number of keys on the ring. Center keys, including restricted keys, are stored in master control in a locked key box accessible by the master control operator, juvenile justice detention officer supervisors (JJDOS), and administrative staff. Juvenile justice detention officer (JJDO) module specific keys are kept in a separate lock box in the supervisor's office which is adjacent to master control. Emergency

keys providing egress through exterior doors are stored in master control and the superintendent's office in which only staff can access. The center maintains a master key inventory which accounts for all key rings by ring number, the number of keys on each ring, to the staff assigned to the key, and the capability of each key. Staff must turn in all personal keys to master control. All personal keys are stored in a secured locker or in master control. The JJDO are issued keys through the supervisor during shift briefing at the beginning of each shift. There is a separate key inventory log completed for JJDO keys and it is validated by the supervisor at the beginning of each shift. A review of the master control logbook and daily shift reports and observation of distribution and collection of keys validated the issuance of keys/key rings were documented in the master control logbook on each shift with the date, time, staff name, and initials of staff issuing the keys. JJDOs are issued keys through the JJDOS during shift briefings. Each JJDO is required to sign and enter the date and time on the key control log when issued their keys. Each JJDO turns their keys back into the JJDOS at the end of their shift and must sign, date, and enter the time again on the key log. Observations conducted during the annual compliance review week confirmed this practice. A review of the master key control inventory during the annual compliance review validated the inventory report matched the actual keys in use. Observations during the annual compliance review week found staff were always carrying their assigned keys on their person, and youth did not have access to any keys. All center keys were accounted for during the review. An informal interview was conducted with the center's superintendent. The superintendent reported only administration staff are issued permanent keys. There have been no incidents of lost keys or incidents in which staff have left the center with center keys since the last annual review. The superintendent confirmed if for some reason keys were lost in the center, the center would be locked down and a search would be conducted immediately. A report would be initiated to the Department's Central Communications Center (CCC) if the keys were not found within two hours. Visitor keys are stored in master control in a locked box. Seven staff were interviewed, and each responded restricted keys included access to medical records, mental health records, and case management records. Four of the seven interviewed staff also included youth property keys and kitchen keys as restricted. Each staff reported youth do not have access to center keys. Each interviewed staff could articulate the daily process for tracking keys at the center, including the usage of a key control log and the turnover of keys during shift briefings.

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

The center has a policy and procedures ensuring vehicles to transport youth are properly maintained, inspected annually, and in good repair. The maintenance manager is responsible for weekly and monthly vehicle inspections. The center has a total of four vehicles currently used to transport youth. Reviewed documentation validated each vehicle had an annual safety inspection conducted by a certified automobile mechanic. Observations of the four vehicles verified each vehicle was locked when not in use. Inspections of the four vehicles confirmed each vehicle had the appropriate number of seat belts, a seat belt cutter, a window punch, and an up-to-date fire extinguisher. There are ten first aid kits with approved and up-to-date items which are in a locked cabinet and one kit is signed out for any vehicle trip. Each vehicle was observed to have a binder which contained the vehicle mileage log, mechanical restraint key,

gas card, vehicle policy, and vehicle registration. Each vehicle is inspected prior to transporting youth using the Department's approved checklist. Reviewed documentation supported this practice. Weekly visual vehicle inspection checks are conducted on each vehicle, as required, and documented on the maintenance check sheets to inspect water coolant, lights, oil, emergency equipment, brakes, horn, interior/exterior, and cleanliness of the vehicle. Monthly vehicle checks are conducted on the tires, battery, windshield, wipers, windows, mirrors, and other visual damage and documented on the mandatory maintenance form. Reviewed documentation supported a pre-trip inspection is completed on each vehicle by two staff. Each vehicle is inspected prior to transporting youth using the Department's approved checklist. During the annual compliance review week, an observation of the pre-transport and post-transport activities was completed. Observations validated the vehicle was searched by staff before and after transport. Staff searched the youth before and after all transports. Youth and staff were observed using their seatbelts. The transport staff were in possession of the vehicle logbook and a binder containing the vehicle log, gas credit card, and vehicle registration.

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

The center follows the statewide detention facility operation procedures regarding tool inventory and management. The maintenance mechanic is required to ensure all tools and equipment related to maintenance are properly maintained, stored, and inventoried. Inspections of all tools are conducted for all tools maintained in the tool shed every day the maintenance mechanic works. Tools are stored in a locked storage shed which is inside a secure area outside of the center's kitchen area. Most of the tools are hung on a pegboard, which has outlined areas for easy identification of what tool belongs in each spot. There are numbers on the pegboard which match the corresponding tool which should be placed in specific areas. This area is locked when not in use, and no youth have access to any tool, nor the area. This area is off-limits to detention staff as well, with only the maintenance mechanic and center administration having authorized access to this area. Discrepancies were found on the reviewed inventories which were completed by the current maintenance mechanic since September 2019. Ten tools were randomly selected for review. Two of the selected items on the pegboard were large handsaws. When compared to the inventory, it reflected these should have been a pop riveter and a ruler. The handsaws could not be found on the inventory. The reviewer tried to locate a hex plumbing wrench. In its spot on the board was a hammer, and the actual hex wrench was hanging on a nail above the board. Having two tools sharing the same number raised serious concerns regarding the inventories which had been completed. The other seven selected tools were found to match what was reflected on the inventory. Due to the identified discrepancies, an additional ten tools were reviewed. An additional four discrepancies were identified during this check. The maintenance mechanic indicated he was told the area was in good shape, and the inventory matched what was in the shed. He has been working to address needed repairs around the center, and has wanted to redo the pegboard, but has not had time. Due to daily inventories being signed and ultimately reflecting all tools were checked and identified as present each day without the identified discrepancies, a call was made by the annual compliance review team to the Central Communications Center (CCC). They accepted the call and assigned it for further review. Interviews with the maintenance mechanic by review team members did not feel there was any intent to deceive, and this information was shared with the CCC. The maintenance mechanic reported they have had to replace broken tools in the last six months. During an interview, the maintenance mechanic indicated any broken or defective tools would be removed for repair or replacement. This would be immediately reported to the

superintendent with an incident report and work order also being completed. Immediately following repairs or replacement of a tool these would be marked with the required designation and be secured in the appropriate storage area. The center's tools were inspected during the annual compliance review and most were found to be marked with an identification code identifying the tool as Department property. Some of the loose screwdrivers on the pegboard had no identifying marks found on them. The detention center superintendent indicated the tool shed would be a priority for correction. He was going to reach out to the regional maintenance staff for assistance.

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

The center follows the statewide detention facility operating procedures which address youth access to and the use of tools and cleaning items. The youth in the center only have access to mops, brooms, buckets, and cleaning rags. An observation of youth performing cleaning detail also supported the policy is implemented and youth do not access any inappropriate tools or cleaning items. Observations further reflected these approved cleaning tools are used under the direct supervision of staff. Seven interviewed youth each responded they use mops and brooms only. Seven interviewed staff each reported youth are only allowed to use mops and brooms.

5.10 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 follows the statewide detention facility operation procedures which address the inventory of flammable, toxic, caustic, and poisonous items. Cleaning chemicals are stored in a locked storage shed for supplies in the secure fenced in area outside of the kitchen. This shed was neat and free from clutter. A review of the inventory for cleaning chemicals maintained in the large shed was not accurate. The fiscal assistant is responsible for tracking and ordering the chemicals stored in this locking shed. She only conducts an inventory of the area at the end of each month. As new chemicals are received during the month, they are placed in the shed, but are not added to the inventory. During the month, any chemicals which are removed are signed

out on a separate log. This system does not allow for accountability of the chemicals at any given time, other than when inventory is conducted at the end of each month. Two annual compliance review team members attempted to use invoices for chemicals received and those signed out to ascertain if the correct amounts of five different cleaning products stored in this area were accurate. Two randomly selected items matched what should have been on hand, while the other three did not. The kitchen maintains a working stock of cleaning chemicals, to include bleach, in a locking cabinet with the kitchen area. There was no inventory for the items maintained in this cabinet. The kitchen manager developed a laminated tracking sheet which was put in use during the annual compliance review week to track the chemicals stored in this area. The flammable items for the center are kept in three easily identifiable yellow flammable item cabinets which sit outside the tool shed. The inventories for the items maintained in these sheds were checked, and no discrepancies were found. Safety Data Sheets (SDS) for all flammable, toxic, caustic, and poisonous items were maintained in binders. The SDS binders are maintained near the chemicals, and are accessible, if needed, for reference in each area chemicals were stored. Chemical inventory and storage are maintained by maintenance staff for all flammable items, and access to these are limited according to the center administration staff and the maintenance mechanic. The flammable cabinets and storage shed are both in a secure area and are inaccessible to youth.

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

The center follows the statewide detention facility operation procedures regarding access to any flammable, toxic, caustic, and poisonous items. The policy prohibits youth from handling or having access to any flammable, toxic, caustic, and poisonous items. All flammable, toxic, caustic, and poisonous items are stored inside locked flammable cabinets and a locked storage shed inside a secure area outside of the center's kitchen. Key access to the shed and storage cabinets is restricted to maintenance and administrative staff only. The flammable storage cabinets and storage shed were always observed locked during the review. All seven of the interviewed youth indicated they have not handled any cleaning agent such as bleach, laundry soap, window or toilet cleaners during their time in the center.

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

The center has a policy and procedures regarding the disposal of all flammable, toxic, caustic, and poisonous items. An interview with the maintenance mechanic confirmed their knowledge of the procedure for disposal of all flammable, toxic, caustic, and poisonous items. He indicated they would follow any disposal procedures which were on the Safety Data Sheets (SDS) or contact their contracted vendor for disposal. They indicated most chemicals are maintained until

they are completely used up, and do not require disposal. The kitchen has a storage area outside to collect grease and other waste. This is collected at least once a quarter by a contracted vendor. Medical biohazardous waste is disposed of through a contracted vendor as well. The interview with the maintenance mechanic further confirmed there were no chemical spills or leaks at the center within the annual compliance review period.

5.13 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 center follows the statewide detention facility operating procedures regarding confinement of youth. The center had 937 confinements during the previous six months, and ninety-three were selected to review for compliance with this indicator. This policy had a major revision, which was put into effect on September 5, 2019. The center does not have designated confinement cells. A youth is typically confined in the room they have been assigned to sleep in. Nine of the reviewed reports were completed prior to the implementation of the revised policy. Eight of the nine confinements reflected the confinement room was searched prior to placement. A review of these confinements also confirmed staff were consistently documenting an incident report in the Facility Management System (FMS) within the one-hour time frame after an incident. All nine of these confinement reports reflected a juvenile justice detention officer supervisor (JJDOS) completed a review for fairness and appropriateness within the two-hour requirement. Each of these nine reviewed reports reflected three-hour checks were completed by a JJDOS without exception. Each visit documented in FMS also had information indicating the need for continued confinement, if applicable. Eight of these nine confinement reports had the superintendent/designee review completed within the forty-eight hour requirement. The other report was reviewed two days late.

The other eighty-four confinement reports which were randomly selected for review occurred after the revised policy was implemented on September 5, 2019. Forty-five of these reports did not reflect the required search of the confinement room prior to placement having been conducted. The center indicated they may not always have the opportunity to search the room at this time due to the combative nature of the youth. They provided contraband search documentation reflecting each room was searched at least once on each shift; however, youth may have had the opportunity to enter their room after the search and prior to confinement, and potentially bringing something inappropriate into their room. All eighty-four reviewed reports reflected a check of the confinement by a JJDOS within the two-hour requirement; however, they did not reflect their approval of one confinement in the reviewed notes entered on the reports. All three-hour reviews by a JJDOS were completed within the required timeframe, with one exception. One check was completed one hour and twenty-five minutes late. There was no indication in their note to indicate this was a late entry. All the JJDOS reviews reflected specific reasons for continued confinement, when applicable. The review found nine of the eighty-four superintendent/designee reviews were not completed within the required twenty-four hour timeframe. These were completed from one to twenty-seven days late. The superintendent indicated there was a concern with a former assistant superintendent who was assigned this review task. This staff is no longer employed with the Department. Observations and interviews with three staff during the annual compliance review confirmed education materials are available for youth who are confined during school hours. The teaching staff are notified when a youth is in confinement. They offer youth an educational packet which they may work on in this

placement. Observations found youth can have reading materials with them while in confinement.

All seven interviewed staff indicated they complete ten-minute checks and would search the room prior to placing youth in confinement. Six of the staff indicated they would complete a confinement report. Staff also reflected they completed checks at five-minute intervals during the first hour of confinement. A review of visual observation reports for confined youth confirmed this practice.

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

The center follows the statewide detention facility operating procedures regarding confinement of youth. This policy had a major revision, which was put into effect on September 5, 2019. A review of the confinements for the past six months found seven confinements in which youth were confined for over twenty-four hours. Each of these confinements occurred on August 25, 2019. Three applicable reports were selected for review. All three reports indicated the room was searched prior to the placement. All three reports were entered into the facility management system (FMS) within one hour of the placement, and each had a review by a juvenile detention officer supervisor (JJDOS) within two hours of the placement to ensure the placement was fair and appropriate. All three-hour reviews by the JJDOS were done within the required timeframe, with two exceptions. These exceptions were found to have been completed thirty and ninety-three minutes late. The reviewed entries during the room checks reflected specific reasons for continued confinement, when applicable. Each of these reports reflected extensions beyond the initial twenty-four-hour placement due to the nature of the incident. None of these youth were confined beyond forty-eight hours. All three reports reflected a review was conducted by the superintendent/designee within forty-eight hours of the youth's release.

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

The center has a policy and procedures ensuring a plan in place to manage various emergencies and disaster events. The center's Continuity of Operations Plan (COOP) was approved by the Department in January 2019. The center is currently awaiting the memorandum of understanding agreement (MUA) with Pinellas County Sheriff's Officer prior to this year's COOP approval. The COOP was reviewed and approved by the center's superintendent on January 31, 2020. Copies of the COOP are kept in master control and the assistant superintendents' office for accessibility to all staff. Center documentation confirmed there were three COOP drills conducted, which is more than the two drills required. A hurricane drill was conducted in May 2019, just prior to hurricane season as required. Severe weather drills were conducted twice in December 2019. These three drills exceed the required two COOP drills a year. Observations made of the drill forms indicated each contained written scenarios and COOP Drill forms, critique forms, and e-mails used to document the drills. All drills were documented on the drill form and in the logbooks. Seven staff were interviewed and asked what drills they have participated in within the last six months. All staff reported participating in fire, escape, and medical/mental health drills. Five staff reported participating in a severe weather drill. Two responded they have participated in a major disturbance drill.

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

The center has a policy and procedures ensuring there is a plan in place to prevent, manage, and address youth escapes. A review of the prevention plan confirmed all required elements outlined in the Department's policy. The center requires escape drills to be conducted at least once a quarter. A review of the center's escape drills since the last annual compliance review, along with corresponding logbook entries, verified the center exceeded the requirement. Drills are reviewed during staff meetings and shift briefings. Reviewed documentation found all drills were documented on drill forms and in the logbook. Additionally, staff signed a roster acknowledging they participated in the drill. A review of seven staff training records validated annual escape training was completed by each reviewed staff. Seven staff were interviewed and asked what drills they have participated in within the last six months. All staff stated they have participated in an escape drill.

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

The center has a policy and procedures ensuring fire prevention and safety of the center. The center's fire prevention and safety plans are currently awaiting approval by the local fire marshal due to some deficiencies identified during the last fire inspection. The local fire marshal will be

at the center at the end of February 2020 to verify all deficiencies have been corrected and will approve the fire prevention and safety plan. Annual inspections are conducted by the fire marshal. The center has evacuation egress plans posted throughout the center. Each egress plan defines primary and secondary exit routes, and the locations of emergency equipment, such as fire extinguishers and first aid kits. A review of the emergency drills and logbook documentation for the past six months confirmed the center conducts fire drills every month, one each shift, during different times, as required. Drills are reviewed during staff meetings and shift briefings. A review of seven staff in-service training records validated annual fire prevention training was completed by each reviewed staff. Seven interviewed staff each reported they have participated in a fire drill at least monthly. Seven youth were interviewed, and all reported they have been instructed on what to do in case of a fire.