BUREAU OF MONITORING AND QUALITY IMPROVEMENT
PROGRAM REPORT FOR

Volusia Regional Juvenile Detention Center
Department of Juvenile Justice
(State-Operated)
3840 Old Deland Road
Daytona Beach, Florida 32124

Review Date(s): April 4-7, 2017

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:

<table>
<thead>
<tr>
<th>Satisfactory Compliance</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Limited Compliance</td>
<td>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.</td>
</tr>
<tr>
<td>Failed Compliance</td>
<td>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.</td>
</tr>
</tbody>
</table>

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:

Mike Marino, Office of Program Accountability, Lead Reviewer (Standard 1)
Kevin Greaney, Office of Program Accountability, Regional Monitor (Standard 4)
Darrell Johnson, DJJ Detention Services, North Region, Chief (Standard 2)
Joseph Shuler, Jacksonville Youth Academy, G4S Youth Services, Facility Administrator (Standard 5)
Christi Stua, DJJ Detention Services, North Region, Operations and Management Consultant II (Standard 3)
Amy Tyson, Office of Program Accountability, Regional Monitor (Standard 1 and Standard 4)
Program Name: Volusia Regional Juvenile Detention Center
MQI Program Code: 139
Provider Name: Department of Juvenile Justice
Contract Number: NA
Location: Volusia County / Circuit 7
Number of Beds: 64
Review Date(s): April 4-7, 2017
Lead Reviewer Code: 37

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
- # Clinical Staff
- # Food Service Personnel
- # Healthcare Staff
- # Maintenance Personnel
- # Program Supervisors
- # Other (listed by title): Asst. Superintendent, training coordinator

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
- # Health Records
- # MH/SA Records
- # Personnel Records
- # Training Records/CORE
- # Youth Records (Closed)
- # Youth Records (Open)
- # Other: JJIS alerts
- 14 Volunteer files

Surveys

- 7 # Youth
- 7 # 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

<table>
<thead>
<tr>
<th>Standard 1 - Management Accountability</th>
<th>1.01 Satisfactory</th>
<th>1.02 Limited</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.03</td>
<td>Initial Background Screening</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>1.04</td>
<td>Staff Code of Conduct</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>1.05</td>
<td>Five-Year Rescreening</td>
<td>Limited</td>
</tr>
<tr>
<td>1.06</td>
<td>* Incident Reporting</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>1.07</td>
<td>Protective Action Response (PAR)</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>1.08</td>
<td>* Pre-Service/Certification Requirements</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>1.09</td>
<td>In-Service Training</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>1.10</td>
<td>Logbook Maintenance</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>1.11</td>
<td>Logbook Reviews</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>1.12</td>
<td>*Entering Alerts (JJIS)</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>1.13</td>
<td>Sharing of Alert Information</td>
<td>Satisfactory</td>
</tr>
</tbody>
</table>

* 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

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.01 Admission</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>2.02 Orientation</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>2.03 Classification</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>2.04 Classification of Gang Members</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>2.05 Notification of JPO Circuit Gang Rep</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>2.06 Admission of Youth Personal Property</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>2.07 Storage of Youth Personal Property</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>2.08 Release</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>2.09 Release of Youth Personal Property</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>2.10 Release of Meds, Aftercare Instructions</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>2.11 Review of Youth in Secure Detention</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>2.12 Review of Youth on Home Detention</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>2.13 Daily Activity Schedule</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>2.14 Adherence to Daily Schedule</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>2.15 Educational Access</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>2.16 Career Education</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>2.17 Behavior Management System</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>2.18 * Unauthorized Use of Punishment</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>2.19 Grievances</td>
<td>Satisfactory</td>
</tr>
<tr>
<td>2.20 Trauma-Informed Care</td>
<td>Satisfactory</td>
</tr>
</tbody>
</table>

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**Standard 3: Mental Health and Substance Abuse Services**

**Detention Rating Profile**

<table>
<thead>
<tr>
<th>Indicator Ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Standard 3 - Mental Health and Substance Abuse Services</strong></td>
</tr>
<tr>
<td>3.01</td>
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<td>3.02</td>
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<tr>
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<td>3.04</td>
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<tr>
<td>3.15</td>
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<td>3.16</td>
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</tbody>
</table>

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# Standard 4: Health Services

## Detention Rating Profile

### Indicator Ratings

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.01</td>
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<td>4.35</td>
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<tr>
<td>4.36</td>
<td>Satisfactory</td>
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<tr>
<td>4.37</td>
<td>Limited</td>
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<td>4.38</td>
<td>Satisfactory</td>
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<td>4.39</td>
<td>Satisfactory</td>
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<td>4.40</td>
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<tr>
<td>4.41</td>
<td>Satisfactory</td>
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</tbody>
</table>

* Designated Health Authority/Designee
* Psychiatrist/Designee

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## Standard 5: Safety and Security

### Detention Rating Profile

<table>
<thead>
<tr>
<th>Indicator Ratings</th>
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</thead>
<tbody>
<tr>
<td><strong>Standard 5 - Safety and Security</strong></td>
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<tr>
<td>5.01</td>
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<td>5.02</td>
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<td>5.03</td>
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Strengths and Innovative Approaches

- The center continues to maintain a very effective working relationship with the Volusia County School District. In addition, to teachers at the center, the school district has assigned support staff and a guidance counselor to the center. The education staff ensure youth receive credit for schoolwork completed while at the center and transfer records to each youth’s assigned school upon release.

- The center continues to receive grant funding from Very Special Arts of Florida. The grant allows the center to provide art classes one day each week. Youth art projects were prominently displayed throughout the center.
Standard 1: Management Accountability

Overview

The Volusia Regional Juvenile Detention Center is located in Daytona Beach, Florida, and has a designated capacity of sixty-four beds. The center houses male and female youth pending adjudication, disposition, or placement in a commitment facility. There were thirty-seven youth in the center on the first day of the annual compliance review. The center serves Volusia, Flagler, and St. Johns counties.

Management staff include the superintendent, two assistant superintendents, nine juvenile justice detention officer supervisors (JJDOS), and a training coordinator. Center staffing includes fifty-one juvenile justice detention officers (JJDO), five food service staff, one maintenance mechanic, and one administrative secretary. Seven JJDO positions were vacant and four JJDO positions were "on hold", at the direction of headquarters, at the time of the annual compliance review. Contracted provider staff provide medical and mental health and substance abuse treatment services. Education services are provided by the Volusia County School District.

1.01 Initial Background Screening

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

The center has a written policy and procedures to address initial background screening. Since the last annual compliance review, the center had ten new staff and fifteen volunteers requiring an initial background screening. All new staff and volunteers were background screened prior to their date of hire or start date, and all were rated as eligible. An Annual Affidavit of Compliance with Level 2 Screening Standards for the center was completed and sent to the BSU on January 5, 2017. An Annual Affidavit of Compliance with Level 2 Screening Standards for school board teachers was completed and sent to the BSU on January 10, 2017.

1.02 Five-Year Rescreening

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

Eight staff required a five-year background re-screening during the annual compliance review period. Five-year rescreens were completed for all eight staff, but five of the rescreens were completed between one to five-and-a-half months late. The superintendent explained the center based their rescreening dates on previously completed rescreens, rather than staff hire dates, which resulted in rescreens for the five staff being completed more than a year prior to their anniversary of hire date, and thus not in compliance with Department policy. Once BSU notified the center of the error, the center corrected the way they track rescreens, basing them on the date of hire.
1.03 Staff Code of Conduct

<table>
<thead>
<tr>
<th>Satisfactory Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Program staff adheres to a code of conduct prohibiting any form of abuse, profanity, threats, harassment, intimidation, “horseplay”, or personal relationships with youth.</td>
</tr>
</tbody>
</table>

| 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. |

Seven staff personnel files were reviewed for code of conduct. Each staff signed the code of conduct upon hire. An additional personnel file was reviewed for disciplinary action, a termination, which was the only disciplinary action at the facility during the annual compliance review period. The staff in question was immediately removed from contact with youth, after an incident when he used physical interventions not approved in Protective Action Response (PAR) techniques. Documentation showed administration took appropriate action to review and address the incident, which included involving regional detention staff. The center awards staff with certificates each month when staff have perfect attendance for the month.

Seven staff were surveyed and all were able to articulate the process for allowing a youth to call the Florida Abuse Hotline, or Central Communications Center (CCC), if a youth is eighteen years old. Each staff stated the supervisor is notified and responds, if possible. The supervisor then takes the youth to a phone to facilitate the call to the Florida Abuse Hotline or CCC, and allows the youth to make the report. If a supervisor is not available, the staff facilitates the call. Each staff reported they had never heard a youth being denied a call to the Florida Abuse Hotline or CCC. Each staff stated they had never heard co-workers using profanity or threats, intimidation, or humiliation towards youth.

Seven youth were surveyed and none of them reported ever being stopped from reporting abuse to the Florida Abuse Hotline or CCC. All seven youth reported staff were respectful when speaking with them. Four youth said they had never heard staff use profanity. Three youth said they had heard staff use profanity once or occasionally, though, it was not directed toward youth. Each youth reported he/she felt safe in the center.
1.04 Incident Reporting (CCC)  
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.

There were twenty-one incidents reported to the Central Communications Center (CCC) within the last six months. All were reported to the CCC within two hours of the incident or of staff becoming aware of the incident. A review of logbooks and internal incidents found there were no additional incidents requiring a report to the CCC.

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 detention center had sixty-four Protective Action Response (PAR) incidents in the last six months. Seven PAR reports were reviewed, of which six were completed by the end of the workday, including statements from all staff involved. In the remaining report, one staff statement was completed the next day. The supervisor review was completed after all statements had been completed in five of the seven reports. In one report, the supervisor review was completed prior to one of five staff statements completed in the report. In another report, the supervisor review was documented prior to two staff statements. Each report was reviewed by a PAR instructor, with six of the seven PAR instructor reviews being completed after all staff statements. In one report, the PAR instructor review was completed prior to one staff statement. All seven reports were reviewed by the superintendent or designee after all staff statements, supervisor reviews, and PAR instructor reviews and within seventy-two hours. A post-PAR interview was conducted within thirty minutes for each PAR incident reviewed. The center’s practice is to take all youth involved in a PAR incident to medical to be checked by a nurse, which was documented in six of the seven PAR reports reviews. In the remaining report, the post-PAR interview clearly documented the youth was not injured and a medical review was not necessary. Seven youth and seven staff were surveyed. All youth and all staff stated staff try to talk to youth prior to using physical restraints. The center’s PAR plan was approved for 2017 by the Department’s Staff Development and Training Office.

1.06 Pre-Service/Certification Requirements  
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.

Seven training files were reviewed for pre-service training. Two of the staff had been employed over 180 days and each had completed the detention officer academy. Five staff were more recent hires and are scheduled to attend the detention officer academy. All seven staff were certified in Protective Action Response (PAR), Cardiopulmonary Resuscitation (CPR), First Aid, and use of an Automated External Defibrillator (AED) within ninety days. All staff had received
training in suicide prevention, mental health and substance abuse services, detention operations, and emergency procedures.

### 1.07 In-Service Training

<table>
<thead>
<tr>
<th>Satisfactory Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>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.</strong></td>
</tr>
<tr>
<td><strong>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.</strong></td>
</tr>
</tbody>
</table>

Seven training files were reviewed for in-service training. All staff were current with first aid, cardiopulmonary resuscitation (CPR), and automated external defibrillator (AED) certifications. Each staff completed sixteen hours of Protective Action Response (PAR) update training. All staff received well over twenty-four hours of training in 2016, with training hours completed, ranging from thirty-two to sixty-two hours. Four of seven records documented training in suicide prevention in 2016 and three did not. Two of the staff who did not have suicide prevention training in 2016 were out on extended family medical leave during 2016 and completed suicide prevention training when they returned to work in 2017. Four staff had documentation of training in ethics and three did not. Three training files of supervisory personnel were applicable for eight hours of management training. One supervisory staff had twenty-seven hours of training in management related topics and one supervisor had nine hours of training in supervisor related topics. The remaining supervisor completed seven hours of training on supervisory related topics.

### 1.08 Logbook Maintenance

<table>
<thead>
<tr>
<th>Satisfactory Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>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.</strong></td>
</tr>
<tr>
<td><strong>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.</strong></td>
</tr>
<tr>
<td><strong>Log entries regarding Medical, Special Needs, and Mental Health alerts, or other issues impacting facility safety and security shall be highlighted.</strong></td>
</tr>
</tbody>
</table>

Logbooks were reviewed from each module and master control. All logbooks were bound and had numbered pages. There were no missing pages in any of the logbooks reviewed, though the spine binding the pages together was in bad condition for two module logbooks. When errors were made, staff struck through them with a single line. The staff did not use white-out in the logbooks. Each entry had the time of the occurrence and the initials or signature of the staff member who recorded the entry. The dates were recorded at the top of each page. Staff recorded when youth were placed in and released from confinement. All admissions, releases, movements, activities, drills, emergencies, alerts, perimeter checks, visitations, and counts were
recorded by staff. Blank lines were noted in master control logbooks, including some with times entered and highlighted. Highlighting was not evident for significant events in the module logbooks.

1.09 Logbook Reviews

<table>
<thead>
<tr>
<th>Satisfactory Compliance</th>
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<tbody>
<tr>
<td><strong>The superintendent or designee reviews all logbooks on a weekly basis.</strong></td>
</tr>
<tr>
<td><strong>The supervisor(s) reviews the facility logbook maintained at master control when he/she accepts responsibility for the facility.</strong></td>
</tr>
<tr>
<td><strong>The Juvenile Justice Detention Officer (JJDO) Supervisor(s) reviews logbooks maintained in each living area daily.</strong></td>
</tr>
<tr>
<td><strong>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.</strong></td>
</tr>
</tbody>
</table>

Logbooks from the modules and master control were reviewed for supervisory reviews. Supervisors reviewed the logbooks for each module and the master control logbook at the beginning of each shift. The superintendent and assistant superintendents documented at least weekly reviews of module and master control logbooks.

1.10 Entering Alerts (JJIS)

<table>
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<tr>
<th>Satisfactory Compliance</th>
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</thead>
<tbody>
<tr>
<td><strong>Superintendents shall ensure Critical and Special Alerts are reviewed and responded to appropriately.</strong></td>
</tr>
<tr>
<td><strong>Upon completion of the Admission Wizard, the officer shall ensure all Critical and Special Alerts are listed in JJIS.</strong></td>
</tr>
<tr>
<td><strong>The JJIS alert report shall be reviewed daily by supervisors and administrators to ensure it correctly reflects the status of youth.</strong></td>
</tr>
<tr>
<td><strong>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.</strong></td>
</tr>
<tr>
<td><strong>Medical and mental health staff shall review alerts to ensure each alert is correctly tracked and managed.</strong></td>
</tr>
<tr>
<td><strong>The responses and updates by medical, mental health and other staff should be documented in JJIS alerts as they pertain to that critical alert.</strong></td>
</tr>
</tbody>
</table>

Seven youth records were reviewed for alerts in the Juvenile Justice Information System (JJIS). Alerts were appropriately entered in JJIS on the date each alert was identified, with one exception. The one exception was one of multiple alerts for one youth. In this case, the youth had a suicide alert already open when he entered the center and staff were not authorized the close it and reopen a new one for the day of admission. Only authorized staff entered and closed alerts.
<table>
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<tr>
<th>1.11 Sharing of Alert Information</th>
<th>Satisfactory Compliance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>JJDOS’s shall inform staff of alerts during shift briefing. When a JJDOS receives changes to the alert list, he or she shall notify the staff affected by changes and add the information to the shift briefing for the oncoming shift upon receipt of the information.</strong></td>
<td></td>
</tr>
</tbody>
</table>

Alert information is shared during each shift briefing. Staff read each alert aloud during the briefing and are issued a copy of the JJIS alerts to carry with them during their shift. Updated alert lists are provided to the kitchen. All staff surveyed said the system for sharing information is good or very good.
Standard 2: Assessment and Performance Plan

Overview

Circuit probation operates a call center to screen youth for detention. Through the call center, law enforcement contacts a juvenile probation to determine if youth qualify for secure detention, home detention, or straight release. If qualifying for secure detention, law enforcement transport the youth to the detention center. Youth are searched by detention staff upon their arrival at intake. Multiple screenings are completed during the intake process, to include screening youth for suicide risk, medical issues, and room assignment. Youth are provided an orientation to the center's rules and expectations and youth property is inventoried and secured during the intake process.

Education is provided by the Volusia County School District. The school portables were remodeled during the past year. A guidance counselor, teachers, and support staff are on-site to ensure education services.

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 policy and procedures in place addressing the admission of youth. Seven youth files were reviewed and all had the necessary documentation for admissions, including an arrest affidavit or custody order, a Detention Risk Assessment Instrument (DRAI), and Suicide Risk Screening Instrument (SRSI). The admission wizard in all files indicated the youth was searched, allowed to use the phone to contact family, and offered a meal.
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.

Seven youth files were reviewed. Each file indicated the youth received orientation. The files indicated the orientation included information on youth rights, visitation, the grievance process, telephone calls, and access to the Florida Abuse Hotline. Seven youth were surveyed, of which six reported they received orientation upon admission to the center and one reported he did not.

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.

Seven youth files were reviewed to ensure youth were classified using the Secure Detention Admission Wizard. The admission wizard provides basic demographics, such as physical characteristics and age, as well as boxes to be checked to identify special needs, gang affiliation, history of violent behavior, history of sex offenses, and suicide risk. Staff also review intake paperwork, such as the Positive Achievement Change Tool (PACT) and Suicide Risk Screening Instrument (SRSI), to determine appropriate room classification and supervision level for all youth admitted.
2.04 Classification of Gang Members | Satisfactory Compliance
---|---
All newly admitted youth are screened to determine if he or she is a criminal street gang member or is affiliated with any criminal street gang.

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

The center has a policy and procedures addressing classification of gang members. A review of seven youth files found each youth was screened for gang affiliation. The center has designated a detention officer as the gang representative. A review of the alert list confirmed the center enters a gang alert in the Juvenile Justice Information System (JJIS) in the event gang affiliation is suspected.

2.05 Notification of Juvenile Probation Officer Circuit Gang Representative | Satisfactory Compliance
---|---
Each center shall identify the Juvenile Probation Officer designated as the Circuit Gang Representative to communicate suspected gang activity.

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

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

The center has a policy and procedures addressing the notification of the juvenile probation officer of suspected gang involvement by youth in the center. The gang representative was interviewed and indicated the assigned juvenile probation officer is notified by email when youth are identified with gang affiliation. The email includes the name of the gang and how affiliation was identified (i.e. youth report). Local law enforcement is also notified by email.

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

The center has a policy and procedures in place addressing the admission of youth personal property. Youth property is inventoried during admission. The items are listed on a property sheet from the Juvenile Justice Information Systems (JJIS). The youth’s name, the date, and Department of Juvenile Justice Identification Number appears on the property bag and the property sheet. All money and personal items are verified and secured in a clear tamper proof bag. A review of seven files found each youth signed their property sheet and a letter of acknowledgement regarding unclaimed property. Seven surveyed youth reported they signed property sheets.
2.07 Storage of Youth Personal Property

Satisfactory Compliance

The program safeguards each youth’s personal property until it can be returned to the youth and/or legal guardian.

The center has a policy and procedures in place addressing the storage of youth personal property. Youth personal property is stored in plastic, sealed, see-thru bags. Each bag has the youth’s name, date, and Department of Juvenile Justice Identification Number on the bag. Valuable property is placed in a safe, to which only designated staff have access. The safe is under video surveillance and there is a logbook to document valuable property is placed in the safe. There have been no Central Communications Center (CCC) reports in the past six months regarding youth property at this detention center.

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 and a release was observed during this annual compliance review. The supervisor verified a court order was in place to authorize the youth’s release and verified the identity of the youth. The supervisor obtained and photocopied identification for the parent/guardian to confirm his/her identity. The supervisor reviewed all the documents pertaining to the release and obtained youth and parent/guardian signatures on applicable release forms. Four closed files were reviewed. A photocopy of the identification for the parent/guardian was in each closed file and documentation showed the youth and parent/guardian were notified of the youth’s pending court dates. Each closed file documented youth, parent/guardian, and staff signatures were present on applicable release forms. A review of JJIS found admission and release dates for each youth were accurate. A review of Central Communications Center (CCC) reports found there have not been any unauthorized releases from the center during the past six months.
2.09 Release of Youth Personal Property  

**Satisfactory Compliance**

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

The center has a policy and procedures addressing the release youth property. Each of the four closed files contained property forms signed by the youth and his/her parent/guardian to document receipt of the property. One youth release was observed. The releasing officer retrieved the youth property. The youth and the person receiving the youth both signed the property sheet, verifying the property was received. For property left at the center and not claimed for thirty days, notification is sent to the youth’s parent/guardian with a copy of the letter signed by the youth acknowledging property left at the center for over thirty days is subject to disposal. The superintendent was interviewed and able to explain the center’s procedures and practices related to youth personal property.

2.10 Release of Medication, Aftercare Instructions  

**Satisfactory Compliance**

*The program ensures there are provisions in place to ensure prescribed medication, along with medical instructions, accompanies detained youth upon release.*

The center has a policy and procedure in place addressing the release of medication and aftercare instructions. Three closed files were reviewed for youth who were released with medication. Each file contained an acknowledgment of receipt for the medication and aftercare instructions signed by the parent/guardian or person taking custody of the youth.

2.11 Review of Youth in Secure Detention  

**Satisfactory Compliance**

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

The center has a policy and procedures in place to address the review of youth in secure detention. Detention review meetings are held every Wednesday and include a review of all youth in secure detention and youth on home detention. The meeting is attended by representatives from the detention center, probation, the Department of Children and Families (DCF), mental health, medical, and education. A detention review meeting was observed during the review. The meeting included a review of court dates, placement dates, release information, and youth behaviors for each youth in secure detention.

2.12 Review of Youth on Home Detention  

**Satisfactory Compliance**

*Detention reviews are conducted by the program on a weekly basis to ensure proper management of youth placed in home detention and appropriate sharing of information. The superintendent appoints an appropriate staff person to coordinate detention reviews.*

The center has a policy and procedures in place to address the review of youth on home detention. Detention review meetings are held every Wednesday and include a review of all youth in secure detention and youth on home detention. The meeting is attended by representatives from the detention center, probation, the Department of Children and Families (DCF), mental health, medical, and education. A detention review meeting was observed during
the review. The meeting included a review of court dates, placement dates, and release information for each youth on home detention.

2.13 Daily Activity Schedule  
Satisfactory Compliance

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

The center has a policy and procedures addressing the daily activity schedule. The center maintains a master daily activity schedule and a faith-based schedule. All required elements were present on the daily schedule, including time for hygiene, meals, education, and recreation. Gender-specific programming is included in the daily activity schedule. The schedules are posted on each module.

2.14 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.

Logbooks for the past three months were reviewed and the review team observed several activities during the annual compliance review. The logbooks and review team observations confirmed the daily scheduled is followed, with youth being moved to meals, education, and recreation activities, as well as participating in activities on the dorms at designated times. Seven youth were surveyed, and each youth said the center had a daily schedule and the schedule is followed. Seven staff were surveyed and also said the daily schedules are followed.

2.15 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 school at the center is operated by the Volusia County School District. Youth are able to earn credits towards graduation. Classes are held year round. School is scheduled on weekdays, starting at 8:00 a.m. and ending at 2:30 p.m., with the exception of Wednesdays. On Wednesdays, school ends at 12:05 p.m. Logbooks reviewed and review team observations confirmed youth attended school, as scheduled. Seven youth were surveyed and all stated they attended school daily and took a variety of different classes.

2.16 Career Education  
Satisfactory Compliance

Each youth is given the MyCareerShines assessment tool within the first five days of being admitted. Youth receive Type 1 career education programming daily.
### 2.17 Behavior Management System

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<tr>
<th>Satisfactory Compliance</th>
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<tbody>
<tr>
<td>The program provides a system of rewards, privileges, and consequences to encourage youth to fulfill the program’s expectations.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>The behavioral norms and expectations for youth shall be posted in all living areas and shall clearly specify appropriate and inappropriate behaviors.</td>
</tr>
</tbody>
</table>

The center uses the level system, which consists of three levels. The level system is described in the center policy and procedure manual. All youth enter the center on level two. A youth can be dropped a level for negative behavior and move up a level with positive behavior. Youth on level three get to go to the multi-purpose room to play games and interact with other youth on level three. Seven youth were surveyed of which two youth rated the behavioral management system as fair, three rated it as good, and two rated it as very good. Four youth reported consequences they had received were fair and the remaining three youth stated they had never received consequences. All surveyed youth denied any meals, snacks, clothing, bedding, or sleep was taken away as a consequence. All youth surveyed said youth were never able punish other youth. Seven staff were surveyed, and all said they felt the detention center’s behavior management system is effective. All staff reported they discuss consequences with youth prior to imposing them and youth are given the opportunity to explain their behavior. All surveyed staff denied any meals, snacks, clothing, bedding, or sleep was taken away as a consequence. All surveyed staff stated they receive feedback on their implementation of the behavioral management system, with two staff saying weekly and five saying as needed and explaining this routinely occurs at shift briefings.

### 2.18 Unauthorized Use of Punishment

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<tbody>
<tr>
<td>The center’s behavior management system restricts certain types of penalties on youth who demonstrate negative behaviors.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>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.</td>
</tr>
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</table>

The center has a policy and procedures addressing the unauthorized use of punishment. Corporal punishment is never used at the center. The administration team addresses any form of unauthorized punishment. The center had one officer terminated for the unauthorized use of force. The youth surveys indicated the youth felt safe at the center and the staff surveys indicated the staff did not practice the use of unauthorized punishment.
2.19 Grievances | Satisfactory Compliance
--- | ---
The grievance procedures establish each youth’s right to grieve and ensure all youth are treated fairly, respectfully, without discrimination, and their rights are protected. The process includes:

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

The center has a policy and procedures addressing youth grievances. The grievance process includes informal, formal, and appeal phases. The informal phase is for youth to address staff to see if the issue can be resolved. In the formal stage, grievances are entered into the center management system, by the staff, on behalf of the youth. Supervisory staff address the grievances and report their findings to the youth. If the youth wishes to appeal, the grievance is addressed by administration. The center has not received a grievance submitted by a youth during the annual compliance review period. Based on the youth surveys, each youth knew about the grievance process. According to staff surveys, the staff has been trained on the grievance process.

2.20 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 addressing trauma informed care practices. The center receives the Very Special Arts (VSA) grant yearly, through which the girls and boys participate in various art activities. The center has painted the modules and dining hall with murals. The center has also placed positive posters around the center and in the modules for positive reinforcement. The females are allowed to have slippers and pajamas at night and youth on level three are allowed to have sibling visitation. Training files reviewed found all but one staff completed the trauma informed care training. The one staff who did not complete the training was out for a long period of time under the Family Medical Leave Act. (FMLA).
Standard 3: Mental Health and Substance Abuse Services

Overview

The Volusia Regional Juvenile Detention Center has a contract with Correct Care Solutions to provide mental health and substance abuse services. The center has a licensed marriage and family therapist (LMFT) serving as their designated mental health clinician authority (DMHCA). The DMHCA is on-site forty hours weekly and is on-call twenty-four hours a day, seven days a week, when not at the detention center. There is an additional LMFT who is on-site forty hours a week as well, which includes eight hours of weekend coverage. There is a licensed mental health counselor who works a “fill-in/back-up” capacity, as needed. There are no non-licensed mental health professionals on staff. The center’s psychiatrist is on-site weekly to conduct psychiatric evaluations and medication management. When not on-site, the psychiatrist is available, via phone, as needed. The center utilizes Halifax Behavioral Services for crisis stabilization services.

3.01 Designated Mental Health Clinician Authority (DMHCA) [Contract Provider] Satisfactory Compliance

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

The designated mental health clinician authority (DMHCA) is a licensed marriage and family therapist (LMFT). The DMHCA’s license is current according to the Florida Department of Health. The DMHCA is on-site forty hours per week and is on-call twenty-four hours a day, seven days a week, when not at the detention center. The position is responsible for the coordination and implementation of all mental health and substance abuse services provided at the center. Treatment records and documentation reviewed, as well as staff interviews, confirmed the DMHCA provides oversight for all treatment services at the center.

3.02 Licensed Mental Health and Substance Abuse Clinical Staff [Contract Provider] Satisfactory Compliance

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

The center has four licensed mental health professionals on staff, which include the designated mental health clinician authority (DMHCA), who is a licensed marriage and family therapist (LMFT), another full-time LMFT, a licensed mental health counselor (LMHC) who works in a “fill-in/back-up” capacity, as needed, and the psychiatrist. All licensed mental health professionals have a current license according to the Florida Department of Health. Treatment records and documentation reviewed showed the licensed staff worked within the scope of their licensure.
3.03 Non-Licensed Mental Health and Substance Abuse Clinical Staff [Contract Provider] | Satisfactory Compliance
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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.

There are no unlicensed mental health professionals working at the detention center. The contract with the provider and policy and procedures outline requirements for the provider to follow, if an unlicensed mental health professional provides services at the center.

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.

Seven mental health treatment records were reviewed and each had a Suicide Risk Screening Instrument (SRSI) completed in the Juvenile Justice Information System (JJIS). Each section was completed by the appropriate staff, which included a juvenile probation officer (JPO), a juvenile justice detention officer (JJDO), and a mental health professional. Each youth also had a Positive Achievement Change Tool (PACT) and Massachusetts Youth Screening Instrument – Version 2 (MAYSI-2) completed by a juvenile probation officer (JPO). All youth were identified during admission to have “hits” on their SRSI and/or indicators on the PACT and/or MAYSI requiring an Assessment of Suicide Risk (ASR). Appropriate referrals for an ASR and supervision were documented in each of the records. All youth had an ASR completed within twenty-four hours or less of admission. A review of JJIS found all youth requiring an ASR had a corresponding alert with one exception. For this youth, who was admitted on March 2, 2017, there was already an open suicide alert in JJIS, entered by another program in October 2016. The center closed the alert on March 3, 2017, when the youth was removed from precautionary observation.

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 Circuit 7 Probation office contracts with Stewart Marchman, who conducts substance abuse/mental health (SAMH) assessments. Seven records were reviewed and all records included a Positive Achievement Change Tool (PACT) reviewed by detention and mental health staff. All records indicated the need for a SAMH assessment. The designated mental health clinician authority (DMHCA) communicates weekly with Stewart Marchman, in an effort to receive completed reports within the fourteen-day time frame. The reports for four requiring a SAMH assessment had not been received at the time of the annual compliance review (the four youth had been in detention less than thirty days). The remaining three requiring a SAMH
assessment had evaluations completed by Correct Care Solutions staff. All youth whose PACT indicated a “hit” for suicidal ideation or history were placed on precautionary observation and had an ASR completed in twenty-four hours or less.

### 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.*

Three records reviewed were applicable for treatment services. Each record contained a signed Authority for Evaluation and Treatment (AET). All three records contained documentation of referrals and mini-treatment team involvement. All services provided were documented on Office of Health Services (OHS) mental health forms. A mini-treatment team meeting was observed during the review. Attendees included representatives from education, medical, and mental health, as well as representatives from the detention center and Probation. Each applicable youth was also present when discussed and participated in the meeting. Mini-treatment team meetings are held weekly at the center. An interview with the designated mental health clinician authority (DMHCA) provided information on the group therapy conducted at the center. Groups are offered daily and include ten or less youth regardless of topic.

### 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.*

Three records were reviewed were applicable for treatment planning. Each record included the appropriate referrals, AETs, and treatment plans. All treatment plans were signed by the designated mental health clinician authority (DMHCA), youth, and at least one member of the mini-treatment team. Parental contact and/or attempts at notification were documented in each record. Two of the three records reviewed were applicable for including a discharge summary; both were signed by the DMHA and a mini-treatment team member. An additional discharge summary from a closed file was reviewed and reflected the same practice. The summaries are hand delivered to parent/guardian at release, if possible, otherwise they are mailed. The center sends a copy of the discharge summaries, by email, directly to the youth’s juvenile probation officer.
3.08 Psychiatric Services [Contract Provider]  
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.

Three records were reviewed for youth admitted with psychotropic medication. Each record contained a referral and current Authorization for Evaluation and Treatment (AET). Each youth was evaluated by the psychiatrist within the required time frame. The psychiatrist used the required Office of Health Services (OHS) forms for each evaluation. The initial psychiatric interviews were thorough and complete, including all required information. The Clinical Psychotropic Progress Notes (CPPN) reviewed were completed in their entirety and attempts at parental notification were documented.

3.09 Suicide Prevention Plan [Detention Staff]  
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’s Suicide Prevention Plan includes procedures for identification and assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral system, communication, notifications, documentation, immediate staff response, and review process. The plan was reviewed and signed by the Superintendent and designated mental health clinician authority (DMHCA) on July 19, 2016.

3.10 Suicide Prevention Services [Detention Staff/Contract Provider]  
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.

Seven records were reviewed and all required the completion of an Assessment of Suicide Risk (ASR). Each ASR was completed by a licensed mental health professional. All youth were stepped down from precautionary observation to an appropriate level of supervision. Most youth were assessed the same day as they were admitted. A review of JJIS found suicide alerts were entered by the center for all youth requiring them, with the exception of one. For this youth, who was admitted on March 2, 2017, there was already an open suicide alert in JJIS, entered by another program in October 2016. The center closed the alert on March 3, 2017, when the youth was removed from precautionary observation. Logbooks were reviewed for documentation of placement on, and removal from, precautionary observations. Placement on precautionary observation was documented in all cases in master control and module logbooks. Removal from precautionary observation was documented in master control for all youth and
module logbooks for three of three female youth reviewed. Removal from precautionary observation was not recorded in module logbooks for two of four male youth reviewed.

### 3.11 Suicide Precaution Observation Logs [Detention Staff/Contract Provider]

<table>
<thead>
<tr>
<th>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.</th>
</tr>
</thead>
</table>

Seven records were reviewed and each youth was placed on precautionary observation (PO). All PO logs were completed in their entirety, to include signatures for review by the shift supervisor and the designated mental health clinician authority (DMHCA). None of the logs documented warning signs; therefore, no immediate referral/notification to the DMHA was required. All checks were completed in the required time frames. Two secure observation (SO) logs were reviewed. The logs were completed and reviewed by all required parties. For youth placed on PO/SO after admission, the records documented the required step-down to close supervision. Each record contained close observation forms completed and reviewed by all required parties.

### 3.12 Suicide Prevention Training [Detention Staff]

<table>
<thead>
<tr>
<th>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.</th>
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</table>

The Department’s Learning Management System (SkillPro) was reviewed for suicide prevention training for seven staff in pre-service training and seven staff completing in-service training. All staff in pre-service training documented completion of suicide prevention trainings parts I and 2 in SkillPro. Two of the staff who had been with the center long enough to complete the academy had six hours of training in suicide prevention. For in-service training, four of the seven staff completed six hours of training in suicide prevention in 2016. Of the three staff without the suicide prevention training, two staff were on extended medical in 2016 and received the training as soon as they returned to work in 2017. The center maintains a drill binder to document mock suicide drills. The binder contained documentation of quarterly mock suicide drills, on each shift, during the review period, with one exception, which was the 11:00 p.m. to 7:00 a.m. shift, during one quarter.
3.13 Mental Health Crisis Intervention Services [Detention Staff]  
Satisfactory Compliance

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

The center has a combined Crisis Intervention and Emergency Care Plan. The plan includes mental health and substance abuse emergency procedures for youth who are believed to be an imminent danger to themselves or others. The plan includes procedures for immediate staff response, notifications, communication, supervision, obtaining authorization for transport, documentation, training, and review. The plan also outlines procedures for follow-up care once a youth returns to the center from a crisis stabilization unit. The current plan has been in place since 2015 and was most recently reviewed and signed by the superintendent and designated mental health clinician authority (DMHCA) on July 19, 2016.

3.14 Emergency Care Plan [Detention Staff]  
Satisfactory Compliance

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

The center has a combined Crisis Intervention and Emergency Care Plan. The plan includes mental health and substance abuse emergency procedures for youth who are believed to be an imminent danger to themselves or others. The plan includes procedures for immediate staff response, notifications, communication, supervision, obtaining authorization for transport, documentation, training, and review. The plan also outlines procedures for follow-up care once a youth returns to the center from a crisis stabilization unit. The current plan has been in place since 2015 and was most recently reviewed and signed by the superintendent and designated mental health clinician authority (DMHCA) on July 19, 2016.

3.15 Crisis Assessments [Contract Provider]  
Satisfactory Compliance

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

The center has not had any incidents requiring the use a Crisis Assessment since the last annual compliance review. The center does have policy and procedures in place should the need arise for a crisis assessment to be completed.
3.16 Baker and Marchman Acts [Detention Staff/Contract Provider]  Non-Applicable

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 did not utilize a Baker Act or Marchman Act procedure during this annual compliance review period; therefore, this indicator rates as non-applicable.
Standard 4: Health Services

Overview

Volusia Regional Detention Center has a contract with Correct Care Solutions (CCS) to provide medical services at the detention center. The center has a licensed family practice medical doctor (MD), who serves as the designated health authority (DHA). The DHA has been on-site once a week, usually on Mondays, every week for the last six months. The DHA is available twenty-four hours a day, seven days a week to provide services, as needed. When on-site, the DHA conducts routine sick calls, reviews paperwork, conducts physicals, and reviews policy and procedures for maintaining healthcare according to standards. The center has an advanced registered nurse practitioner (ARNP). The ARNP works eight hours a week, usually on Wednesday, and completes comprehensive physical assessments, sick calls, and routine follow-up care. The center also has a licensed psychiatrist on-site once a week, usually on Thursdays, to provide management services for youth receiving psychotropic medications. The psychiatrist is available twenty-four hours a day, seven days a week, as needed. The center has a one full-time registered nurse (RN), one trainee RN, one prn RN, one full-time licensed practical nurse (LPN), a part-time LPN, and a medical clerk to maintain all of the center’s medical needs. There is a nurse on-site every day from 5:00 a.m. to 9:00 p.m.

4.01 Designated Health Authority/Designee [Contract Provider] Satisfactory Compliance

The Designated Health Authority (DHA) is clinically responsible for the medical care of all youth at the facility.

The center has a licensed family practice physician, who serves as the designated health authority (DHA). The DHA has a clear, active, and unrestricted license to practice in the State of Florida. The DHA is on-site once a week, usually on Mondays, to provide services to youth. The DHA has been on-site, at least one time a week, for the last six months, without exception. The DHA is available for services twenty-four hours a day, as needed, through telephone contact. There is also a licensed advanced registered nurse practitioner (ARNP) to assist in providing medical care for youth at the center. The ARNP usually works eight hours every Wednesday and has been on-site, at least once a week, for the last six months. There is a collaborative protocol in place between the DHA and ARNP. There is a relief ARNP available, who is also licensed and has a collaborative protocol in place, if the need arises.

4.02 Psychiatrist/Designee [Contract Provider] Satisfactory Compliance

The Psychiatrist is responsible for the provision of psychiatric services, the management of psychiatric conditions, and the prescribing of psychotropic medications.

The detention center has a licensed and board certified psychiatrist providing services, one day a week, for three hours. The psychiatrist has been on-site, at least once a week, for the last six months, usually on Thursday, without exception. The psychiatrist has a clear, active, and unrestricted license to practice in the State of Florida. The psychiatrist conducts the monthly monitoring of youth on prescribed psychotropic medications. The psychiatrist is available twenty-four hours a day, seven days a week, to provide services, as needed.
4.03 Facility Operating Procedures [Contract Provider]

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<tr>
<td>There shall be Facility Operating Procedures (FOP) for all health-related procedures and protocols utilized at the facility.</td>
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The center has facility operating procedures (FOP) relating to all healthcare matters. Healthcare policies are reviewed annually and were most recently reviewed and signed by the designated health authority (DHA) and superintendent on November 1, 2016. Nursing protocols are reviewed on an annual basis, by all the nursing staff, and includes all changes to the protocols. When initially reviewed, there was no cover letter to show the nursing protocols were reviewed by the DHA, on an annual basis. This was corrected before the review team left, as the DHA signed the protocols. There have been no new hires in medical since the last annual compliance review. Policy states all new medical staff must receive an orientation to healthcare policy and procedures.

4.04 Authority for Evaluation and Treatment [Detention Staff/Contract Provider]

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<tr>
<td>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.</td>
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Seven youth records were reviewed for having a completed Authorization for Evaluation and Treatment (AET) form. All records had an AET signed and dated. Two of the youth had court orders for psychotropic medication. The AET was signed and dated with a Department’s representative as a witness. Five of the seven AETs were valid until the youth’s eighteenth birthday. All seven AETs were completed prior to medical services being rendered, beyond routine screenings. Two of the seven youth were Department of Children Family (DCF) youth, where the parental rights were terminated and the youth was in DCF custody. The two DCF youth had an AET signed by a foster care person. Even though the foster care person documented they were limited in authority and could not sign for psychotropic medication, the center needed to execute a limited AET. Both of the youth had a court order for psychotropic medication. The court order for one youth was initially for thirty days and a new one is executed every thirty days. The other youth’s court order is valid for one year.

4.05 Parental Notification [Contract Provider]

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<tr>
<td>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.</td>
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Seven youth healthcare records were reviewed for having signed parental notifications. These notifications included over-the-counter medication not covered by the Authorization for Evaluation and Treatment (AET), significant changes to existing medications, and for added or changed medications. Notifications were sent to the parents/guardians. None of the seven youth reviewed were sent out for emergency care or invasive surgeries.
4.06 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.

Seven individual healthcare records were reviewed for psychiatric services. Four of the seven youth were applicable for psychiatric services. The other three did not have a need for psychotropic medications. Two of the four youth had court orders signed for psychotropic medications and signed parental consent was obtained, prior to youth receiving psychotropic medication. A parental notification form and the Clinical Psychiatric Progress Note (CPPN) was sent to the youth’s parent/guardian. The CPPN was signed and dated, as required.

4.07 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).

Seven youth records were reviewed for the verification of immunization status upon admission to the center. All seven reviewed youth healthcare records had up-to-date immunization records. None of the youth had any refusals for immunizations for any religious exemptions.

4.08 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.

Seven youth records were reviewed and all seven healthcare records contained a completed healthcare admission screening form. Each health care admission form was completed, by a juvenile justice detention officer (JJDO), on the youths’ date of admission. All seven healthcare admission forms were reviewed by a licensed nurse within twenty-four hours and contained the initials or signature of the nurse and the date. The date of the Admission Wizard for each youth matched the date of the youth’s current admission.

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

The center’s facility operating procedures includes medical alerts, which informs staff of medical issues affecting the safety and security of youth. The alerts are read aloud at all shift briefings and each of the direct care staff carries a copy of the Juvenile Justice Information System (JJIS) alerts with them. The JJIS alerts are also located in the kitchen. In the event changes need to be made, the supervisor will notify the staff of affected changes for oncoming shifts. Alerts are inclusive of chronic conditions, allergies, head trauma, pregnancies, medications interactions, hearing, speech, visual, physical impairments, developmental disabilities, diet, and medication side effects. The medical staff ensures all alerts are accurate, up-to-date, and placed in the
JJIS, as required. Seven staff were surveyed and all seven revealed they are informed of youth’s medical alerts while at shift meetings, four responded through alert forms, and two reported other. All seven surveyed staff rated the process of communicating alerts as very good.

### 4.10 Suicide Risk Screening Instrument (Contract Provider)

**Satisfactory Compliance**

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

All seven reviewed youth healthcare records had a completed Suicide Risk Screening Instrument (SRSI), which was signed and dated within twenty-four hours of admission. The SRSI was completed by medical and/or mental health staff. The SRSIs were filed in the individual healthcare records in the mental health section.

### 4.11 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.

A review of the seven youth healthcare records indicated all youth receive an orientation to healthcare services within twenty-four hours of admission to the center. Topics included sick call, handwashing, the role of healthcare staff, chronic disease information, immunizations, medication administration, Prison Rape Enforcement Act (PREA), emergency and episodic care, and right to refuse care. All required topics were covered. Every new admission date, the healthcare orientation is updated and documented, by medical staff, in the youth’s healthcare record. There was no documentation supporting a review of the youth’s healthcare contacts to ensure accuracy. Youth signatures and dates were not documented.

### 4.12 Designated Health Authority/Designee Admission Notification (Contract Provider)

**Satisfactory Compliance**

The DHA or designee is notified when youth admitted require emergency care or routine notification in accordance with Department requirements.

Seven youth records were reviewed and none of the seven youth needed emergency care upon admission to the center. Four of the seven youth were identified as having chronic conditions. All four youth were referred to see the center’s designated health authority (DHA) and/or the advanced registered nurse practitioner. A review of progress notes revealed all four youth were seen and evaluated for continuation of treatment. The DHA was notified of the four youth within twelve hours of admission. Verbal orders were given whether or not to continue, hold, or discontinue medications.

### 4.13 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.

Seven youth records were reviewed and six were applicable for the requirement of completing a healthcare admission rescreening. One youth did not have a change of custody requiring completion of the form. All six youth had a rescreening completed and reviewed by a nurse within twenty-four hours. The center has a policy and procedures for conducting healthcare readmission screenings.
4.14 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.

All seven youth healthcare records reviewed had the standard Department Health-Related History (HRH) form completed within seven days of admission, and usually the same day as admission. All HRHs are completed on the computer and electronically signed and dated by a licensed nurse. All seven were reviewed by the designated health authority (DHA) or the ARNP. The HRHs were completed on or before the date of the Comprehension Physical Assessment.

4.15 Comprehensive Physical Assessment [Contract Provider]  
Satisfactory Compliance

The Comprehensive Physical Assessment (CPA) form shall be completed for all youth admitted into the physical custody of a DJJ facility.

Seven youth records were reviewed and all seven contained a completed Comprehensive Physical Assessment (CPA). All seven CPAs were completed within seven days of admission. Two were completed by the medical doctor and five were performed by the advanced registered nurse practitioner. All seven CPAs had medical grades listed on the assessments. All the required fields of body mass index, visual, tanner stage, scalp, head, cardiovascular, medical grades, and tuberculosis results were completed. No blocks were left blank. Genital exams, when not clinically indicated, were marked as such. When youth refused genital exams, they signed a separate form. A review of the center’s facility operating procedures does not require youth to sign or initial any part of the exam, if they refuse. Each youth had an updated problem list with their healthcare record.

4.16 Female-Specific Screening/Examination [Contract Provider]  
Satisfactory Compliance

The Department requires all adolescent girls receive gender-appropriate screenings, examinations, and tests to address their unique needs.

Two of the seven youth reviewed were female. One additional female youth record was reviewed. Each of the three females gave consent to complete pregnancy tests. The results of the testing were noted on the admission progress note. Youth consents are documented on the sexually transmitted infections screening form. None of the three youth were identified as being pregnant. Two females were surveyed and were asked if they received prenatal, obstetrical, or gynecological services when needed. One reported yes they have. The other one responded she has not needed the services. The two youth were also asked if they received female sanitary products when needed and each responded yes.

4.17 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.

Seven youth healthcare records were reviewed and all seven youth had at least one verified tuberculosis screening documented in the healthcare record. Tier 1 TB screening was completed on the Medical and Mental Health Screening form on the day of admission. All seven youth had a current TST at the time of admission and none of the seven required follow-up.
4.18 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).

All seven youth records reviewed were screened and evaluated upon admission for sexually transmitted infections (STI). The center’s standing physician order is to have all youth tested, with urine, for STIs upon admission. One of the seven youth refused the testing for STI and signed a refusal progress note. None of the youth needed further evaluations. Testing results were noted on the Infectious Communicable Disease form, as required. None of the seven youth were out of the Department physical custody for over thirty days. A review of the progress notes revealed documentation of sexually transmitted infections testing being completed, with results placed in the youth’s healthcare record.

4.19 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.

Seven youth records were reviewed for being offered counseling, testing, and treatment of Human Immunodeficiency Virus (HIV). HIV testing results are filed in a confidential manner within a sealed envelope, labeled “Confidential”.

There is an agreement with Outreach to provide HIV counseling and testing. The company comes to the detention center once a week, usually on Mondays. Testing and counseling is done for each youth who has consented to testing. Health Education Records documented pre- and post-test counseling for each youth who received testing. The center documents the HIV testing being completed, but not the results. The results are filed confidentially. Seven youth were surveyed and six reported they could ask for a HIV test and one reported he/she could not ask for a HIV test. The availability of HIV testing is addressed and documented during orientation, this information was documented in each record.

4.20 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 conducts regular sick calls twice a day, one from 9:00 a.m. to 11:00 a.m. and the other from 3:30 p.m. to 5:30 p.m. Sick call is held seven days a week, by a licensed nurse. Nurses are on-site from 5:00 a.m. to 9:00 p.m. Shift supervisors review sick call requests when a nurse is not on-site. This review is completed within four hours of receipt of the sick call form. None of the seven youth reviewed had a similar sick call complaint within a two-week period. None of the seven youth from the sample completed sick call requests. Youth have the sick call process explained to them during orientation to the center. Sick call requests are available to all youth through any of the staff. Seven youth were surveyed and four responded they could be seen by a nurse immediately, one reported within twenty-four hours, and the other two did not respond. Seven youth were also surveyed on their rating of the medical care at the center, one said very good, four reported it was good, one responded it was fair. One youth reported the medical care was poor; however, he also reported he could see a nurse immediately and see a doctor if needed.
4.21 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.

When the licensed practical nurse (LPN) conducted sick call, the registered nurse (RN) and/or the medical doctor reviewed them within twenty-four hours. All sick calls are placed into Facility Management System (FMS), which records the encounter on the sick call index and the sick call log. All sick calls notes contain vital signs and are written in the Subjective, Objective, Assessment, and Plan (SOAP) format. A youth signature is not entered on the electronic SOAP note. Seven youth were surveyed and all seven reported they could see a doctor, if needed. Seven staff completed a survey. All seven staff said sick calls are conducted by nursing staff, one reported staff also conducts sick call, and four responded other.

4.22 Restricted Housing [Contract Provider]  Satisfactory Compliance

All youth in Restricted Housing/Confinement shall have timely access to medical care, as required by the Department.

The center has a policy and procedures addressing the use of restricted housing. One youth was placed on medical restrictive housing status since the last annual compliance review because of injuries. Only the electronic records were available to review. The youth is documented to have been seen by healthcare staff daily, to check on his condition. According to the superintendent, there were no other youth placed on a restricted housing status since the last annual compliance review.

4.23 Episodic/First Aid Care [Contract Provider]  Satisfactory Compliance

The facility shall have a comprehensive process for the provision of Episodic Care and First Aid.

Two of the seven youth in the sample set required on-site first aid or emergency care. The center uses the Episodic (First Aid/Emergency) Care Log form. A review of the episodic log was inclusive of date/time of episodic care, name of the youth, DJJID, injury and/or illness, treatment rendered, staff initials, whether it was a registered or licensed nurse, referral, and if off-site care is necessary. None of the incidents required parental notification or youth being placed on an alert list. All incidents were completed by a nurse. Progress notes revealed all elements being outlined, as required. Observations during the tour revealed the center has seven first aid kits. All of the kits contained the approved contents. First aid kits are monitored on a monthly basis and replenished when needed. Two of the first aid kits contained expired eye wash when checked during the tour. Both expired items were replaced almost immediately with properly dated products.

4.24 Emergency Care [Contract Provider]  Satisfactory Compliance

The facility shall have established processes and procedures for either directly providing Emergency Care or facilitating an appropriate response to an emergency situation.

The center has a policy and procedures in place to address emergency care. This care consisted of staff receiving training on the automated external defibrillator (AED) and
The center has two AEDs, one in medical and the other in a shared sub control for two modules. Both of the units are the same brand and each contained a battery with an expiration date of January 2020 and pads with an expiration date of September 2017. Both of the batteries and the pads were changed in September 2016. The AED units are checked once a month to ensure they are ready for use. Both AEDs were tested in front of an MQI Regional Monitor and reported ready for use. Emergency telephone numbers were posted in the living areas. All staff, including direct care and medical staff, are trained on the use of Epi-Pen auto injector. The center conducts quarterly medical drills for each shift to address how to resolve emergency situations. The center was missing one emergency drill in the last year, which was for three to eleven shift. The emergency drills were documented and executed each quarter, on each shift, as required. The drill form included the type of drill, the date, what shift, if 9-1-1 was called, if the drill was placed in the master control logbook, the scenario (attached on a separate sheet), area to mark information on problems and concerns during the drill, a space to make recommendations to improve the emergency response, and signatures from the shift supervisor, facility administrator, medical staff, mental health staff, and dates. There have been no recommendations or critiques of any drill in the last year. The center has a designated hospital for emergency medical care. Seven staff were surveyed and all responded they could call 9-1-1.

**4.25 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.

Seven medical records were reviewed for off-site care and referrals. Three of the seven youth received off-site care. Two of the three included the Summary of Off-Site Care form. All three contained discharge documents, which were reviewed by the DHA, on his next visit. Off-site medical appointments are tracked when necessary. None of the events were emergency off-site care. Seven youth were surveyed and all seven reported they could see a doctor, if needed.

**4.26 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.

Four of the seven youth records reviewed had chronic conditions. All four youth with chronic conditions were initially seen by the designated health authority (DHA) and/or psychiatrist. Protocol procedures are set for youth with chronic conditions to be seen every thirty days, if they are still in the center. None of the youth had a communicable disease. Four of the youth were taking prescribed medications. Four of the youth had medical grades between two through five. All youth had updated problem lists. There was no indication youth had any lapse in medical care.

**4.27 Medication Management – Verification [Contract Provider]**

Satisfactory Compliance

A youth’s medication regimen shall be ascertained upon admission to the facility.

Four of the seven youth records reviewed were applicable for youth admitted to the center with medications. The center has a process in place through which all medications are verified upon
admission by nursing staff. This is accomplished through contacts with the pharmacies and doctors. Nursing staff state the parents usually bring in medications at admission. Only medications are current and in original bottle are accepted. The DHA and/or the psychiatrist are notified upon admission to get a verbal order whether to continue, change, hold, or discontinue the medication.

4.28 Medication Management – Orders/Prescriptions [Contract Provider]  
Satisfactory Compliance

All medications shall have a current, valid order and are given pursuant to a current prescription or Practitioner Order.

Five of the seven youth were admitted to the center on prescribed medications, only four had the actual medication at admission. All medications had current orders and are given according to written prescription. The DHA and/or the psychiatrist are notified on admission to get a verbal order whether to continue, change, hold, or discontinue the medication.

4.29 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.

Observations revealed all medications and sharps were locked and secured in the medical department and inaccessible to youth. The medical department keeps all non-controlled medications, such as over the counter medications, in a separate area, within a locked secure cabinet. All sharps are securely stored in a locked cabinet separate from other products. All refrigerated items are stored in a separate refrigerator, which is used only for medications requiring refrigeration. All oral and topical medications are stored separately from other medications. The center has a process in place for destruction of medications. Medical staff place the medication in a liquid and then it is picked up by a contractor for ultimate destruction. Only medical staff and trained supervisory staff have access to medications.

4.30 Medication Management – Medication and Sharps Inventory [Contract Provider]  
Satisfactory Compliance

All medications and sharps shall be inventoried, as per Department requirements.

Observations revealed all sharps are securely stored and have perpetual inventories. All the sharps are counted at least weekly and after each use. Inventory counts were conducted on three randomly selected sharps and each inventory matched the count. A perpetual inventory is also maintained for bulk stock medication. Medications are counted at least weekly, usually on Saturday, and logged. Inventories were checked on three randomly selected over the counter (OTC) medications. Two of the three inventories matched the physical count of medication. The inventory for one of the three OTC medications did not match the physical count. Diphenhydramine was counted at seventeen, but the perpetual inventory had sixty documented. The center has not recently received any new supplies of OTC medications. The discrepancy was noted as a transposing error instead of a physical count. Three prescribed medications were counted and the inventories matched the physical count.
4.31 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.

Observations confirmed controlled medications were secured behind at least two locks. Three controlled medication were currently at the center and each was counted. All counts were correct according to perpetual inventories versus the physical count. Perpetual inventories are done three times daily: in the morning, supervisor to nurse; in the afternoon, nurse to nurse; and at night, nurse to supervisor. The medical department has a process in place to address any discrepancies with inventory counts.

4.32 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.

Seven youth healthcare records were reviewed. Each of the seven utilized the standard Department of Juvenile Justice form to document youth medications. Observations of medication pass revealed youth initial when medications are given, even if given by nursing staff. Staff also initialed when medications were administered. All medications were given according to orders. The medication administration record (MAR) documented all required elements. Side effect monitoring was done by nursing staff on a weekly basis and documented on the MAR. Four of the seven youth were admitted to the center with prescribed medications. Progress notes revealed the DHA and/or the psychiatrist were called and a verbal order was placed to continue, stop, hold, or adjust the medications.

4.33 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.

One medication administration was observed for medications dispensed by licensed staff. The nursing staff ensured the five rights of medication administration (right youth, right medication, right route, right dosage, and right time) was accomplished at medication pass. All youth medication is administered individually. The youth’s mouth is checked to make sure medications were swallowed. Youth then initial the medication administration record (MAR) once medication was received and taken. Staff also initial the MAR. There were no youth at the center who needed parenteral medications. In the event parenteral medications are needed, only licensed nursing staff would administer the medications. Prescribed medication is not pre-poured. Seven youth were surveyed with three reporting medications are given to them by the nurse. The other four youth responded they did not take any medications.
### 4.34 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.

Trained and designated non-licensed staff are only allowed to assist in the self-administration of over-the-counter medications, such as Ibuprofen and Tylenol, after nursing hours. There are nurses on-site from 5:00 a.m. to 9:00 p.m. All non-licensed staff who administered medications place their initials on the medication administration record (MAR), deduct from the count, and fill out the standard form. The licensed nurses will review the MAR in the morning, as required. In the event an episodic incident occurs, the non-licensed staff would call the medical doctor to get orders to proceed. This information would be left for the nurse to review the following morning and then placed in the youth’s healthcare record.

### 4.35 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.

Records for three youth who were admitted with a prescription for psychotropic medication were reviewed. The psychiatrist was notified of each youth upon admission. An order was obtained from the psychiatrist, by a licensed nurse, to resume, hold, discontinue, or change the medications. A psychiatric evaluation was conducted within fourteen days, by the psychiatrist, in each case. The psychiatrist completed the Clinical Psychotropic Progress Note (CPPN), as required. Medication monitoring was completed every thirty days by the psychiatrist. The licensed nurse monitors youth for side effects at least on a weekly basis.

### 4.36 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 facility operating procedures include an infection control policy and procedures to address common infectious diseases. The plan states each newly admitted youth will be screened for healthcare needs and the signs and symptoms of serious infectious diseases. The screening contains questions regarding signs and symptoms of tuberculosis, Human Immunodeficiency Virus (HIV), sexually transmitted diseases, hepatitis, and observations of signs and symptoms of viral respiratory illnesses. Staff and youth are also to be trained on universal precautions, which includes handwashing, personal protective equipment, health care equipment, and maintenance of a safe, clean, and healthy environment. There were no cases of reportable infectious diseases since the last annual compliance review.
4.37 Infection Control – Education [Contract Provider]  
Limited 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.

Seven pre-service staff training files were reviewed for infection control training topics and each of the staff had training in infection control, exposure control, and blood borne pathogens. Seven in-service training files were reviewed and none received training in infection control, exposure control, and blood borne pathogens in 2016. Of the seven youth records reviewed, all had received infection control training within seven days of admission. Training topics included hand washing, universal precautions, prevention of communicable diseases, vaccinations, and guidelines for infection control.

4.38 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 facility operating procedures include an exposure control plan, which was signed and dated on August 5, 2016, by the designated health authority (DHA) and superintendent. The exposure control plan includes the risk assessment and methods of compliance, as required. The procedures outline practices to provide management of any communicable disease in the center. This procedure includes necessary steps for administrative staff, healthcare staff, and the local health department. The procedures include prevention, containment, treatment, and reporting requirements.

4.39 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.

Three closed records were reviewed for the delivery of prenatal services. Each of the three girls was pregnant at the time of admission. The nursing staff implemented prenatal services upon each youth’s admission to the center. Staff documented each day potential warning signs of difficulties with each youth’s pregnancy. The designated health authority was contacted at the time of admission and whenever a youth complained about her pregnancy. The nursing staff were not able to do a thirty-day follow-up with any of the youth, as they were all discharged from the detention center.

4.40 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.

Three closed youth records were reviewed for girls who were pregnant. All three of the youth were admitted to the center already diagnosed as pregnant. A review of the practitioner’s orders
included prenatal vitamins daily, weekly vital signs, regular diet unless otherwise stipulated, two mattresses for comfort, obstetrician education packet, no strenuous activity, and notify designated health authority if fever is over 101. The center completed a pregnancy treatment flow sheet including daily monitoring of weight, blood pressure, and urine dipstick.

<table>
<thead>
<tr>
<th>4.41 Prenatal Staff Education [Contract Provider]</th>
<th>Satisfactory Compliance</th>
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</thead>
<tbody>
<tr>
<td>All non-healthcare staff involved in the supervision or treatment of pregnant youth shall receive appropriate education.</td>
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</table>

A review of seven staff training files revealed all staff received in-service training from a nurse on prenatal and pregnancy topics. Each of the seven staff received education on pregnant youth relating to observations and emergency care of pregnant youth.
Standard 5: Safety and Security

Overview

Juvenile justice detention officers (JJDO) and supervisors are responsible for the supervision of youth in the detention center. Staff used two-way radios to communicate general information, such as movements and counts, as well as call for assistance in emergency situations. Staff conduct ten-minute checks anytime a youth is in a sleeping room. Master control staff are responsible for documenting youth counts at the beginning and ending of each shift and various times throughout each day. The center has experienced a higher than usual vacancy rate during the past year, but has ensured adequate staffing levels to meet established staff-to-youth ratios.

The center has four modules, three of which are for male youth and one is for female youth. One of the male modules is not used for sleeping purposes, but is used for activities during the day. There is an outside recreation area, which is enclosed by fencing, lined with no climb mesh, and topped with razor wire. School portables are adjacent to the outside recreation area and also enclosed by fencing.

Security of tools and chemicals is typically the responsibility of the maintenance mechanic, but the maintenance mechanic was out on extended medical leave at the time of the annual compliance review. Other staff have covered this responsibility while the maintenance mechanic has been out. Food service personnel are responsible for the inventory and security of knives and other kitchen items.

5.01 Active Supervision of Youth

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.

Review team observations found detention staff maintained active supervision of youth at all times. Observations clearly indicated a minimum of two juvenile justice detention officers (JJDO)
in supervision of youth during daily activities. When youth are participating in large muscle activities outside, a minimum of three staff were noted during observation. Interviews with youth and JJDOs indicates juvenile justice detention officer supervisors (JJDOS) are also present for added supervision. Staff interactions with youth were observed to be positive and pleasant in all cases. Seven staff were surveyed and each staff felt there has been enough staff to provide for the safety and security of the youth and the staff.

5.02 Ten-Minute Checks

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<tr>
<td>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.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>There shall be no obstructions (e.g., clothing, memos, pictures) over windows and areas where direct line of sight is needed.</td>
</tr>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

All ten-minute checks are done using a wand system recording the date, time, and staff conducting the check. Staff tap a metal pin by each room with the wand. Video tapes were observed on three different nights and various shifts for the completion of ten-minute checks by staff. The review of the tapes and electronic documentation found staff conducted checks of youth in their sleeping rooms every ten-minutes or less, with most checks being completed prior to the ten-minute requirement. Seven staff completed a survey and each staff reported youth placed in their rooms for sleeping or non-punishment reasons are checked at least every ten minutes.

5.03 Census, Counts, and Tracking

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<tbody>
<tr>
<td>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:</td>
</tr>
<tr>
<td>• At the beginning and end of each shift.</td>
</tr>
<tr>
<td>• 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.</td>
</tr>
<tr>
<td>• Prior to and following routine group movement.</td>
</tr>
<tr>
<td>• Any time a population change occurs.</td>
</tr>
<tr>
<td>• Randomly, at least once on each shift.</td>
</tr>
</tbody>
</table>

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).
Census counts conducted in accordance with Department standards and the center’s policy and procedures. Counts are conducted and logged in the master control log book at the beginning of each shift, mid-shift, and at the end of shift. Counts were observed being taken prior to and after group movements, with each movement and count reported to master control. Located in master control is a board utilized to track admissions, discharges, secure detention census, home detention census along with identifying module assignments for each youth. Each module also records counts in their logbooks, which mirrored the master control logbooks of youth movements and counts. Seven staff were surveyed and each staff was familiar with the requirement for emergency counts, indicating emergency counts would be completed if a youth was believed to be missing, or if a count does not reflect the correct number of youth.

### 5.04 Key Control

<table>
<thead>
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<tbody>
<tr>
<td>Each facility is responsible for maintaining inventory and control of all facility keys.</td>
</tr>
<tr>
<td>All keys shall be placed on a tamper-resistant key ring designed to inhibit the removal of keys.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>The key(s) on these rings shall provide egress through facility exterior doors providing access to evacuation areas.</td>
</tr>
<tr>
<td>A key inventory shall be maintained by the Superintendent or designee at all times.</td>
</tr>
</tbody>
</table>

(For the entire indicator statement, please reference the Monitoring and Quality Improvement FY 2016-2017 Detention indicators.)

The center has a policy and procedures for key control. Staff interviews confirmed staff are aware of the policy and demonstrate the procedures daily. The center uses a chit system to account for keys, with each staff being assigned a chit they must turn in, along with their personal keys, to get facility keys. The chit is placed on the hook for the keys assigned to the staff, which identifies the staff has those keys. Observation of shift change found the key procedures were followed. Staff were able to explain the procedure in place for keys lost, damaged, or taken home. There have been no instances of lost or damaged keys in the last six months, but there was one instance in which a staff mistakenly exited the shift with their facility keys. Staff followed proper procedures of ensuring the center was contacted and the keys were returned within the allotted time frame. Seven staff were surveyed and all staff were able to explain the chit system for key assignment and how keys are tracked. The staff indicated keys to medical, mental health, and property were restricted. Direct care staff reported their keys only open doors to the modules, common areas, and classrooms.
### 5.05 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 total of six vans used for transporting youth. Each van was observed to have a knife for life, window punch, seat belt cutter, and first aid kit. All first aid kits were equipped with the required materials, none of which were out of date. Each van also had a fire extinguisher, which was inspected and in compliance. Annual vehicle inspections for all vehicles were completed in January 2017. Documentation showed vehicles are inspected prior to the morning shift and again before any transports. All vehicles have seat belts, which are intact and accessible for use.

### 5.06 Tool Inventory and Management

**Satisfactory Compliance**

The program ensures all tools and equipment related to maintenance are properly maintained, stored, and inventoried.

The center has a policy and procedures for tool inventory and management. Staff interviewed were familiar with the policy and what to do if a tool is missing. Tools are kept in the maintenance office, which is locked at all times when not in use. Within the maintenance office is a shadow board and locked tool boxes for the storage of tools. There is a sign-out/sign-in log to document whenever tools are used and returned. All tools observed were marked with an identifying label. Daily and monthly inventories are completed to ensure there are no missing tools, with the monthly inventory being reviewed and signed by the superintendent or designee. A review of the inventories along with observation of the shadow board found the inventories were accurate and all tools were present.

### 5.07 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.

Kitchen knives and other hazardous kitchen sharps are stored in locked drawers when not in use. An itemized inventory is taken of all kitchen tools at the beginning and end of each kitchen shift. The inventory was reviewed and found to be accurate. The food service manager was interviewed and able to clearly explain the policy and procedures for kitchen tools. Seven youth were surveyed, none of the youth reported they were allowed access to kitchen tools.
## 5.08 Youth Access & Use of Tools, Cleaning Items

<table>
<thead>
<tr>
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<tbody>
<tr>
<td><strong>Youth are forbidden to use or access any tools, including kitchen or medical equipment.</strong></td>
</tr>
<tr>
<td><strong>Youth may use cleaning items such as mops, brooms, buckets, and other common household items under direct supervision.</strong></td>
</tr>
</tbody>
</table>

Youth assist with cleaning, but only under the direct supervision of staff. Seven youth and seven staff were surveyed, none of the youth or staff indicated youth are allowed access to tools other than mops or brooms used during cleaning, which conducted under staff supervision.

## 5.09 Inventory of all Flammable, Toxic, Caustic, and Poisonous Items

<table>
<thead>
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<tbody>
<tr>
<td><strong>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.</strong></td>
</tr>
<tr>
<td><strong>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.</strong></td>
</tr>
<tr>
<td><strong>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.</strong></td>
</tr>
<tr>
<td><strong>No hazardous chemicals should be mixed, as this could result in an explosion or emission of toxic gas.</strong></td>
</tr>
</tbody>
</table>

The detention center has a safety plan in place, which addresses the inventory and storage of flammable, toxic, caustic, and poisonous items. Personnel responsible for the inventory and storage of flammable, toxic, caustic, and poisonous items were interviewed and familiar with the requirements outlined in the safety plan. All flammable, toxic, caustic, and poisonous items were securely stored in a locked cabinet located outside the kitchen. Inventories for the items were reviewed and found to be accurate. Material Safety Data Sheets (MSDS) or Safety Data Sheets (SDS) for each item were kept in the secured cabinet.

## 5.10 Access to all Flammable, Toxic, Caustic, and Poisonous Items

<table>
<thead>
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<tbody>
<tr>
<td><strong>Flammable, toxic, caustic, and poisonous fluids and other dangerous substances may only be drawn or acquired by authorized personnel.</strong></td>
</tr>
<tr>
<td><strong>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.</strong></td>
</tr>
</tbody>
</table>

Flammable, toxic, caustic, and poisonous items are stored in a locked cabinet located outside the kitchen. Staff interviews indicated this cabinet is locked at all times and only designated personal have access. Youth are not permitted to handle cleaning chemicals. If youth assist
during cleaning, staff maintain the cleaning chemicals at all times and spray surfaces to be clean, which youth wipe up afterward. Seven staff were surveyed and all staff said youth are not allowed to handle cleaning chemicals or any other type of toxic item. Five of the seven youth reported they do not clean with any type of cleaning chemicals. Two of the seven youth reported they assist with cleaning, but staff maintain control of the cleaning chemicals and youth simply wipe up after staff spray the surface being cleaned.

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

The center has a policy and procedures for the disposal of flammable, toxic, caustic, and poisonous items. The kitchen manager was interviewed and able to explain disposal procedures. The center uses the local landfill to assist with the disposal of flammable, toxic, caustic and poisonous items. Documentation showed items were disposed of in accordance with protocols found in the Material Safety Data Sheets (MSDS) or Safety Date Sheets (SDS).

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

The center has a policy and procedures for the use of confinement under twenty-four hours. Interviews with an assistant superintendent and juvenile justice detention officer supervisor (JJDOS) found they were familiar with confinement procedures. The center uses youth sleeping rooms for youth placed in confinement. Room windows were free of obstructions. Five confinements under twenty-four hours were reviewed. Each report documented the youth and room used for confinement were searched, prior to the youth being placed in the room. Each confinement report was completed and submitted to the JJDS within one hour of the incident. All five confinement reports documented JJDS reviews within two hours to determine fairness and appropriateness. All five confinements had documentation of JJDS reviews within every three hours to determine the need for continued confinement. All five confinement reports were reviewed by the superintendent or designee within forty-eight hours. Seven staff completed a survey, which confirmed the use of confinement at the center.
5.13 Confinement Over Twenty-Four Hours

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

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

Documentation reviewed found two youth had been placed in confinement for more than twenty-four hours. In each instance, approval to extend the youth beyond twenty-four hours was granted by the superintendent or designee within every twenty-four-hour period, which included the reason(s) for continued confinement. Documentation in each case showed the youth and room used for confinement were searched, prior to the youth being placed in the room. Each report documented JJDO(s) reviews at or within three-hour intervals to determine the need for continued confinement, based on the severity of the rule violation, past disciplinary history, or behavior in confinement. Neither youth remained in confinement beyond three days.

5.14 Continuity of Operations Planning (COOP) Drills

COOP drills shall be conducted and documented, at minimum, twice a year, with one drill being completed prior to the hurricane season, which begins June 1st.

A review of the drill binder and logbooks found the center exceeds the requirement for Continuity of Operations Planning (COOP) drills being completed twice a year. A hurricane drill was conducted in June 2016 and the center had to actually evacuate for Hurricane Matthew in October 2016. Seven staff completed a survey. Staff responses to the survey indicated each staff had participated in multiple COOP related drills.

5.15 Escape Drills

The center shall develop, implement, and maintain an escape prevention plan incorporating the Department’s established policies and procedure regarding escapes.

The facility shall conduct and document quarterly mock escape drills.

The center has an escape prevention plan incorporating the Department’s established policies and procedure regarding escapes. Documentation showed escape drills were conducted quarterly, as required, with drills conducted on each shift quarterly, with one exception, which was the second shift during the last quarter of 2016. Each drill was documented in the master control logbook.
5.16 Fire Drills

Management has implemented a disaster preparedness plan and fire prevention plan.

Monthly fire drills (with procedures being approved by local fire officials) are documented and conducted under varied conditions and on each shift.

The center has a fire prevention plan approved by local fire officials. The most recent annual inspection was completed in January 2017. One minor deficiency was noted during the annual inspection. The center corrected the issues prior to the corrective action due date. Documentation showed fire drills are conducted monthly on each shift, with few exceptions. Fire drills were not documented for the first shift in March 2017 and for the first and third shifts for October 2016 (note: the center was evacuated for multiple days in October 2016 due to Hurricane Matthew). Seven staff were surveyed and each staff reported fire drills are conducted monthly on each shift. Seven youth were surveyed and all reported they had been told what to do in case of a fire.

Program Name: Volusia Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: Volusia County / Circuit 7
Review Date(s): April 4-7, 2017

MQI Program Code: 139
Contract Number: NA
Number of Beds: 64
Lead Reviewer Code: 37

Overall Rating Summary

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

<table>
<thead>
<tr>
<th>Limited Ratings</th>
<th>Failed Ratings</th>
</tr>
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<tbody>
<tr>
<td>1.02 Five-Year Rescreening</td>
<td></td>
</tr>
<tr>
<td>4.37 Infection Control - Exposure Control Plan</td>
<td></td>
</tr>
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