STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

PROGRAM REPORT FOR

Southwest Florida Regional Juvenile Detention Center

Department of Juvenile Justice

(State-Operated)
2525 Ortiz Avenue
Fort Myers, Florida 33905

Review Date(s): August 7-10, 2018

PROMOTING CONTINUOUS IMPROVEMENT AND ACCOUNTABILITY
IN JUVENILE JUSTICE PROGRAMS AND SERVICES

Rating Definitions

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

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

Review Team

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

Shawna Prope, Office of Program Accountability, Lead Reviewer (Standard 1)
Paula Friedrich, Office of Program Accountability, Regional Monitor (Standard 3)
Kimbley Jacobs, Palm Beach Regional Juvenile Detention Center, Assistant Superintendent (Standard 2)
Marie Lockwood, Office of Program Accountability, Regional Monitor (Standard 4)
Shakela Minns, Office of Program Accountability, Regional Monitor (Standard 4)
Maryann Sanders, Officer of Program Accountability, Deputy Regional Supervisor (Standard 3)

Program Name: Southwest Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: Lee County / Circuit 20
Review Date(s): August 7-10, 2018

MQI Program Code: 1046
Contract Number: N/A
Number of Beds: 50
Lead Reviewer Code: 158

Methodology

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

Persons Interviewed

- ☒ Program Director
- ☒ DJJ Monitor
- ☒ DHA or designee
- ☒ DMHCA or designee
- ____ # Case Managers
- x # Clinical Staff
- x # Food Service Personnel
- x # Healthcare Staff
- x # Maintenance Personnel
- x # Program Supervisors
- ____ # Other (listed by title): ____

Documents Reviewed

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

Surveys

- 5 # Youth
- 5 # Direct Care Staff
- ____ # Other: ____

Observations During Review

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

Comments

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

Standard 1: Management Accountability
Detention Rating Profile

Indicator Ratings

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

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

Standard 2: Youth Management
Detention Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Detention Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Detention Rating Profile

Indicator Ratings

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

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Strengths and Innovative Approaches

- The center provides positive peer leadership mentoring monthly, utilizing speakers who come on-site to mentor and teach youth how to become positive leaders.

- The center utilizes numerous faith-based organizations three to four times a week which provide youth with spiritual learning. These faith-based opportunities are voluntary for all the youth in the center.

- Youth at the center are able to express their artistic abilities by painting murals displayed on walls, halls, and in the modules.

- The center participates in the twenty-one days of Christmas, providing games, speakers, and arts and crafts for the youth while out of school.

- The center provides tours of Hodges University to youth who have met the requirements of the behavioral management system.

Standard 1: Management Accountability

Overview

The Department of Juvenile Justice (DJJ) operates the Southwest Regional Juvenile Detention Center located in Fort Myers, Florida. The detention center is a fifty bed, hardware-secure facility housing youth detained by various counties within Circuit 20. The center houses both female and male youth who are detained pending adjudication, disposition, or placement in a residential commitment facility. The services for youth include booking and orientation, behavior management, safety and emergency procedures, transportation, mental health, and healthcare services. The center has an educational component which is provided by the District School Board of Lee County. The mental health and healthcare services are provided through contracted providers. Food services include menus and meal planning, meal schedules, special diets, nutritional analysis and daily allowance, food preparation, health certifications, food product standards, sanitation, and cleaning. The center has a staff development training program to ensure the professionalism and competency of staff. The center's management team is comprised of a superintendent, two assistant superintendents, administrative assistant, maintenance mechanic, juvenile justice detention officer supervisors (JJDOS), juvenile justice detention officers II (JJDO II), and juvenile justice detention officers (JJDO I). At the time of the annual compliance review, the center had one juvenile justice detention officer I staff vacancy. A tour of the center during the annual compliance review found all areas clean and well-maintained, free of infestation, and with minimal graffiti.

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

The center maintains a written policy and procedures for background screening. Prior to hire, background screenings are conducted on all Department employees, contracted providers, volunteers, mentors, and interns who have access to confidential youth files and healthcare records. All required documents are forwarded to the Department's Background Screening Unit (BSU) and all results are mailed back to the center. The center hired eighteen new staff, two contracted staff, and three mentors since the last annual compliance review. All staff received a background screening prior to hire. The two contracted staff background screenings were processed and maintained in the Care Provider Background Screening Clearinghouse database owned and maintained by the Agency for Health Care Administration (AHCA). None of the staff had prior criminal history requiring exceptions from the Department's Inspector General's Office prior to hire. An Affidavit of Compliance with Level 2 Screenings Standard was submitted to BSU on January 2, 2018 and for school board teachers on January 12, 2018, respectively, meeting the annual requirement.

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

The center maintains a written policy and procedures for five-year background rescreening. A rescreening is completed every five years from the date of hire for all staff. A review of the staff and volunteer roster indicated one staff was applicable for a five-year rescreening since the last annual compliance review. Reviewed documentation supported the staff's five-year rescreening was submitted to the Background Screening Unit (BSU) at least ten days prior to the anniversary hire date.

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

The center has written policy and procedures outlining staff code of conduct. The center's staff are required to adhere to the code of conduct which prohibits any form of abuse, profanity, threats, harassment, intimidation, horseplay, or personal relationships with youth. As a Department employee, all staff are required to review and sign the code of conduct acknowledgement form prior to hire. Five staff personnel records were reviewed, and each contained the required code of conduct documentation. Each code of conduct was acknowledged with a signature of the staff member. Three staff records were reviewed for disciplinary actions pertaining conduct. Two staff were terminated, and one staff received a verbal reprimand and additional training. Five staff were interviewed, and each reported they have not observed any violations of the code of conduct by coworkers. The five interviewed staff stated they have never heard staff using profanity or encouraging youth to be aggressive in any

way. Each interviewed staff stated they have never denied a youth the opportunity to call the Florida Abuse Hotline or to the Department's Central Communications Center (CCC). Five youth were interviewed during the annual compliance. Each youth reported staff are respectful and do not intimidate youth. Each interviewed youth reported never hearing staff use profanity when addressing youth.

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

The center has written policy and procedures for incident reporting which documents the requirements for reporting incidents to the Department's Central Communications Center (CCC). The program had sixteen CCC reports within the last twelve months. All sixteen CCC reports were reported to the CCC within the required two-hour time frame of the incident and/or staff becoming aware of the incident. Each of the reviewed incidents were documented in the master control logbook. Reviewed logbooks, grievances, and internal incidents confirmed there were no additional incidents which should have been reported to the CCC but were not. Five interviewed staff and five interviewed youth each indicated youth are never denied a call to the Florida Abuse Hotline. Each staff indicated the youth is immediately given the opportunity to make a call and the staff stand back so the youth have privacy while making the call. Staff have visual contact with youth during the call.

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

The center has written policy and procedures for Protective Action Response (PAR). The center had 136 PAR incidents during the past six months and thirteen PAR reports were reviewed for the past six months. The PAR reports included statements from all staff involved. None of the reviewed PAR reports resulted in injury requiring a report to the Central Communications Center (CCC) and none of the youth were alleging abuse. All thirteen PAR reports were reviewed and processed within seventy-two hours by all required parties. Each report was reviewed by the supervisor and PAR instructor to determine if use of force was consistent with Departmental policy. All reviewed PAR reports were completed by the end of the staff completing the report's workday. None of the youth required a PAR medical review. An interview with the superintendent revealed the detention center's management team reviews reports and video coverage daily, to determine if PAR moves or techniques were used appropriately and in accordance with Florida Administrative Code (F.A.C.) 63H-1.004. The center maintains all PAR reports electronically in the Department's Facility Management System. A review of five staff training records confirmed each staff receive ongoing PAR refresher training. Reviewed internal incidents, grievances, and logbooks found there were no additional PAR incidents. Five interviewed staff indicated they speak to youth prior to any physical restraints, and each staff confirmed they try to use verbal techniques to control the situation Five interviewed staff indicated staff utilize verbal intervention before they utilize PAR.

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

The center maintains a written policy and procedures regarding pre-service training. Five staff training records were reviewed for pre-service training. Reviewed documentation found each staff completed the certification requirements within the 180 days of hire. Each staff completed the required training prior to contact with youth to include Protective Action Response (PAR), cardiopulmonary resuscitation (CPR), first aid, mental health services, substance abuse services, suicide recognition and intervention, safety and security, Prison Rape Elimination Act (PREA), human trafficking, and detention operations. All pre-service training was documented in the Department's Learning Management System (SkillPro).

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

In-service training is provided through a combination of the Department's Learning Management System (SkillPro) and instructor-led courses. Five staff training records were reviewed for in-service training requirements. Each staff received the required Protective Action Response (PAR) refresher training, suicide prevention, and professionalism and ethics. Each staff maintained current certifications in cardiopulmonary resuscitation (CPR) and automated external defibrillator (AED). All five staff exceeded the twenty-four-hour training requirement. Three staff required supervisory training, and each exceeded the eight-hour requirement. In addition, reviewed documentation in the three supervisory staff training records reflected each completed the required Epi-Pen Auto Injector training. All training was documented in the Department's Learning Management System (SkillPro). During an interview, the superintendent confirmed the training requirements for staff. In addition, he stated he has attained certification in supervisory management and is a certified public manager.

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

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

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

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

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

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

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

The center maintains a written policy and procedures regarding entering alerts in the Department's Juvenile Justice Information System (JJIS) and the use of an internal alert system. A review of the center's Admission Wizard, logbooks, and internal alert system found each applicable youth with an identified issue was appropriately documented. A review of the Department's JJIS found each applicable alert was updated as required. Medical staff are responsible for entering medical alerts. Mental health alerts are entered by mental health staff, gang and other safety and security alerts are entered by the intake juvenile justice detention officers (JJDO) and juvenile justice detention officer supervisors (JJDOS). A review of five youth healthcare records, five mental health and substance abuse records, and five case management records documented each youth's alerts were entered in JJIS as required. Reviewed shift briefing minutes indicated the open alert report is reviewed before the start of each shift by the center's administration, supervisors, and JJDO staff. The supervisors discuss and distribute the alert list to all working direct-care staff, at each shift briefing. A shift briefing was observed during the annual compliance review which validated this practice. Each staff carries the current alert list throughout their shift. When an alert needs to be added or updated subsequent to a shift's briefing, the supervisor is notified of the change and the information is verbally disseminated to staff until a new alert list can be printed and distributed. Five interviewed staff indicated they were informed of alerts through the logbook, shift debriefings, alert forms, and JJIS.

Standard 2: Assessment and Performance Plan

Overview

All youth are screened and classified upon admission to the detention center according to their level of risk to ensure they can be placed into the general population and are not in need of immediate healthcare, mental health, or substance abuse services. All youth receive an orientation to the center within twenty-four hours of admission. All youth admitted to the center, and those placed on home detention services, are reviewed and discussed weekly at the detention review meeting. The center has an activity schedule posted to ensure all youth are involved in structured activities throughout the day. The center provides all youth with educational and vocational programming during their stay in detention. The center has a behavioral management system in place which provides a system of rewards, privileges, and consequences to encourage positive behavior. All juvenile justice detention officers complete mandatory trainings annually on trauma informed care. The center has a grievance process and displayed grievance forms in the living modules with access to all youth.

2.01 Admission	Satisfactory Compliance

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

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

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

The center has a written policy and procedures outlining youth admitted into the center in accordance with Florida Administrative Code. Five youth case management records were reviewed and found each included paper work from law enforcement and screening staff. Each reviewed record contained supporting documentation of the youth being electronically searched, frisked, and stripped search by an officer of the same gender as the youth. All five records included documentation of the youth placing a call to his /her parent/guardian at the facility's expenses and indicated the youth received a meal upon admission. Each record documented the youth was screened to identify medical, mental health, and substance abuse needs. An observation of one admission was conducted during the annual compliance review and validated the center's practice.

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

The center has a written policy and procedures to ensure orientation is provided to each youth within twenty-four hours of being admitted into the center. All youth admitted into the center are advised of the orientation process verbally and in writing. The orientation brochure informs all youth of center rules and regulations, grievance procedures, visitation, telephone calls, available medical, mental health, substance abuse services and how to access them, how to access the Florida Abuse Hotline or the Central Communications Center (CCC) for youth eighteen years of age or older, expectations for behavior and related consequences, possible new law violations for destruction, and youth rights. The center's written policy and procedures ensures orientation is provided to each youth within twenty-four hours of being admitted into the center Five interviewed youth indicated they were provided with the center's rules, daily schedule, education services, visitation, abuse reporting, and behavior management system (BMS) information upon admission. An orientation was observed during the annual compliance review which validated the center's practice.

2.03 Classification	Satisfactory Compliance

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

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

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

The center has a written policy and procedures indicating all youth being admitted into the detention center shall be classified to provide the highest level of safety and security. The center considers all factors prior to placing a youth into a room/module ranging from height, weight, age, sex, level of aggression, mental illness, developmental disabilities, physical disabilities, history of violence, gang affiliation, criminal behavior, history of sexual offenses, vulnerability to victimization, suicide risk identified or suspected. A review of five youth case management records found each contained a copy of the individual booking classification form and the Department's Juvenile Justice Information System (JJIS) Admission Wizard paper work, which included the classification results and the Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) form. Youth with a history of sexual offenses or a victim of a sexual offenses are placed in a single room. Youth may be reclassified if changes in status occurs subsequent to admission. The center's facility operating procedures does not require the use of any supplemental forms.

2.04 Classification of Gang Members	Satisfactory Compliance

All newly admitted youth are screened to determine if he or she is a criminal street gang member or is affiliated with any criminal street gang.

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

The program has a policy and procedures which states all newly admitted youth are screened to determine if he/she is a criminal street gang member or is affiliated with any criminal street gangs. The superintendent or designee remains informed of how to identify and address local gangs by working closely with the assistant superintendent who acts as the center's gang representatives and local agencies. Five youth case management records were reviewed, and documentation confirmed each youth was screened upon admission. Documentation reflected one youth was identified as a gang member; therefore, two additional youth records were requested and reviewed. Reviewed documentation for the three youth confirmed appropriate

alerts were entered into the Department's Juvenile Justice Information System (JJIS). In addition, admitting the juvenile justice detention officer notified the center's gang liaison of each youth gang information by electronic mail. A review of the Department's Juvenile Justice Information System (JJIS) and the internal alert system confirmed each applicable youth had an appropriate alert.

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

The program has a policy and procedures to ensure all newly admitted youth are screened to determine if he/she is a criminal street gang member or is affiliated with any criminal street gangs. The center has a gang representative to communicate suspected gang activity. The gang representative notifies the juvenile probation officer (JPO) representative, superintendent, and the JPO's supervisor regarding any indication of gang activity by electronic mail. The probation gang representative forwards the gang related information (pictures, tattoos, drawings) to the appropriate law enforcement agency. The gang alert is then entered in the Department's Juvenile Justice Information System (JJIS) upon written confirmation from law enforcement. Three applicable youth case management records were reviewed which confirmed the center's practice.

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

The program has a written policy and procedures to ensure the youth's property is maintained securely during admission and returned to the youth or the parent/guardian upon release. Five youth case management records were reviewed, and each had a personal property receipt signed by the youth and the juvenile justice detention officer (JJDO) receiving the property. The youth's personal property is inventoried, upon their admission, and stored in a locked secure safe which is under surveillance twenty-four hours a day. All valuable items are inventoried and placed in a clear and tamper-resistant sealed bag. The sealed bag is placed in the locked secure safe. The youth and JJDO receiving the property sign the bag. The youth's valuable items are documented in the property logbook for tracking purposes. All reviewed youth records included a letter of acknowledgment regarding unclaimed property signed by the youth. The superintendent stated all personal property such as clothing and shoes are stored in individual garment bags. Valuables, such as money, picture identification cards, and jewlery, are locked in a safe at intake. The superintendent and assistant superintendents have access to the safe. Items are removed daily, logged and stored in a locked cabinet until the youth is released, or a parent/guardian picks up the property.

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

The program has a written policy and procedures to ensure the youth's property is maintained securely during admission and returned to the youth or the parent/guardian upon release. An observation of the storage area during the annual compliance review found all valuable property is locked away in a safe under surveillance twenty-four hours a day. Each youth's property is locked in a secure room and placed inside of a green storage bag. The superintendent stated all personal property such as clothing and shoes are stored in individual garment bags. Valuables, such as money, picture identification cards, and jewlery, are locked in a safe at intake. The superintendent and assistant superintendents have access to the safe. Items are removed daily, logged and stored in a locked cabinet until the youth is released, or a parent/guardian picks up the property.

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

The center has a policy and procedures addressing the release of youth from detention. The releasing officer shall verify the courts authorization to release the youth. Prior to release the on-duty juvenile justice detention officer supervisor (JJDOS) reviews all paperwork prior to release. The JJDOS is responsible for ensuring there are no holds, court orders, or other legal reasons to not release the youth. The youth are identified prior to release. Parents/guardians are identified, and a photo copy of identification is placed in the youth's record. A review of three closed youth case management records documented the center's practice. A review of reports to the Central Communications Center (CCC) and internal incidents for the past six months supported there were no unauthorized releases from the detention center. There were no applicable released during the annual compliance review to observe.

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

The center has a written policy and procedures to ensure the youth's property is maintained securely during admission and returned to the youth or to the parent/guardian upon release. Upon release from the center, the detention officer, the youth, and the parent/guardian reviews and sign the property receipt form and accounts for all the youth's personal property. A copy of the signed property receipt, which acknowledges the return of the youth's personal property, is placed in the youth's record. Any items of the youth's personal property left in the center for more than thirty days after the parent/guardian has been notified to either retrieve or make arrangements to retrieve, the property will be considered abandoned. An interview conducted with the assistant superintendent confirmed after thirty days, a letter is sent to the parent/guardian advising of unclaimed property. The center did not have any unclaimed property over thirty days since the last annual compliance review.

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

The center has a written policy and procedures to ensure there are provisions in place to ensure prescribed medication, along with medical instructions, accompanies detained youth upon release. The center documents the release of medication on the Department's Medication Receipt for youth being release with medication. The Detention Release Wizard indicates all applicable medication was provided to the parent/guardian when the youth was released. Three applicable closed youth case management records were reviewed for youth who were released from the center with medication. Each record documented receipt of medications signed by the person receiving the youth.

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

The center has a written policy and procedures to ensure detention reviews are conducted on a weekly basis to ensure proper management of youth placed in secure detention and home detention and appropriate sharing of information. The superintendent appoints an appropriate staff person to coordinate detention reviews. An observation of the center's weekly detention review confirmed the center conducts a weekly secure detention/home detention review consisting of the detention review liaison, probation staff, medical staff, mental health staff, education staff, and a commitment manager. All staff attending the meeting are accounted for by signing the sign-in sheet weekly. The team reviews, alerts, court hearings, placement dates, physical or behavioral issues and all other pertinent information relating to the youth. Reviewed detention review documentation for the past six months validated the center's practice. The superintendent stated the detention review specialist maintains and conducts a weekly review meeting with stakeholders including mental health, probation, medical, commitment, the Department of Children and Families, and the superintendent, or designee in person or by

phone. Release dates, medical needs, commitment dates, potential release issues and mental health issues are discussed.

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

The center has a written policy and procedures providing youth the opportunity to participate in constructive activities. The superintendent has developed a daily schedule, including weekdays, weekends, and holidays, incorporating both structured and free time. The schedule includes time frames of all activities provided to youth weekly, such as personal hygiene, meal time, visitation, education, recreation, life and social skills, and indoor activities. A tour of the center confirmed the schedule is posted on the walls of each living module, dining room, and other areas of the center. The program provides groups addressing gender-specific programming and restorative justice programing. Five staff and five youth were interviewed and each indicated the center's daily schedule is followed. Five interviewed staff confirmed the facilitation of gender-specific groups.

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

The center has a written policy and procedures which outlines daily activities schedules. A review of the center's daily schedule logbook, observations during the annual compliance review, and interviews with staff confirmed adherence to the daily schedule. Informal interviews with the assistant superintendent confirmed the schedule is followed by all staff and youth, unless circumstances arise which causes serious disruption (safety and/or security issues) or to adjust for inclement weather. Five youth were interviewed and indicted the center has a daily schedule which is followed daily.

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

The center has a policy and procedures in place regarding educational access. The center provides daily education for all eligible youth through the Lee County Public School system. All youth are required to participate in educational and career-related programs 250 days a year, for 300 minutes a day, according to the lead teacher. Educational instruction is scheduled Monday through Friday in the on-site portable classrooms. Youth in the educational program have the opportunity to earn course credit for completion of the education and training experience. A review of the program's daily schedule and logbook supported minimal

interference of educational instruction. An interview with the Lee County School Board district personnel supported these findings. Five interviewed youth stated they attend school Monday through Friday without exception.

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

The center has developed and implemented a career education competency development program for all youth in secure detention. The center has defined career education programming which is appropriate based upon the youth's age, assessed educational abilities, goals of the youth, length of stay, and custody characteristics at the center. The center utilizes Type 1 career educational and vocational programming. The program teaches personal accountability and behaviors leading to development of work habits to maintain employment and living standards. Career education programming includes communication interpersonal, decision making and life skills.

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

The center has a written policy and procedures outlining a uniform behavior management system (BMS) offering a predictable set of rewards, privileges, and consequences for rewards. The center utilizes the state-approved BMS in all centers. The behavioral norms and expectations for the youth were observed posted throughout the center and clearly specify appropriate and inappropriate behavior. Documentation of the orientation brochure signed by newly admitted youth, confirms the BMS was discussed. The BMS is a three-tier system ranging from level one to level three. Upon arrival to the center newly admitted youth are placed on level two. Positive behavior displayed by the youth moves the youth up to level three. If the youth continues to display positive behavior, the youth will remain on level three for the remainder of their stay in secure detention; however, compliance/non-compliance with the rules of the center can result to youth moving up or down with levels based upon their behavior. Observation of daily activities and reviewed log book entries during the annual compliance review supported the center's use of the BMS. Five interviewed staff stated the BMS was effective. Each staff also stated they speak with the youth regarding their behavior and all youth are given the opportunity to explain their behavior. In addition, each interviewed staff reported levels and points may be taken as a consequence for negative behavior. Five youth were interviewed, and three youth rated the BMS system as fair. One youth did not feel the BMS was fair because he did not like the consequences and one youth has no opinion of the BMS other than to state he never received any consequences.

2.17 Unauthorized Use of Punishment (Critical)	Satisfactory Compliance

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

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

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

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

The center's behavior management system restricts certain types of penalties on youth who demonstrate negative behavior. The use of group punishment and corporal punishment shall not be used in detention facilities. All allegations of corporal punishment of any youth by detention center staff shall be reported to the Florida Abuse Hotline, pursuant to Chapter 39, Florida Statutes, and the Central Communication Center (CCC). Five interviewed staff and five interviewed youth confirmed consequences for inappropriate behavior do not include loss of meals, snacks, sleep, or school. Interviewed staff indicated they have never seen a co-worker take meals, snacks, clothing, education, or medical care from a youth because they were acting out.

2.18 Grievances	Satisfactory Compliance

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

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

The center has a written policy and procedures to ensure each youth has the right to grieve and ensure all youth are treated fairly, respectfully, without discrimination, and their rights are protected. The center's procedures indicate the grievance does not replace the responsibility of reporting any suspected abuse. All youth admitted into the center are provided a copy of the orientation brochure upon intake, which includes the grievance procedures. Grievance forms were observed on each living module. Six grievances were filed in the last twelve months and each was reviewed. Reviewed grievances found each was forwarded to the on duty-supervisor within two hours, through the Facility Management System (FMS), and the youth was informed of the findings by the end of the shift. When applicable, the superintendent/assistant superintendent reviews the grievance through FMS within seventy-two hours. Staff are encouraged to have more open communication with the youth to ensure they have a better understanding of youth concerns. Five interviewed staff reported never seeing a co-worker

taking education, snacks, clothing, or medical care from a youth because they were acting out. In an interview, the superintendent stated when a youth has a grievence, the direct care staff should allow the youth to complete the informal, Phase I of the grievence form. The staff should then try to resolve the grievence. If the youth is still not satisfied, the girevance will be addressed by administrative staff.

2.19 Trauma-Informed Care	Satisfactory Compliance

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

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

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

The center has a policy and procedures in place for trauma-informed care. A tour of the center during the annual compliance review confirmed the center has a soft room and other areas throughout the program painted with soothing colors. The center also created a gardening program to help aid youth who have experienced trauma. In addition, staff receiving training in trauma informed care are part of their pre-service and in-service curriculum. The superintendent stated the center has lowered both, incidents and length of confinement. They have painted the facility with brighter colors, and adding superhero art to the walls. In addition, they have improved the behavior management system with greater oversight and better rewards and have continued to train staff in the benefits of understanding and promoting trauma-informed care.

Standard 3: Mental Health and Substance Abuse Services

Overview

The Southwest Regional Juvenile Detention Center maintains a contract with Maxim Healthcare Services, Inc. to provide mental health and substance abuse services. Maxim Healthcare Services, Inc. subcontracts with Camelot Community Care, Inc., to provide comprehensive mental health and substance abuse services including psychiatric services. The center has a full-time licensed clinical social worker, who serves as the designated mental health clinician authority (DMHCA), through Camelot Community Care, Inc. and provides on-call services twenty-four hours a day, seven days a week, for emergency consultation. The center also has a licensed mental health counselor (LMHC), and a regional clinical director who provides oversite and supervision to the center's DMHCA. In addition, the center has one master's-level therapist who is a certified addiction professional (CAP). Clinical services are provided seven days a week. The clinical staff provide comprehensive mental health and substance abuse services including clinical screening of youth for mental health and substance abuse needs, comprehensive and diagnostic assessment, treatment planning, psychiatric evaluations, psychotropic medication management, and individual, group, and family therapy. Specialized services include suicide prevention, suicide risk assessment, and crisis intervention. Clinical staff complete a clinical discharge summary identifying follow-up care for each youth receiving treatment services while in the detention center. The center conducts mini-treatment team meetings, on a bi-weekly basis, for applicable youth receiving services. The center utilizes Salus Care, Colonial Campus in Fort Myers, Florida, for Baker Act crisis stabilization and for Marchman Act.

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

The center maintains a written policy and procedures to ensure there is a single licensed mental health professional identified as the designated mental health clinician authority (DMHCA), who is responsible for the coordination and implementation of mental health and substance abuse services. The center maintains a contract with Maxim Healthcare Services, Inc. to provide mental health and substance abuse services. Maxim Healthcare Services, Inc. subcontracts with Camelot Community Care, Inc., to provide comprehensive mental health and substance abuse services. Psychiatric services are provided through Camelot Community Care, Inc. The DMHCA is responsible for the coordination and implementation of mental health and substance abuse services in accordance with Florida Administrative Code (F.A.C) 63N-1. Reviewed documentation supported the center's DMHCA is a full-time licensed clinical social worker (LCSW). The DMHCA maintains a clear and active license to practice in the State of Florida, as verified on the Florida Department of Health website with an expiration date of March 31, 2019. The DMHCA is on-site forty hours a week, Monday through Friday which was verified by sign-in and out logs. An interview with the DMHCA indicated she is available twenty-four hours a day and available for crisis intervention. The DMHCA provides weekly direct clinical supervision to one part-time master's-level certified addiction professional. The DMHCA also meets weekly with the psychiatrist to discuss each youth who is receiving services.

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

The center maintains a written policy and procedures to ensure mental health services and substance abuse services are provided by individuals with appropriate qualifications. The center's contract with Maxim Healthcare Services, Inc. provides for a regional mental health and substance abuse clinical director for the south region, one full-time designated mental health clinician authority (DMHCA), and a psychiatrist for approximately two hours each week. Maxim Heath Care Services, Inc. subcontracts with Camelot Community Care, Inc. for the provision of all mental health and substance abuse services and Camelot Community Care, Inc. subcontracts with a psychiatrist who is an Osteopathic Physician. Reviewed practice found the center maintains a full-time DMHCA and a licensed psychiatrist. The DMHCA is employed with Camelot Community Care, Inc., and the psychiatrist is subcontracted with Camelot Community Care, Inc. The center also maintains a licensed mental health counselor. Reviewed licenses for each licensed professional found each maintained a clear and active license to practice in the State of Florida as verified on the Florida Department of Health website.

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

The center maintains a written policy and procedures to ensure mental health services and substance abuse services are provided by individuals with appropriate qualifications. Clinical supervisors must assure clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience. Reviewed documentation validated there is one part-time certified addictions professional. Reviewed documentation found the non-licensed therapist is qualified to provide services based on her education, training, and experience. The non-licensed therapist holds a master's-level degree in education and human services. The non-licensed therapist completed twenty hours of training and supervised experience including five Assessments of Suicide Risk (ASR) and/or crisis assessments conducted on-site in the physical presence of the licensed clinical social worker (LCSW). The designated mental health clinician authority (DMHCA) provides weekly face-to-face clinical supervision, which includes a summary of directions, instructions, and recommendations. Weekly supervision is documented on the Department's Licensed Mental Health Professionals and Licensed/Certified Substance Professionals Direct Supervision Log (MHSA 019).

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

The center maintains a written policy and procedures ensuring the mental health and substance abuse needs of the youth are identified through a comprehensive screening process and ensuring referrals are made when youth are identified with mental health and/or substance abuse needs or are identified with a possible risk of suicide. The procedures included a standardized screening process, which included a review of the Positive Achievement Change Tool (PACT) Mental Health and Substance Abuse Report and Referral Form, a review of the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2), and Suicide Risk Screening Instrument (SRSI). A review of five youth mental health and substance abuse records validated upon a youth's intake to the juvenile assessment center (JAC), the juvenile probation officer (JPO) administered the PACT, MAYSI-2, and the SRSI. Additionally, the procedures outlined a standardized process for the referral of youth identified as in-need of an Assessment of Suicide Risk (ASR) or further mental health and/or substance abuse evaluation to the Camelot Community Care, Inc. clinician. All five reviewed records documented the SRSI detention section was completed by a juvenile justice detention officer (JJDO) in the Department's Juvenile Justice Information System (JJIS). The SRSI nursing and/or mental health section was completed by the mental health clinician in all five reviewed records. Each of the five youth were identified with a need for further assessment based on the admission assessments and each youth was identified with an elevated suicide risk factor. Reviewed documentation validated each applicable youth was placed on precautionary observation (PO) and a mental health referral was completed for each youth. Documentation found each of the five youth had an ASR completed by the licensed or non-licensed trained clinical staff.

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

The center maintains a written policy and procedures ensuring youth who are identified through preliminary screening, during intake and admission, as having mental health and/or substance abuse issues or needs are referred for a further in-depth mental health and/or substance abuse evaluation. A review of five youth mental health and substance abuse records found one youth was referred for a mental health and substance abuse evaluation. Two additional applicable records were requested and reviewed. The juvenile probation officer (JPO) will request for a comprehensive evaluation to be conducted by an outside agency for youth who are being considered for commitment. Reviewed practice validated each of the three reviewed records had completed evaluations by outside agencies prior to admission to the center. In addition, each of the three applicable youth had completed new or updated Biopsychosocial Assessments completed within thirty days of referral. The center does not have a detention provider to conduct comprehensive assessments.

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

The center maintains a written policy and procedures ensuring mental health and substance abuse treatment planning focuses on providing mental health treatment and/or substance abuse treatment, which will reduce or alleviate the youth's symptoms of mental disorder or substance abuse impairment and enable the youth to function adequately. Each youth determined to need mental health treatment, including treatment with psychotropic medications or substance abuse treatment while in the center, must be assigned to a mini-treatment team. The mini-treatment team meets bi-weekly to discuss each youth receiving services. A review of five youth mental health and substance abuse records indicated one youth required treatment services. Two additional applicable youth records were requested and reviewed. Reviewed mini-treatment team documentation supported each applicable youth was assigned to a mini-treatment team consisting of the designated mental health clinician authority (DMHCA), the center's administration, mental health and substance abuse staff, nursing department staff, and juvenile detention officer staff. Observation of a mini-treatment team meeting during the annual compliance review and an interview with the DMHCA validated the center's practice. Reviewed records found each youth had a copy of an Authorization for Evaluation and Treatment (AET) form. In addition, each applicable reviewed record contained a signed youth consent for substance abuse treatment (MHSA 012) and youth consent for release of substance abuse treatment records (MHSA 013). Two of the reviewed treatment plans outlined each youth will receive individual counseling once every two weeks, participate in psychoeducational groups monthly, and attend their mini-treatment team. One treatment plan documented the youth will see the psychiatrist every two weeks for medication management and participate in individual sessions every two weeks. Reviewed documentation validated the two-applicable youth participated in individual and group counseling. Reviewed sign-in sheets supported group therapy was limited to ten or fewer youth with mental health diagnoses for mental health groups and fifteen or fewer youth with substance abuse diagnoses for substance abuse treatment groups. Five youth were interviewed and two were receiving mental health and substance abuse services. Both youth reported the services were 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 facility. *All youth who receive mental health and/or substance abuse treatment while in a detention facility shall have a discharge summary completed documenting the focus and course of the youth's treatment and recommendations for mental health and/or substance abuse services upon youth's release from the facility.*	

The center maintains a written policy and procedures ensuring mental health and substance abuse treatment planning focuses on providing mental health treatment and/or substance abuse treatment which will reduce or alleviate the youth's symptoms of mental disorder or substance abuse impairment and enable the youth to function adequately. All youth receiving mental health and substance abuse treatment 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 the youth's release. A review of five youth mental health and substance abuse records found one youth was applicable for requiring an initial treatment plan completed within seven days of initiation of treatment. Two additional applicable youth records were requested and reviewed. Two of the three reviewed plans were completed within the required seven-day time frame and included the reason for referral for treatment, the initial Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) diagnosis, initial treatment methods, and goals. One youth did not have an initial treatment pan but did have an individual treatment plan which was completed eight days after the psychiatric interview. It is the center's practice not to complete an initial treatment plan for committed youth, but rather complete an individual treatment plan. Each youth was applicable for psychiatric services and/or psychotropic medication and frequency of monitoring. The reviewed plans were signed by the youth and mini-treatment team members to include the licensed clinician, mental health staff, center administration, and other applicable treatment team members. Attempts to contact the parent/guardian to provide verbal consent was documented on each reviewed plan. A review of five youth mental health and substance abuse records indicated one youth was applicable for an individual treatment plan. Two additional youth records were requested and reviewed. Each reviewed plan supported they were developed by the thirty-first day of the youth's admission and were signed by the licensed mental health clinician within the ten-day required time frame. Each was signed the same day the plan was developed. Each reviewed individual plan identified the youth's DSM-5 diagnosis, symptoms which are treatment focused, treatment goals, strengths, and abilities. All three reviewed plans were applicable for psychiatric services and/or psychotropic medication monitoring. Each reviewed individual treatment plan required one thirty-day treatment plan review. Documentation found reviews were completed and signed by the clinical staff, youth, and licensed mental health clinician for two of the three youth. One reviewed youth record contained a discharge summary. The mental health and substance abuse discharge summary was completed on the Department's Mental Health and Substance Abuse (MHSA) Form 011. The discharge summary was signed by the youth, clinical staff, licensed mental health clinician, treatment team members, and parent/guardian, when applicable. Reviewed documentation supported a copy of the discharge summary was sent to the assigned juvenile probation officer (JPO) by email. The center is not required to keep medical records for youth who have left the center; therefore, there were no other completed discharge summaries available for review. The center conducts mini-treatment team meetings

bi-weekly for applicable youth receiving services. A mini-treatment team was observed during the annual compliance review which confirmed the center's participants and practice.

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

The center maintains a written policy and procedures ensuring psychiatric services are provided to youth in need to include psychiatric evaluation, consultation, medication management, and medical supportive counseling. Psychiatric services are provided to youth in need of services, as indicated by symptoms of mental disorder or substance-related disorder, or to youth who are being treated with psychotropic medication subsequent to their admission to the center. Scheduling of the psychiatrist will be coordinated by Camelot Community Care, Inc. and the center's superintendent for services to meet contractual and Florida Administrative Code (F.A.C.) 63N requirements for psychiatric services. Reviewed sign-in and out logs confirmed the psychiatrist was on-site providing services three hours a week, pursuant to the contract. A review of five youth mental health and substance abuse records indicated there was one applicable youth who was admitted to the center on prescribed psychotropic medications. Two additional reviewed mental health records indicated each youth was admitted to the center prescribed a psychotropic medication. Each youth was referred for an initial psychiatric diagnostic interview. The initial psychiatric interview was conducted within fourteen days of each youth's admission and included all required elements inclusive of the reason for the referral, history, mental status examination, Diagnostic and Statistical Manual of Mental Disorders Fifth Edition (DSM-5) diagnosis, treatment recommendations, prescribed medication with the explanation for the need, and frequency of medication monitoring. There were no youth applicable for being prescribed medication subsequent to admission. Each of the three youth on psychotropic medications received an in-depth psychiatric evaluation within thirty days of intake or the referral utilizing the Department's Clinical Psychotropic Progress Note (CPPN). Reviewed practice reflected the psychiatrist provided on-going medication management and all CPPNs were completed in full. There were no applicable youth requiring Tardive Dyskinesia monthly monitoring. Reviewed documentation validated consent for psychotropic medication was obtained, as required. Each reviewed youth record contained a copy of the signed Authority for Evaluation and Treatment.

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

The center maintains a written policy and procedures ensuring a suicide prevention plan is in place to safely screen, refer, assess, monitor, and protect youth with elevated risk of suicide in the least restrictive means possible. The plan was revised and approved by the superintendent and designated mental health clinician authority (DMHCA) on July 23, 2018. The plan included the identification and assessment of at-risk youth for suicide, suicide risk alert, levels of supervision, suicide precautions, referrals, notification and communication, immediate staff response, use of extra precautions, review process, and emergency contact telephone

numbers. The plan is maintained in the mental health office and training room and accessible to all staff.

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

The center maintains a written policy and procedures ensuring a suicide prevention plan is in place to safely screen, refer, assess, monitor, and protect youth with elevated risks of suicide in the least restrictive means possible. A review of five applicable youth mental health and substance abuse records indicated each youth was placed on precautionary observation (PO) resulting from being identified with an elevated risk of suicide. Reviewed documentation found all five applicable youth records documented a suicide alert was placed in the Department's Juvenile Justice Information System (JJIS). Each of the five records documented the youth were placed on standard supervision after the completion of the Assessment of Suicide Risk (ASR). Each of the five completed mental health/substance abuse referral summary contained documentation requesting an ASR be completed for each youth. The ASR was completed within twenty-four hours for all applicable youth. Three ASRs were completed by the licensed mental health counselor (LMHC) or the licensed clinical social worker (LCSW) and two were completed by a master's-level non-licensed therapist. Both ASRs completed by the non-licensed therapist were reviewed by the LMHC or the LCSW. Reviewed training records for the non-licensed mental health therapists reflected she received the required suicide prevention training to complete the ASR. The non-licensed therapist completed twenty hours of training and supervised experience including five Assessments of Suicide Risk (ASR), and/or crisis assessments, conducted on-site in the physical presence of the LCSW. The training record documented the completion date of August 12, 2016. A review of the center's logbooks clearly documented the beginning and ending times youth were placed on PO. There was documentation to reflect administrative and/or supervisory staff provided instructions related to the suicide risk assessment findings and suicide precaution decisions during the shift briefings. The five youth who were placed on PO were interviewed and four stated they were always in the presence of staff. One youth refused to answer. Five interviewed staff were able to articulate the center's procedure when a youth is identified with an elevated suicide risk. Each staff stated they 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.

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

The center maintains a written policy and procedures ensuring the staff assigned to monitor each youth on suicide precautions must maintain one-to-one supervision or constant supervision and document their observations of the youth's behavior on the Department's Suicide Precautions Observation Log. A review of five applicable youth placed on precautionary observation (PO) documented the Suicide Precautions Observation Logs were maintained for each youth. Each completed log documented the safe housing areas, and each documented the observations in real time, at required intervals. Reviewed logs supported the mental health therapist and shift supervisor(s) reviewed and signed, as required.

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

The center maintains a written policy and procedures ensuring all staff will receive at least six hours of suicide prevention and implementation of suicide precautions training annually. The mental health clinical staff will assist in training staff on suicide prevention, including verbal and behavioral cues which indicate a suicide risk, throughout the year. All staff who work with youth must be trained in suicide precautions and emergency response procedures and participate in mock suicide drills quarterly, on each of the three shifts. Five reviewed staff training records found each received the required four hours of instructor-led and two hours of computer-based training of suicide prevention and implementation of suicide precautions training, in the Department's Learning Management System (SkillPro). The center conducts mock suicide drills on each shift, at least quarterly. Reviewed mock suicide drills from October of 2017 through July of 2018, indicated drills were conducted at least quarterly on all three shifts. Observations during the facility tour validated the location and contents of the center's four suicide kits included the knife-for-life, wire cutters, and needle nose pliers. The center maintains one additional suicide response kit in the training room which is used for training purposes, only.

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

The center maintains a written policy and procedures ensuring the center responds to youth in crisis in the least restrictive means possible to protect the safety of the youth and others while maintaining control and safety of the center. The center maintains a crisis intervention plan which was revised and approved by the superintendent and designated mental health clinician authority (DMHCA) on July 23, 2018. The plan detailed crisis intervention procedures inclusive

of verbal de-escalation and Protective Action Response as set forth in Florida Administrative Code (F.A.C.) 63H-1, notification and alert system, referrals including self-referral, crisis assessment and follow-up mental health status examination, communication, supervision, mental health supportive services, and documentation and review. The plan is maintained in the center's mental health office and training room and accessible to all staff.

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

The center maintains a written emergency care plan outlining mental health and substance abuse emergency procedures and ensure youth who are believed to be an imminent danger to themselves or others, due to mental illness or substance abuse impairment, receive emergency mental health or substance abuse services. The plan was revised and approved by the superintendent and designated mental health clinician authority (DMHCA) on July 23, 2018. The plan detailed emergency procedures inclusive of immediate staff response, notification and communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment under Chapter 394 Florida Statute (Baker Act), transportation for emergency mental health evaluation and treatment under Chapter 397 Florida Statute (Marchman Act), return from emergency mental health or substance abuse services, documentation, training and mock drills, and review. The center utilizes Salus Care, Colonial Campus in Fort Myers, Florida, for Baker Act crisis stabilization and for Marchman Act. The plan is maintained in the center's mental health office and training room and accessible to all staff.

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

The center maintains a written policy and procedures ensuring the detention center responds to youth in crisis in the least restrictive means possible to protect the safety of the youth and others while maintaining control and safety of the center. An interview was conducted with the designated mental health authority clinician authority (DMHCA) who confirmed the center had two applicable youth requiring a crisis assessment since the last annual compliance review. A review of the two completed crisis assessments found each were completed by the DMHCA. Each crisis assessment was completed on the Department's Mental Health and Substance Abuse (MHSA) Form 023 and each applicable youth remained on alert until a follow-up Mental Status Examination was conducted. The Department's Juvenile Justice Information System

(JJIS) was updated with the applicable alert. The completed crisis assessments were reviewed and electronically signed by the superintendent or designee.

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

The center maintains a written policy and procedures ensuring staff must immediately respond to youth presenting an imminent danger to self or others, due to mental illness or substance abuse impairment, to protect the youth and others from harm. An interview conducted with the designated mental health authority clinician authority (DMHCA) indicated the center had one applicable youth requiring Baker Act procedures since the last annual compliance review. The reviewed Certificate of Professional Initiating Involuntary Examination indicated the DMHCA completed the forms and proceeded to send the youth to Salus Care, Colonial Campus in Fort Myers, Florida. The youth's parent/guardian was notified as required. The youth was maintained on precautionary observation (PO) constant supervision until transported to the crisis stabilization unit and upon return to the center until the Assessment of Suicide Risk was completed. A mental status examination was also completed. The Department's Juvenile Justice Information System (JJIS) was updated, as required, to include the initiation and discontinuation of a suicide alert. The center had no applicable Marchman Act procedures since the last annual compliance review.

Standard 4: Health Services

Overview

Southwest Florida Juvenile Detention Center is a fifty bed, hardware secure facility serving youth. Youth are supervised and are provided comprehensive health services to include medical, mental health, substance abuse, and psychiatric services. The center's respective policy and procedures addressing each service comply with requirements specified by the Centers for Disease Control and Prevention (CDC), the Department of Labor and Occupational Safety and Health Administration (OSHA), and the Department. Staff participate in pre-service and in-service training to ensure their knowledge of current policy and procedures, youth specific needs and position specific requirements. Services are contracted through Maxim Healthcare Services, Inc., and afford a designated health authority (DHA) to provide on-site services two hours each week. Additional staff include an advanced registered nurse practitioner (ARNP) to provide on-site services six hours a week, a full-time registered nurse (RN), a full-time licensed practical nurse (LPN), a weekend licensed practical nurse (LPN), and a full-time medical records clerk. On-site nursing coverage is available twelve hours each day Monday through Friday and eight hours each day on weekends. Sick call is provided from 9:00 a.m. to 10:00 a.m. and 4:00 p.m. to 5:00 p.m., daily, or as needed by a licensed healthcare professional. Non-healthcare staff trained by the RN may assist youth with self-administration of oral prescription medication or over-the-counter medication only when licensed nurses are not available on-site. The center's psychiatrist provides comprehensive mental health services on-site three hours each week. Diamond Pharmacy Services is utilized for the procurement of prescribed medication. As needed, the local health department provides human immunodeficiency (HIV) testing as well as sexually transmitted infectious disease (STIs) testing for youth. On-site, the LPN is certified to conduct HIV testing and counseling.

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

The Department has a contract agreement with Maxim Healthcare Services, Inc., to provide comprehensive on-site medical services to youth in the custody. The center currently has a licensed osteopathic physician (DO) who holds an unrestricted license and meets all requirements for independent and unsupervised practice in the State of Florida as verified on the Florida Department of Health website. The physician serves as the designated health authority (DHA) for the center and is responsible for providing clinical healthcare services. Reviewed documentation of the medical license confirms the DHA is licensed in the State of Florida as verified on the Florida Department of Health website, with an expiration of March 31, 2020. The center also has a designated advanced registered nurse practitioner (ARNP). The ARNP is contracted to be on-site one day a week, for six hours. A review of the medical and mental health sign-in and out logbook in consort with an informal interview with the ARNP validated the ARNP was on-site during the months of February, March, April, May, June, July, and August 2018 for a minimum of six hours each week. Reviewed documentation of the medical license confirms the ARNP is licensed in the State of Florida as verified on the Florida Department of Health website, with an expiration of April 30, 2019. The ARNP has a Collaborative Practice Protocol (CPP) in place indicating the physician serving as the facility designated health authority (DHA). During vacation or scheduled absences, coverage is

provided by another physician designated by Maxim Healthcare Services, Inc. The DHA is responsible for communication with the registered nursing staff and administration regarding youth medical needs and is available for consultation twenty-four hours per day, seven days a week. A review of the medical and mental health sign-in and out logbook validated the DHA was on-site in the months of February, March, April, May, June, July, and August 2018 for a minimum of two hours each week. An interview with the DHA confirmed his role at the center.
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4.02 Facility Operating Procedures [Contract Provider]	Satisfactory Compliance
There shall be Facility Operating Procedures (FOP) for all health-related procedures and protocols utilized at the facility.	

The center maintains written policy and procedures for all health-related procedures and protocols specific to the detention center. The superintendent and designated health authority (DHA) signed each health-related facility operating procedure revised on July 5, 2018 to confirm their review and approval. Reviewed documentation supported the center also maintained nursing protocols, which were reviewed and updated by the DHA on July 27, 2018. All healthcare staff signed the nursing protocols acknowledging changes/updates on July 30, 2018, August 2, 2018, and August 4, 2018. Healthcare staff signed a cover page to indicate their review of the facility operating procedures (FOPs) on August 2, 2018, and August 4, 2018. The psychiatrist reviews and signed FOPs which are psychiatric-related to include psychotropic medication procedures.

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

The center maintains a written policy and procedures regarding the authorization of treatment for all youth. A review of five individual healthcare records (IHCR) found each youth had a completed Authority for Evaluation and Treatment (AET) form filed in their record. Each reviewed AET had a parent/guardian signature along with a witness signature. A review of the AETs found one was an original signed AET and four copies stamped with the word “COPY” stamped in red. There were no applicable youth who were under the care of the Department of Children and Families (DCF).

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

The center maintains a written policy and procedures to inform the parent/guardian of significant changes in the youth’s condition and obtain consent when new medications and treatments are prescribed. The center’s practice is to notify the parent/guardian by mailing the Department’s Parental Notification of Health-Related Care: General (Form HS 020) and Parental Notification of Health-Related Care: Medication Management (Form HS 021). The center also obtains verbal consent for new medications, over-the- counter (OTCs) medication not covered by the Authority for Evaluation and Treatment (AET), and vaccinations from the parent/guardian and document the consent in the chronological progress notes in the youth’s individual healthcare record (IHCR). A staff is present to confirm and witness telephone contacts and attempts. Five

youth IHCRs were reviewed and were not applicable for changes in their health status. Each youth remained on the same medication regimen (dosage and type) in when the youth was admitted. All OTCs were covered by the AET, and confirmed during an informal interview with the registered nurse (RN). The center is not required to maintain youth medical records after they have been released and there were no youth at the center during the annual compliance review applicable for new or changes in medication.

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

The center maintains a written policy and procedures to inform the parent/guardian and obtain consent for the prescription of new psychotropic medications, discontinuances of medications or psychotropic medication adjustments. The center's practice is to is obtained prior consent before the initiation of new psychotropic medications and/or changes in psychotropic medication. The center also notifies the parent/guardian by mailing page three of the Clinical Psychotropic Progress Note (CPPN). Five youth individual healthcare records were reviewed and were not applicable. Three additional healthcare records were requested for review. Each youth remained on the same medication regimen (dosage and type) in when the youth was admitted; therefore, the CPPN was not required to be mailed to the parent/guardian. There were no applicable youth under the supervision of the Department of Children and Families (DCF) during the annual compliance review.

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

The center has a written policy and procedures to obtain each youth's immunization history, status, and verify them to meet State and Department requirements. Medical staff are required to obtain the Florida Certification of Immunization and the immunization history through the Florida Shots website for the designated health authority and/or advanced registered nurse practitioner to sign. A review of five youth healthcare records (IHCR) found each included a copy of the youth's immunization information from Florida Shots and/or the Department of Health (DOH). There were no applicable youth claiming religious exemption from immunization.

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

The center has a written policy and procedures to ensure youth are screened upon admission and readmission for healthcare concerns which may require a referral for further assessments by healthcare staff. Five youth individual healthcare records (IHCR) were reviewed for youth in relation to screening upon admission for healthcare concerns. Five reviewed records contained a Medical and Mental Health Screening Form completed, on the date of admission, by a juvenile

justice detention officer (JJDO). Five screenings were completed by a direct care staff and were reviewed by a licensed practical nurse (LPN) or higher, within twenty-four hours, typically on the date of admission. Each healthcare admission screening information was entered into the Department's Juvenile Justice Information System (JJIS) Admission Wizard. An informal interview with the center's superintendent verified the center's process.

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

The center has a written policy and procedures to alert staff of medical issues which may affect the security and safety of the youth in the center. A review of the center's internal alert system Facility Management System (FMS) confirmed the nursing staff updates the system daily. Five youth healthcare records were reviewed for medical alerts. Alerts for each youth with medical conditions were entered in the Department's Juvenile Justice Information System (JJIS), as required. The youth were identified with one or more of the following; allergies, or taking a medication with significant side effects, pregnancy, chronic conditions, and/or on psychotropic medication. Five staff interviews indicated each is informed of a youth's medical alerts through shift briefing discussions. Four staff indicated they are informed of a youth's medical alerts through the alert form. The superintendent reported during an informal interview all youth are screened during intake for medical conditions, allergy concerns, or special diets and are placed on the alert list. A licensed medical staff will then verify the information to ensure its accuracy.

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

The center has a written policy and procedures to ensure a Suicide Risk Screening Instrument (SRSI) is completed for each youth within twenty-four hours of admission and filed in the youth's individual healthcare record (IHCR). A review of five youth healthcare records reflected the Department's Suicide Risk Screening Instrument (SRSI) was reviewed by mental health staff; therefore, this indicator rates as non-applicable.

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

The center maintains a written policy and procedures to ensure each youth admitted to the center receives a healthcare orientation within twenty-four hours of admission. A review of five youth individual healthcare records (IHCR) documented each youth received a general healthcare orientation within twenty-four hours of admission. Each youth IHCR contained a medical services access orientation form, verifying each youth received a healthcare orientation covering the required topics, as outlined on the Health Education form (HS 013). Each healthcare orientation was signed and dated by the youth and medical staff. The orientation form included all required elements outlined in the Department's Rule 63M-2.0046.

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

The center has a written policy and procedures to notify the designated health authority (DHA) of all youth admitted into the program identified with chronic health conditions or youth in need of emergency care. Notification to the DHA is required within twelve hours of the youth's admission. Five youth individual healthcare records (IHCR) were reviewed. Each youth healthcare record included documentation the DHA was notified of the youth's medical concern or chronic health condition beyond the twelve-hour requirement of each youth's admission. One youth was admitted on 6/8/2018, and the DHA was notified on 6/11/2018. Another youth was admitted on 6/19/2018, and there was no documentation to confirm the DHA was notified. One youth was admitted on 6/16/2018, and the DHA was notified 6/18/2018. Another youth was admitted on 7/24/2018, and the DHA was notified 8/2/2018. One was admitted on 7/19/2018, and the DHA was notified 8/2/2018. Each youth was documented on the center's chronic conditions log identifying the date and time, youth name, medical condition, and DHA notification.

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

The center has a written policy and procedures which require a healthcare admission rescreening be completed each time the physical custody of the youth changes and the youth is subsequently returned or readmitted to the center. This screening is performed utilizing the Medical and Mental Health Admission Screening form in the Department's Juvenile Justice Information System (JJIS) Admission Wizard. Five youth individual healthcare records were reviewed and none were applicable for healthcare rescreening. According to nursing staff, the center has not had any applicable youth where the physical custody changed, and a new healthcare admission was required since the last annual compliance review.

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

The center maintains a written policy and procedures ensuring the Health-Related History (HRH) is completed by nursing staff, no later than seven calendar days following the date of admission for each youth. A review of five youth individual healthcare records (IHCR) documented each youth had a HRH form completed within seven days of admission. One of the five records HRH forms were new, and one HRH forms was updated. All five HRH documents were completed by a licensed nurse prior to the completion of the Comprehensive Physical Assessment (CPA).

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

The center maintains a written policy and procedures regarding the completion of the Comprehensive Physical Assessment (CPA) for each youth admitted into the center. A review of five youth individual healthcare records (IHCR) found each youth had a current CPA. A review of each IHCR found all had a Health-Related History (HRH) form completed within seven days of admission. Four of five youth's CPA was completed within seven days of admission. One youth's CPA was completed seventeen days late. Reviewed documentation confirmed each HRH form was completed by a licensed nurse prior to the completion of the CPA. Five applicable IHCRs with a CPA were reviewed, initialed, and dated by the designated health authority (DHA) or the advance registered nurse practitioner (ARNP). All five reviewed CPAs documented the medical grade respectively and were completed in full. A review of the Department's Problem List indicated it was updated for each youth, as required.

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

The center has a written policy and procedures addressing the completion of gender-specific screening. All females who are sexually active and identify their menstrual cycle as more than two weeks late or request testing, will receive a qualitative urine pregnancy screening test with the youth's verbal consent at the time of admission. One of five applicable youth individual healthcare records (IHCR) was reviewed for gender-specific screening. Two additional record were requested and reviewed. Each youth provided verbal consent to receive testing/ examination. All three reviewed IHCRs documented a qualitative urine pregnancy test was conducted. The test results were documented and filed in the youth's individual healthcare records under the laboratory section. Informal interviews with three female youth confirmed they may consent to a gynecological examination.

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

The center maintains a written policy and procedures outlining all youth are required to be screened for tuberculosis (TB). A review of five youth individual healthcare records (IHCR) reflected each youth had a minimum of one verified tuberculosis skin test (TST) documented in each youth's IHCR. Each of IHCRs documented Tier One TB screenings were completed within seventy-two-hours of the youth's admission. The information was documented on each youth's Infectious and Communicable Disease (ICD) form, Admission Wizard, and on the completed Comprehensive Physical Assessment (CPA). None of the reviewed youth required further evaluation or treatment.

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

The center has a written policy and procedures regarding the completion of the sexually transmitted infection (STI) screening. The center shall ensure all sexually active youth admitted into the custody of the Department are clinically screened and evaluated for STIs. The test results are noted on the Department's Infectious and Communicable Disease (ICD) form filed in the youth's individual healthcare record (IHCR). Five IHCRs were reviewed. Reviewed documentation reflected each youth was clinically screened and evaluated for STIs. Two of five youth were referred to the designated health authority (DHA) for further assessment.

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

The center has a written policy and procedures to address human immunodeficiency virus (HIV) counseling, testing, and referrals for treatment. The center routinely offers counseling, testing, and referrals for medical treatment to all youth with a possible risk for (HIV). A certified HIV counselor shall conduct the testing. Five individual healthcare records (IHCR) were reviewed for HIV testing. Each IHCR documented each youth was provided the basic HIV education and offered HIV testing. The youth were given the HIV antibody test consent form to review and sign. Two of the five youth consented for HIV testing. One additional record was reviewed and confirmed the youth consented for HIV testing. HIV results are securely sealed in an envelope marked confidential and filed in each youth's ICHR. The center also maintained a HIV and sexually transmitted infection (STI) testing log. Five interviewed youth indicated they can request a HIV test and counseling.

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

The center maintains written nursing protocols and non-healthcare protocols for the provision of sick call approved by the designated health authority (DHA). A tour of the center reflected hard copies of sick call request forms were available to the youth in each living module. Sick call is conducted from 9:00 a.m. to 10:00 a.m. and 4:00 p.m. to 5:00 p.m., daily, or as needed by a licensed healthcare professional. The center utilizes the Facility Management System (FMS) to enter a sick call request. Sick Call Request forms included the subjective complaint, objective findings, an assessment, and a plan (SOAP) format. Each youth accesses the sick call process by notifying a juvenile justice detention officer (JJDO) of any medical complaints and the JJDO enters the sick call request into the center's FMS, which electronically generates a notification of the submitted sick call request to the nursing staff. The DHA and/or advanced register nurse practitioner (ARNP) provides routine sick call and follow-up care when youth are referred to them by nursing staff. The center had separate written protocols for the provision of sick call by nursing staff and by non-healthcare juvenile justice detention officer supervisors (JJDOS) for times when no licensed nurse is on-site. Five youth individual healthcare records (IHCR) were reviewed. Four applicable youth who submitted a sick call request were seen by nursing staff in

a timely manner and the sick call documentation was filed in each youth's IHCR. None of the reviewed IHCRs included a youth who presented a similar sick call complaints three or more times, in a two-week period. None of the youth complained of any pain with which staff were unfamiliar. Four of five interviewed youth reported they can be seen within one day of submitting a sick call request. One youth reported being seen more than three days later after submitting a sick call request.

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

The center maintains a written policy and procedures ensuring all youth are able to make a sick call request and have their complaints treated through the program's sick call system. A review of five youth individual healthcare records (IHCR) found four applicable youth's IHCR included a sick call index, the corresponding Facility Management System (FMS) generated, sick call list, sick call request form, and sick call referral log. All applicable records documented sick calls were conducted by a registered nurse (RN) in less than twenty-four hours of the request being made. An observation of the sick call process revealed the youth was escorted by a juvenile justice detention officer (JJDO) to be seen by the advanced registered nurse practitioner (ARNP). The examination was one-on-one with the ARNP where vital signs were taken behind a medical barrier. Five interviewed staff reported the doctor and nurse conducts sick calls. Four interviewed youth reported the nurse conducts sick calls. One youth reported the doctor conducts sick calls.

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

The center maintains a written policy and procedures ensuring all youth in the program will be able to access healthcare staff while in restricted housing (confinement, seclusion, room restriction, and/or secure observation). Five youth individual healthcare records (IHCR) were reviewed and were not applicable. Three additional records were requested and reviewed for restricted housing while at the center. A confinement report was generated in the Facility Management System (FMS). Nursing staff made a daily visit and a complete detailed narrative entry was found in the chronological progress notes in the youth's IHCR for each youth who is treated while in restricted housing. Applicable youth on restricted housing received their prescribed medication as ordered and on time.

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

The center maintains a written policy and procedures for the provision of episodic care and first aid which included documentation requirements for episodic care performed by non-healthcare staff. Emergency medical and dental care, including emergency medical services (EMS), is available twenty-four hours a day, seven days a week. A review of five youth individual healthcare records (IHCR) found two youth were applicable for episodic/first aid care. One additional record was requested for review. Each applicable IHCR was reviewed for the provision of episodic care and each contained appropriate documentation of the episodic care

events. Each youth was seen by a license medical staff person. The center maintained an Episodic Care Log to document the provision of episodic care and first aid treatment. A review Episodic Care documentation found standard narrative charting was used. A review of the logs indicated episodic care was administered by the nursing staff. None of the three youth required off-site care. All inspected first aid kits contained all items required by the designated health authority (DHA), and none of the contents were expired. Nursing staff inventory and restock each first aid kit monthly and maintained on a log located in the medical clinic. First aid kits were found located throughout the center and kits are maintained in each of the vehicles used to transport youth.

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

The center has a written policy and procedures for the provision of emergency care. A review of staff training documentation found all non-healthcare and licensed healthcare staff are trained in first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), and EpiPen Auto Injector procedures. All licensed nursing staff maintain current CPR with AED certification. Quarterly mock emergency drills were held with the participation of all the center's staff, on various shifts. A list of emergency numbers was located in master control and accessible to staff. The center maintains two AEDs which were maintained in the secure master control lobby area and the medical office. Observations of nursing staff conducting a test on each AED found the master control AED batteries expire in October 2021 and the pads expire August 2018. The AED located in the medical clinical found the batteries expire in October 2021 and the pads expire in August 2018. The nursing staff reported the pads are on order status at the time of the annual compliance review. Both AEDs were found operational. The AED procedures were located on each AED unit, which also provided automated audible application instructions. Supporting documentation verified the registered nurse checked to ensure each AED was operable and the AED batteries and pads were properly functioning daily. The checks were documented on the AED Battery and Pad Log. Five interviewed staff reported they can call 9-1-1 if it is necessary.

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

The center maintains a written policy and procedures to provide timely referrals and coordination of medical services for youth requiring off-site care. Five youth individual healthcare records (IHCR) were reviewed for off-site care. One of five youth was applicable for off-site medical care. Two additional records were requested for review. The IHCRs contained a summary of off-site care form and discharge instruction documents when applicable. Reviewed documents confirmed the center provides for timely referrals and coordination of off-site healthcare medical services. None of the reviewed IHCRs required notification to the designated health authority (DHA) of an emergency. Reviewed documentation confirmed the youth followed up with the DHA. Informal interviews with staff reflected all off-site care is coordinated by the center's medical staff.

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

The center has a written policy and procedures for the provision of treatment for youth identified as having a chronic medical condition. During the intake process, youth are screened for any medical conditions requiring periodic evaluations or follow-up care. A review of five youth healthcare records (IHCR) found each youth was identified with a chronic medical condition and/or taking prescribed medications. The center maintained a chronic conditions roster to document the youth identified with certain medical conditions. Reviewed documentation also supported the youth were placed on the center's internal alert system. An informal interview with the registered nurse confirmed periodic evaluations were not completed every three months since there were no instances of youth with a chronic condition in the center long enough.

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

The center maintains a written policy and procedures to ensure prescribed medication is accepted only from a licensed pharmacy. The prescription container and label must be original and specific regarding the patient, medication and dosing instructions. A review of five youth individual healthcare records (IHCR) found each youth was prescribed medication subsequent to their admission to the center. Documentation of prescription medication verification was present in each youth individual healthcare record to include contact with the youth's parent/guardian. Orders were obtained from and signed by the designated healthcare authority (DHA).

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

The center maintains a written policy and procedures ensuring all medications prescribed for youth have a current, valid order and are given pursuant to a current prescription or Practitioner Order. A review of five youth healthcare records (IHCR) found each youth was prescribed medication subsequent to their admission to the center. The designated healthcare authority (DHA) orders were documented on the Practitioner Order Form maintained in each youth's IHCR. A review of each youth's Medication Administration Record (MAR) verified medication was initiated and monitored pursuant to the Practitioner Order. A review of practice confirmed over-the-counter (OTC) medication is administered pursuant to approved protocols.

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

The center maintains a written policy and procedures ensuring all medication is stored and secured in designated areas in compliance with federal, state and industry standards. All

prescription medication, over-the-counter (OTC) medication, and topical medication currently in use by youth is stored in the locked medication cart situated in the medical clinic and is inaccessible to youth. Controlled substances are stored in a locked box within the locked medical cart. Additional supplies of medication, sharps, and medical supplies are stored in designated, locked cabinets within the medical clinic. Visual confirmation verified a locked refrigerator is used to store tuberculin skin test (TST) solution. No other medication requiring refrigeration was present during the annual review. Established policy and procedures ensure medication is inaccessible to youth. The center contracts with Diamond Pharmacy Services for the delivery of medication; unused non-controlled medication is returned to the pharmacy for credit and documented on the pharmacy log. The consulting pharmacist and nurse use the RX Pill Destroyer to discard all medication not returned to the pharmacy. Disposal of medication and bio-hazardous waste is performed in accordance with Federal Regulations (CFR) Sections 1307.21 and 1910.2030 and the Florida Department of Environmental Protection. The center maintains a current modified Class II Pharmacy Permit (PH21552) with an expiration date of February 28, 2019. In the absence of licensed healthcare staff, trained juvenile detention officer supervisors (JDOS), assistant detention center superintendents (ADCS) and the detention center superintendent (DCS) supervise the administration of prescribed and over-the-counter (OTC) medication. Review of training records verified eleven staff are currently trained to supervise medication in the absence of licensed healthcare staff. Medication access is restricted to nursing and trained staff. The pharmacy consultant reviews the medical clinic monthly and provides recommendations and training as needed.

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

The center maintains a written policy and procedures ensuring all medication, sharps and pharmaceutical products are inventoried in accordance with Department Rule 63M-2.024, 63M-2.025, and 63M-2.026, Health Services. A review of documentation for the previous six months verified a perpetual daily running inventory of medication utilization for prescription and over-the-counter (OTC) medication. Perpetual and weekly inventory counts were documented for sharps (syringes, needles, scissors, and suture removal kits), opened over-the-counter (OTC) medication, first aid equipment and supplies. A random inventory of three different sharps, three prescribed medications, and three over-the-counter (OTC) medications provided each count was accurate and documented by licensed nursing staff. Nursing staff confirmed the center's practice for shift-to-shift controlled medication counts. No youth were prescribed controlled medication at the time of this review. No records for youth previously prescribed controlled medication were available as applicable youth had transferred to other programs or were released from the center. Nursing interview verified the center's practice to report any discrepancy in inventory immediately to the superintendent. The center reported no medication discrepancies during the annual review period. Medical information is conveyed during daily shift briefings and through the center's established procedures for notification. A copy each current shift report is maintained on top of the medication cart for reference.

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

The center maintains a written policy and procedures ensuring all controlled medication shall be inventoried, stored, and documented according to the Board of Pharmacy and Department requirements outlined in Department Rule 63M-2.024, 63M-2.026 Health Services. Nursing staff verified the center maintains controlled medication in a locked box which is housed within the locked medication cart in the medical clinic. No youth in the center were prescribed controlled medication at the time of the annual compliance review. The center is not required to maintain medical records for youth who have released. An interview with the nurse provided shift-to-shift counts are conducted and documented prior to medical staff initiating medication pass for youth prescribed controlled medication. The number of pills, tablets, or remaining dosages after each administration is documented on the individualized Controlled Medication Inventory Record.

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

The center maintains a written policy and procedures ensuring a Medication Administration Record (MAR) is maintained for each youth who has a current, valid medication order. A review of five youth individual healthcare records (IHCR) found each youth was prescribed medication subsequent to admission. Reviewed documentation supported the center utilizes the standard Department of Juvenile Justice MAR form HSO19 to document medication administration. In accordance with 63M-2, F.A.C., all requisite elements were documented on the MAR to include youth name, Department of Juvenile Justice identification number, date of birth, youth allergies, precautions, medical grade, medical alerts and current photograph of the youth. Medication start and stop dates were clearly denoted in each reviewed IHCR. A review of each IHCR found youth and administering staff initialed the MAR. Licensed nursing staff documented side effect monitoring, weekly. No errors or lapses in medication administration or youth refusal of medication was noted and each order was consistent with the MAR. No youth were prescribed parenteral medication during the time of the annual compliance review.

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

The center maintains a written policy and procedures ensuring medication administration shall occur as scheduled in a comprehensive, accurate, and organized manner in the facility, only by a licensed nurse. Trained, non-healthcare staff assist youth with self-administration of oral prescription medication and over-the-counter (OTC) medication only when licensed nursing staff are not available on-site. A review of the staffing schedule and an interview with the nurse validated nursing staff are on-site Monday through Friday 7:00 a.m. to 8:00 p.m., and from 7:00 a.m. to 3:00 p.m., on Saturday and Sunday. The center's medical clinic consists of one full-time registered nurse (RN), one full-time licensed practical nurse (LPN), and one part-time weekend LPN. The center also utilizes an advanced registered nurse practitioner (ARNP) who provides on-site services one day each week for six hours; the designated health authority (DHA) provides on-site services one day each week for two hours and is available for consultation twenty-four hours a day, seven days a week. The psychiatrist provides on-site services one day a week for three hours.

Observation of medication administration for four youth during the annual compliance review provided licensed nursing staff maintained the medication administration area in a clean and organized manner. The Five Rights of Medication Administration were verified as was the individual youth Medication Administration Record (MAR). A copy of the Five Rights of Medication Administration was affixed to the top of the medication cart. Each youth approached the nursing staff individually and nursing staff ensured medication and diagnostics were administered in a confidential manner. Prior to departing the medical clinic, nursing staff verified youth had ingested their medication. No youth refused medication. At the time of the annual compliance review no youth were prescribed parenteral medication.

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

The center maintains a written policy and procedures ensuring trained, non-healthcare staff may assist youth with self-administration of oral prescription medications or over-the-counter medication, only when licensed nurses are not available on-site. The nurse shall delegate the delivery, supervision, and oversight of youth during self-administration of medications. A review of eleven staff training records confirmed non-healthcare staff were trained by the center's registered nurse (RN) to assist youth with self-administration of oral prescription and over-the-counter medication. Review of training records verified eleven staff are currently trained to supervise medication administration in the absence of licensed nursing staff to include juvenile detention officer supervisors (JDOS), assistant detention center superintendents (ADCS), and the detention center superintendent (DCS). Pursuant to the center's policy and procedure staff assisting youth with medication administration are not required to conduct or supervise alternate activities during this time. Three of five applicable youth interviewed confirmed the nurse administers medication. Two interviewed youth were not prescribed medication. A review of five youth Medication Administration Records (MARs) for youth not interviewed provided youth were administered medication by licensed nursing staff. The nurse interview provided youth are rarely supervised in self-administration of medication by non-licensed staff due to the availability of nursing staff on-site.

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

The center maintains a written policy and procedures ensuring the monitoring of psychotropic medication and youth safety. Five youth individual healthcare records (IHCR) were reviewed to ensure compliance with established policy and procedures for monitoring psychotropic medication. Each of the reviewed IHCRs indicated none of the five youth were prescribed psychotropic medication. Three additional applicable IHCRs were requested and reviewed. Reviewed documentation verified the designated health authority (DHA) was notified upon each youth's admission to the center. Each youth receiving psychotropic medication prior to admission was continued on their respective medication and was seen by the psychiatrist within fourteen days of admission for their initial diagnostic evaluation. Documentation verified the

psychiatrist monitored youth psychotropic medication every thirty days. The center does not have standing, emergency or pro re nata (PRN) orders for psychotropic medications.

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

The center maintains a written policy and procedures ensuring infection control procedures are implemented. Policy and procedures address infection control containment, treatment and reporting requirements in compliance with Occupational Safety and Health Administration (OSHA) federal regulation and the Centers for Disease Control and Prevention (CDC). A review of documentation supported all staff are trained regarding universal precautions, as well as the center's Exposure Control Plan. A comprehensive process for needlestick post-exposure evaluation is documented. Hepatitis B immunizations are offered to staff. An interview with licensed nursing staff and the superintendent verified there were no cases of reportable infectious diseases requiring notification to the local county health department, Centers for Disease Control and Prevention (CDC), and/or the Department's Central Communications Center (CCC).

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

The center maintains a written policy and procedures ensuring all staff and youth receive health education on infection control. A review of five staff training records substantiated staff receive pre-service and in-service infection control training. A review of five youth individual healthcare records (IHCR) verified youth received infection control education within seven days of their admission to include guidelines for hand-washing techniques, universal/precautions, prevention/transmission of communicable diseases, prevention of blood borne pathogens, and guidelines for infection control. A copy of the Health Education Record (HER) form (HS013) was maintained in each reviewed IHCR. All training and education was provided in accordance with the Center for Disease Control and Prevention guidelines.

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

The center maintains a written policy and procedures addressing infection and exposure control to ensure the provision of education and prevention procedures. The policy and procedures provide staff with knowledge of appropriate prevention, containment, treatment and reporting requirements of infectious diseases. The Infection Control Plan and Exposure Control Plan comply with the requirements of Occupational Safety and Health Administration (OSHA) standards (29 CFR 1910) and the requirements of the Department. The Infection Control Plan was last approved by the designated healthcare authority (DHA) on July 5, 2018 and is signed

by the (DHA) and superintendent. The Exposure Control Plan was last approved and signed by the designated healthcare authority (DHA) on August 3, 2018. The center had no incidents involving contagious disease requiring the quarantine or hospitalization of youth or staff during the annual compliance review period.

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

The center maintains a written policy and procedures ensuring appropriate care and treatment of pregnant youth. A review of five youth individual healthcare records (IHCR) provided one youth was applicable. Two additional closed IHCRs were requested for review. Reviewed documentation verified prenatal care was initiated immediately upon determination the youth was pregnant. Prenatal care was provided at the level appropriate for the individual youth. A review of case notes, medication administration record (MAR), and physician's orders for two youth verified the designated healthcare authority (DHA) and advanced registered nurse practitioner (ARNP) provided routine, focused medical oversight of youth pregnancy every thirty days. One youth was not in the center for thirty days; however, received oversight. Documented prenatal orders were inclusive of medication monitoring, prescription of prenatal vitamins, activity monitoring, nutrition monitoring and education, weekly monitoring of weight and vital signs. Pregnant youth were offered unrestricted access to water, additional healthy snacks and were provided an extra mat for sleeping. Licensed nursing staff provided daily monitoring of each youth for any indications of pregnancy complications.

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

The center maintains a written policy and procedures ensuring pregnant youth are provided nutritious foods in sufficient quantities meeting the standards of the minimum daily allowances for pregnant youth. A review of five youth individual healthcare records (IHCR) provided one youth was applicable. Two additional IHCRs were requested for review. Each reviewed IHCR verified youth are provided nutritious foods in sufficient quantities to meet the minimum daily allowances for pregnant youth. Youth were encouraged to eat a well-balanced diet inclusive of fruits and vegetables. Extra snacks and water were provided daily. Youth weight, vital signs, and urine were monitored weekly as well as prenatal vitamins. Each reviewed IHCR provided pregnant youth receive education regarding alcohol and drug use, smoking, nutrition, sexually transmitted diseases, contraception, prenatal care and the birthing process. Additional education provided includes postpartum care, basic child care, child/infant development and parenting skills. Each IHCR documented the provision of healthcare education.

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

The center maintains a policy and procedures ensuring all non-healthcare staff involved in the supervision or treatment of pregnant youth shall receive appropriate education. A review of five staff training records verified the center's registered nurse RN provides all non-healthcare staff involved in the supervision or treatment of pregnant youth education on the monitoring, observation and care of pregnant youth. The curriculum on women's health provides staff with information relating to pregnancy, increases staff awareness of pregnancy related complications and instructs staff how to respond to pregnancy related needs/complications.

Standard 5: Safety and Security

Overview

Southwest Florida Regional Juvenile Detention Center staff are responsible for the custody, and control of youth in their care at this fifty-bed secure facility providing youth supervision twenty-four hours a day, seven days a week. The center has two living modules which are divided by male and female. Staff communication is facilitated by the use of two-way radios for general information including youth movement and counts, as well as calls for assistance in emergency situations. Staff conduct ten-minute checks anytime youth are in their assigned sleeping rooms utilizing the Guard One Plus Wand System. Master control staff conduct, and document youth counts at the beginning and end of each shift as well as at various random times throughout each day. The center's outside recreation area is enclosed by razor wire topped fencing which is lined with no climb mesh. The maintenance staff is responsible for maintaining an inventory of center keys and tools, as well as the storage, inventory, and disposal of chemicals, poisonous, flammable, and toxic materials. Food service staff are responsible for the inventory of kitchen tools including the security of knives.

5.01 Active Supervision of Youth (Critical)	Satisfactory Compliance

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

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

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

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

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

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

The center maintains a written policy and procedures to address youth supervision. During the annual compliance review, daily observations of youth supervision were made which validated the active supervision of youth by detention staff. A review of the center's logbooks for the six months prior to the annual compliance review indicated headcounts were conducted on a consistent basis, at the start and end of each shift, at youth movements, and during sleeping hours. During the annual compliance review, youth were observed during daily activities such as school, meals, breaks, medication pass and line movements with staff actively supervising youth at all times. Staff were positioned in a manner providing them full view of the youth in the area. No inappropriate interactions were observed between staff and youth, and staff were

generally positive while interacting with youth. Five of five interviewed staff indicated there are enough staff to provide for the safety and security of the youth.

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

The center maintains a written policy and procedures addressing ten-minute checks, installation, and review of electronically generated wand system reports. Staff utilize the electronic Guard One Plus wand by placing the wand on the check point sensors located on the outside of each youth's room door. Data from each wand is downloaded daily into the electronic system to ensure no data is lost. Observation of video footage confirmed staff visually observe youth in a manner ensuring the safety and security of each youth. The wand system documents observations electronically in real time for each room checked. Observation of youth living modules and rooms confirmed there were no obstructions over the sleeping room window and areas where direct line of sight is required. Documentation reviewed for ten-minute checks conducted on randomly selected shifts and modules on the dates of July 10, July 13, July 21, July 22, August 2, and August 8, 2018 indicated checks were not consistently completed every ten-minutes as required. Late checks ranged from nine to thirty-two minutes late. During the annual compliance review, five interviewed staff indicated checks are conducted when youth are placed in their room for sleeping or non-punishment reasons. A review of the electronic ten-minute bed check reports and review of corresponding video surveillance footage was conducted on randomly selected one-hour time periods on six dates. The review revealed the checks were not consistently conducted at least every ten-minutes as required while the youth are in their sleeping quarters. Additionally, review of surveillance video footage revealed an instance on August 2, 2018 where both male staff exited the living module leaving no staff on the module for approximately four minutes.

5.03 Census, Counts, and Tracking	Satisfactory Compliance

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

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

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

The center maintains a written policy and procedures to ensure staff know the exact number and location of youth under their supervision at all times. A review of the master control logbook confirmed the census counts of youth are documented at the beginning and at the end of each shift. Emergency situations, inclusive of mock drills, were documented at the end of each shift. Census counts were documented upon any change in center's population and living module counts were documented in their respective logbooks. Counts conducted before and after routine group movements are documented in living module logbooks. The center's master control logbooks were neat and legible.

5.04 Logbook Maintenance	Satisfactory Compliance

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

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

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

The center maintains a written policy and procedures to address the requirements for logbooks to document all events which occur at the center. The center maintained separate, bound, hardcover logbooks in master control. Additionally, the center maintained a bound, hardcover logbook for each living module. Logbooks are also maintained to document the sign-in and sign-out of center visitors and contracted staff, as well as documentation of emergencies and emergency drills. A review of logbooks for the six months preceding the annual compliance review revealed the pages of each bound logbook were numbered. Observation revealed each entry included the date and time with the name of the staff and youth involved, and a brief

description of the event as well as the initials of the staff making the entry. A review of logbooks covering the last six months revealed entries pertaining to the safety and security of the center, including medical, special needs, and mental health alerts were highlighted. Reviewed logbooks reflected all errors are struck through with a single line and dated and initialed by the person correcting the error. Reviewed master control logbooks included emergency situations, incidents, drills, population counts at the beginning and end of each shift, group movements, admissions and releases, as well as the presence of law enforcement. Review of logbooks noted errors were infrequent, but when present, they were struck through with a single line and were initialed by the staff. All reviewed logbook entries included the time of entry; however, ante meridiem (a.m.) and post meridiem (p.m.) were not consistently noted on the time within the logbooks as required by the center's policy. The logbooks also inconsistently documented youth placed in confinement, including the time confinement began and the time confinement ended, as four of five reviewed confinements were not documented within in the logbooks.

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.*	

Logbooks maintained for the six months prior to the annual compliance review were inspected and revealed the superintendent or designee reviewed each of the logbooks on a weekly basis and documented recommendations as to the completeness and accuracy of the information recorded. When assuming center responsibility, the supervisory staff consistently documented their review of the master control logbooks. The logbooks maintained in each living module area consistently documented the daily supervisory staff review at shift change when accepting responsibility for the living modules. Logbook documentation reflected the superintendent, assistant superintendent, or person in charge of the center conducted a tour of the youth living module areas at least once during each shift. Logbook documentation revealed the superintendent, or assistant superintendent, reviewed the logbooks at least weekly and documented the findings of their review.

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

The center maintains a written policy and procedures on key control. This policy addresses key control, issuance of keys to staff, inventory and tracking, key restrictions, and storage as well as the procedures for missing/lost keys and reporting and replacement of damaged keys. All keys are inventoried in the Facility Management System (FMS). The center maintained a master key inventory which accounts for all key rings by ring number, the number of keys on each ring, the capability of each key and to whom the keys are assigned and issued to. A review of the master control logbook and observation of distribution and collection of keys confirmed the issuance of keys/key rings, and radio numbers were documented in the master control logbook on each shift with the date and time of issue, name of person receiving the key ring, time returned, staff turning in their personal keys in exchange for a center key. Observations were made of staff carrying their assigned keys on their person at all times and youth did not have access to handle center keys. A review of the master key control inventory during the annual compliance review revealed the inventory report matched the actual key rings in use. There were no reported incidents during the review period of lost keys or staff leaving the building with access keys to the program. All center vehicles keys were accounted for during the review. Vehicle keys are kept inside each individual vehicle binder in the locked and secured transportation office. Five staff were interviewed, and each staff reported they received training on the center's key control policy and procedures and each were knowledgeable of which center keys are restricted. The key control log was maintained for staff to sign-in and sign-out center keys as they arrived and departed their shifts. Several logs indicated staff inconsistently notate the time they returned their keys to master control and departed the center; however, master control staff consistently notate each key transaction, inclusive of the time, in the master control logbook as the key exchange occurs.

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

The center has a written policy and procedures in place to ensure vehicles transporting youth are properly maintained, inspected annually, and in good repair. The center has nine vehicles, five are vans used for transporting youth. One van was being used by another detention center and available for observation. Reviewed documentation validated all vehicles received annual inspections. Inspection of the four available transport vans confirmed each vehicle had working seatbelts, fire extinguishers with a current inspection, window punch, and seat belt cutters. All vehicles assigned to the center each had a first aid kit stored inside the vehicle. First aid kits are checked by medical staff and items replaced at the beginning of each month. Each vehicle is inspected prior to transporting youth using the Department's approved checklist and each vehicle also has an assigned logbook. A random security check conducted during annual compliance review week found all vehicles were secured when not in use.

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

The center maintains a written policy and procedures addressing tool inventory and management. The maintenance mechanic stores all the center's tools in a secure portable building, adjacent to the detention center and within the secure fenced perimeter. The center has a perpetual inventory of tools to document what tools are utilized by the maintenance staff including the times the tools were checked-out and in for use. Access to this area is limited to only the center administrators and maintenance mechanic staff. An interview with the maintenance staff indicated inventory is conducted on a monthly basis and forwarded to the center superintendent for review. Monthly inventory sheets were inspected and there were no reports of missing tools during the annual compliance review period. There were no tools documented as missing from the center, and there were no tools in the center which were not listed on the inventory. Observation of the storage board for hand tools revealed one hammer was missing from the board and was not in use at the time of the observation. The hammer was located in a toolbox on the floor of the maintenance building, explanation for which was the items in the tool box are used almost every day. Observation of the tools and an interview with the maintenance staff revealed the center's tools are not marked with an identification code as required by Detention Services Facility Operating Procedure 5.15.

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

The center maintains a written policy and procedures addressing kitchen tools and sharps. Inspection of the center's kitchen area was conducted during the annual compliance review. Reviewed documentation evidenced kitchen staff conduct an inventory of kitchen tools three times a day for breakfast at 5:00 a.m., lunch at 11:30 a.m. and dinner at 4:30 p.m. A physical count was conducted during the annual compliance review to compare the actual kitchen tools with the inventory at hand and all kitchen knives and sharp utensils were accounted for. All kitchen tools and sharp utensils are stored in a locked wall-mounted box located inside the kitchen manager's secured office. An interview with the kitchen manager confirmed youth are not permitted in the kitchen area. The center's facility operating procedure requires any lost or damaged kitchen tools be immediately reported to the superintendent or assistant superintendent and an interview with the kitchen manager validated the staff's knowledge of the procedure.

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

The center has a written policy and procedures regarding access to all flammable, toxic, caustic and poisonous items. All flammable, toxic, caustic, and poisonous items are secured and locked in an area, not accessible to youth. Access is restricted only to maintenance and administrative staff. The center's procedures and safety plan provided clear directives regarding the use, proper inventory, storage, procurement, and access to the items. During the annual compliance review, five staff were interviewed, and each reported youth are not allowed to handle toxic, flammable, or poisonous substances. Five interviewed youth all indicated they are not allowed to clean with any type of cleaning agent such as bleach, laundry soap, or toilet cleaners. Five interviewed staff indicated the only tools youth are allowed to use are mops and brooms. Five of five interviewed youth reported using mops and brooms as the only tools they use at the center.

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

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

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

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

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

The center maintains a written policy and procedures for all flammable, toxic, caustic and poisonous materials. The center's inventory for flammable, toxic, and poisonous items indicated chemicals were stored in three locked areas not accessible to youth including shed number one, shed number four, and the center's maintenance shop; however, observation during the annual compliance review indicated the materials were stored in at least seven locked areas not accessible to youth, including the maintenance shop, shed number one, shed number four, the center's large store room, the laundry room, custodian closet number 129, and custodian closet number 106. The maintenance staff maintains an inventory for the chemicals in the store room as well as the maintenance shop and shed number one and number four. A separate inventory for the store room is also maintained by the center's administrative assistant; however, the two inventories for the store room differed from each other. The center maintains a log of the Safety Data Sheets (SDS) in each shed. A review of the center's master inventory for the last six months confirmed the maintenance staff completes a monthly inventory which is then reviewed by the superintendent or designee; however, a count of stored chemicals revealed the inventory was inaccurate as it differed from the amount of materials on hand, with the inventory under count on some materials and over count on others. Additionally, observation of the maintenance shop revealed many chemicals were maintained on-site, which were not included on the center's chemical inventory and for which there were no Safety Data sheets. Two sixteen-ounce cans of WD-40 were stored in the maintenance shop for which Safety Data sheets were on hand; however, WD-40 was not included on the inventory of chemicals. Several chemical items were found stored in locations other than the location indicated on the inventories, including in a shed designated for uniform storage. Observation also revealed chemicals stored in unmarked containers, including an unknown quantity described by the maintenance staff as ant killer and one unmarked spray bottle containing an unidentified liquid which was explained to be bleach with water. Spray bottles labelled as one chemical were found to contain a chemical other than the one identified on the bottle's label. Such items including window cleaner in a spray bottle labelled as Pride MSR-1mildew/stain remover and kerosene or diesel fuel stored in a gasoline container. Staff interviews revealed storage closet 106 is utilized for the storage of chemicals and cleaning supplies for the kitchen, including oven cleaners, soap and bleach; however, no perpetual or monthly inventory of chemicals was maintained for the chemicals stored in closet 106. Additionally, many containers of paint were maintained in a shed designated for the

storage of uniforms and no chemical inventory was maintained for this location. An interview with the maintenance staff revealed he was not aware of the process or procedure for disposal of hazardous, toxic or caustic items. It was explained several chemical and paint containers had been present on-site for at least eleven years which need to be disposed.

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

The center has a written policy and procedures in place prohibiting youth from handling flammable, toxic, caustic, and poisonous items while in custody. The center's procedures forbid youth from handling any hazardous materials. All toxic items are stored in a locked storage portable building and sheds outside the detention center or in secured areas within the center, which are inaccessible to youth. The access to the locked storage portable is limited to the center's maintenance staff and administration. Only authorized personnel are permitted access to flammable, toxic, caustic, and poisonous items. Five youth and five staff were interviewed during the annual compliance review and all confirmed the youth are not allowed to handle or use hazardous chemicals.

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

The center's policy and safety plan address proper use, storage, and disposal of toxic, caustic and poisonous items. The plan addresses the procedure to follow in the event of a chemical leak, or spill. The kitchen has an outdoor container for the disposal of kitchen grease, for which a contract is maintained with A-1 Gator for disposal. The detention center superintendent stated there has been no chemical spills or leaks within the annual compliance review period. An interview with the maintenance staff revealed no hazardous materials and/or chemicals have been disposed since the last annual compliance review.

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

The center maintains a written policy and procedures addressing confinement under twenty-four hours. Documentation of youth placed in confinement for less than twenty-four hours is maintained in the Juvenile Justice Information System (JJIS) Facility Management System (FMS). Five confinement reports were reviewed, and each documented the room was searched prior to each youth being placed. All reviewed confinement reports indicated the confinement

reports were completed within one hour and submitted to the juvenile justice detention officer supervisor (JJDOS). Each confinement report indicated the superintendent and/or designee reviewed the confinement reports within forty-eight hours. Three of the five reviewed incidents leading to confinements resulted from behavior taking place within a classroom and educational staff were aware of each youth's placement in confinement. Two confinements occurred outside of educational hours and therefore did not require notification of the confinement to the education staff. Five of five interviewed staff were knowledgeable of the center's requirements for the submission of confinement reports, conducting ten-minute checks and room searches.

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

The center maintains a written policy and procedures to address confinement exceeding twenty-four hours. Reviewed documentation of confinement reports revealed there were four instances of confinement exceeding twenty-four hours since the last annual compliance review. Documentation for each included review and approval by the superintendent and/or designee as well as the reasons for extended confinement. No youth was held beyond seventy-two hours (three days). Three of the four reviewed confinements had a total of six instances of three-hour supervisory evaluations which were conducted beyond the three-hour requirements. Of the seven late supervisory reviews, four were conducted by the same staff person which were respectively three minutes, nineteen minutes, thirteen minutes and ninety-four minutes late. Each of the other three late supervisory reviews were conducted by different supervisors and were one, four and five minutes late, respectively. One report for a confinement over twenty-four hours did not document approval by the regional office for continuing the confinement and e-mail documentation of the request could not be located.

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

The center maintains a written policy and procedures detailing the center's continuity of operations planning (COOP) to ensure preparation for the response to emergencies and disaster events. The center's COOP successfully passed review by the State of Florida, Division of Emergency Management on December 1, 2017. Reviewed documentation validated the center has conducted COOP drills available to staff on each shift participated. All conducted drills during the annual compliance review period were documented in the center logbooks. Documentation evidenced the center most recently conducted COOP drills on May 2, 2018 and May 24, 2018 and each drill was documented in the center's emergency logbook. Evacuation route plans were observed posted throughout the center, including the living module areas. A review of five staff training records confirmed the center's staff completed training on the center's COOP.

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

The center maintains a written policy and procedures addressing escape drills as well as an escape prevention plan. A review of the center's logbooks for the six months prior to the annual compliance review verified the quarterly escape drills were conducted and documented in the master control logbook. A total of fourteen escape drills were conducted on January 11, February 18, February 22, March 19, April 3, April 8, April 15, April 20, May 16, May 27, June 7, June 22, July 15 and July 27, 2018. Documentation validated the center conducted an escape drill at least once each quarter over the previous twelve months. A review of five staff training records confirmed the center's staff completed training on escape prevention.

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

The center maintains a written policy and procedures pertaining to fire drills. A review of fire drill reports and master control logbooks validated the center conducted a total of twenty-one fire drills during the six months prior to the annual compliance review. Documentation validated fire drills were conducted monthly on each shift. The center contracts with Cintas Fire Protection to conduct annual inspection of the center's fire detectors, fire alarm and sprinkler systems fire extinguishers. Inspections were conducted by Cintas on January 26, 2018 and January 31, 2018. The January 31, 2018 inspection report noted functional test failure on two of sixteen manual fire alarm pull box stations; however, the pull boxes had not yet been repaired/replaced pursuant to the technician's notations. A written estimate for the replacement of the two manual fire pull stations which failed the inspection in January was received by the center during the annual compliance review and was in the process of being scheduled. The center completed

and documented internal monthly fire extinguisher inspections and Cintas Fire Protection completed the annual inspection of the center's fire extinguishers on March 8, 2018. Evacuation route plans are visibly posted throughout the center and readily available to staff members, youth, and visitors. A review of five pre-service records and five in-service training records revealed each staff received fire safety training. Five interviewed youth indicated each youth knows what to do in the event of a fire. Reviewed documentation indicated an annual inspection was conducted on September 5, 2017 by the Division of State Fire Marshall, Bureau of Fire Prevention with five violations identified. The center provided documentation indicating correction of the five identified deficiencies were all completed prior to the assigned October 5, 2017 deadline. Documentation of the completed corrections was submitted by e-mail to the Detention services south region office on December 4, 2017. An interview with the superintendent indicated the center's practice is to notify the Department's regional detention office once corrections are completed. However, there was no documentation to evidence the Division of State Fire Marshal was notified of the corrections as required by their inspection.

Program Name: Southwest Regional Detention Center
Provider Name: Department of Juvenile Justive
Location: Lee County / Circuit 20
Review Date(s): August 7-10, 2018

MQI Program Code: 1046
Contract Number: N/A
Number of Beds: 50
Lead Reviewer Code: 158

Overall Rating Summary

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

Limited Ratings	Failed Ratings
5.02 * Ten-Minute Checks	4.11 DHA/Designee Admission Notification
	5.11 Inventory of all Flammable, Toxic, Caustic, and Poisonous Items