STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Collier Regional Juvenile Detention Center

Department of Juvenile Justice

(State-Operated)
3351 Tamiami Trail
Naples, Florida 34112

Review Date(s): November 19-22, 2019

Promoting Continuous Improvement and Accountability
in Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Marissa Stress, Office of Program Accountability, Lead Reviewer ([Standard 1)
Douglas Kane, St. Lucie Detention Center, Juvenile Detention Officer Supervisor (Standard 5)
Patrick Morse, Office of Program Accountability, Regional Supervisor (Standard 3)
Maryann Sanders, Office of Program Accountability, Regional Deputy Supervisor (Standard 4)
Yvrose Sylvain, Office of Program Accountability, Regional Monitor (Standard 2)

Program Name: Collier Regional Juvenile Detention Center	MQI Program Code: 997
Provider Name: Department of Juvenile Justice	Contract Number: N/A
Location: Collier County / Circuit 20	Number of Beds: 40
Review Date(s): November 19-22, 2019	Lead Reviewer Code: 178

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.02 Five-Year Rescreening	

Standard 1: Management Accountability
Detention Rating Profile

Indicator Ratings

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

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

Standard 2: Youth Management
Detention Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Detention Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Detention Rating Profile

Indicator Ratings

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

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Program Overview

The Collier Regional Juvenile Detention Center is a state-owned detention facility, operated by the Department, located in Naples, Florida. The center serves youth in Collier, Lee Hendry, and Glades Counties in Circuit 20. Male and female youth who are detained pending adjudication, disposition, or placement in a residential commitment program are housed in the forty-bed center. Youth are provided services which include youth orientation, behavior management, safety and emergency procedures, transportation, mental health, and healthcare services. The center's educational services are provided by the Collier County School District. The center's management team includes the superintendent, assistant superintendent, one administrative assistant, one food service director II (FSDII), and training coordinator. The center maintains a contract with Maxim Healthcare Services, Inc. to provide mental health and substance abuse services. Maxim Healthcare Services, Inc. subcontracts with Camelot Community Care, Inc. to provide comprehensive mental health and substance abuse services and psychiatric services. Mental health services are provided by a State of Florida licensed psychiatrist, licensed clinical social worker counselor (LCSW) who serves as the designated mental health clinician authority (DMHCA), and two non-licensed bachelor's-level mental health and substance abuse clinical staff who work under the direct supervision of the LCSW. Clinical services provided by the center include mental health and substance abuse evaluations, mental health treatment planning, individual, group, and family therapy, mental health crisis intervention services, on-site psychiatric services, and availability for substance abuse services for youth with co-occurring disorders. The center has a current contract with Maxim Healthcare Services, Inc. to assume responsibility for the provision of medical services to all youth. All healthcare staff are employed by Maxim Healthcare Services, Inc. Medical services are provided by the osteopathic physician (DO) who serves as the center's designated health authority (DHA), advanced registered nurse practitioner (ARNP), one registered nurse, and two licensed practical nurses. The medical clinic maintains nursing coverage is provided seven days a week from 7:00 a.m. to 7:00 p.m. Food services are provided by Department staff and include menus, meal planning, meal schedules, special diets, nutritional analysis, daily allowance, food preparation, health certifications, food product standards, sanitation, and cleaning. Staff are responsible for the custody and control of youth in their care, providing youth supervision twenty-four hours a day, seven days a week. The center has two living modules which are divided by male and female and one honors module for youth which have earned and maintained a level three on the behavior management system. A tour of the center was conducted by the annual compliance review team during the week of the review and observations found there are sixty-four security cameras at the center, of which all were operational. The center was observed to be clean and free from insect infestation. Common areas, living modules, bathrooms, classrooms, kitchen, and dining areas were observed to be clean, organized, and well maintained. The center had minimal graffiti etched into the Plexi-glass of the youth cells. The living and the common areas were observed to be newly painted. Outside grounds and the perimeter area appeared to be intact and did not have any observed security issues. At the time of the annual compliance review, the center had six vacancies, which included five juvenile justice detention officers (JJDO I) and one food service worker.

Standard 1: Management Accountability

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

The center maintains a written policy and procedures ensuring all Department employees, contractors, and volunteers are background screened prior to hire. Prior to hire, background screenings are conducted on all Department staff, contractors, volunteers, mentors, and interns. The center hired eleven employees and three contractors during the annual compliance review period. The center did not have any new volunteers during the annual compliance review period. A review of eleven staff records and three contractor records confirmed background screenings were completed by the Department's Background Screening Unit (BSU)/Clearinghouse, prior to each individual's date of hire and/or contact with youth or access to confidential information. None of the newly hired staff required an exemption. Each newly hired staff's Florida Department of Law Enforcement (FDLE), criminal history, Staff Verification (SVS) module, and Department's Central Communications Center (CCC) Person Involvement Report were reviewed. Each Department's direct care staff is required to complete a pre-employment assessment and receive a passing score. Reviewed documentation validated a pre-employment assessment was completed by each newly hired direct care staff and a copy of the passing score was maintained in each staff's electronic personnel record. The three contracted staff background screenings were processed and maintained in the Clearinghouse database. An Affidavit of Compliance with Level 2 Screening Standards was completed and submitted to BSU on November 13, 2018 and for school board teachers on January 23, 2019, meeting the annual requirement.

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

The center maintains a written policy and procedures ensuring five-year background rescreenings are completed. A background rescreening is completed on all Department staff, contractors, and volunteers every five years based upon their original date of hire. Rescreening documentation must be submitted to the Department's Background Screening Unit (BSU)/Clearinghouse at least ten days prior to the staff's five-year anniversary date. The center maintains a staff roster which is reviewed routinely by the center's administrative staff to

determine when a five-year rescreening is required. A review of the staff roster found two Department staff were applicable for five-year rescreening since the last annual compliance review. Reviewed documentation found both background rescreenings were completed past the staff member's anniversary hire date. One background screening was completed twenty-two days late and one was completed fifty-six days late. One of two screenings was not submitted to the BSU/Clearinghouse within ten days of the staff's anniversary hire date. The screening was submitted fifty-six days after the staff members' anniversary hire date. The other reviewed rescreening was submitted on September 18, 2019 which was within ten days of the staff member's anniversary hire date; however, there was no follow-up with the BSU until November 14, 2019 in which the BSU informed the center the paperwork was never received. The center resubmitted the paperwork on November 14, 2019. The rescreening was subsequently completed on November 15, 2019 which resulted in the rescreening being completed twenty-two days late.

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

The center maintains a written policy and procedures ensuring all staff adhere to a Code of Conduct. The center utilizes the Department's employee handbook, which contains a Code of Conduct. Staff are required to adhere to the Code of Conduct which prohibits any form of abuse, profanity, threats, harassment, intimidations, or personal relationships with youth. Five applicable staff personnel records were reviewed, and each contained a signed acknowledgement, receipt, and review of the Department's Code of Conduct, which was completed during their phase one training period. An additional three personnel records were reviewed for disciplinary action. Documentation found each staff received a written reprimand for violations of the Department's Code of Conduct. An additional three personnel records were reviewed for commendations. Documentation validated two staff received Employee of the Month awards and one staff received Food Service Director of the Year. A review of the internal incidents, Department's Central Communications Center reports, and Protective Action Response reports confirmed there were no incidents which should have been documented as a violation of Code of Conduct but were not. An interview with the center's superintendent was conducted and confirmed the center adheres to a strict Code of Conduct, inclusive of youth's confidentiality, prohibiting staff horseplay, verbal or physical abuse, and any personal

relationship with staff and youth. Additionally, staff who violate the Code of Conduct are subject to an internal investigation and disciplinary action. Five randomly selected staff were interviewed regarding the working conditions of the center. Three staff reported the working conditions are very good, and two staff indicated the working conditions were good. Each of the interviewed staff reported they have never seen a co-worker threaten or use profanity when speaking to a youth. Five randomly selected youth were interviewed. Each youth reported staff are respectful and they have never heard staff use curse words towards another youth. Each interviewed youth reported they have never been threatened by a staff member and they have never seen a staff member threatened another youth.

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

The center maintains a written policy and procedures ensuring all incidents are reported to the Department's Central Communications Center (CCC). The center shall notify the CCC within two hours of a reportable incident or within two hours of becoming aware of the reportable incident. The center had twenty-five incidents reported to the CCC since the last annual compliance review. The center indicated twenty-seven reportable incidents during last year's annual compliance review; therefore, demonstrating a reduction in reported incidents. The center had seven incidents reported to the CCC during the last six months, of which five were reviewed. Documentation validated each incident was reported to the CCC within the mandatory two-hour time frame and in accordance with the CCC reporting procedures. The center maintains a master control logbook for documenting reports to the CCC. A review of the logbook validated four out of five reports were documented. A review of internal incidents and grievances for the past six months determined there were no incidents which should have been reported to the CCC but were not. An interview was conducted with the center's superintendent and confirmed all staff must contact the Department's CCC within two hours of a reportable incident occurring. Additionally, all staff are mandated reporters and must contact the Florida Abuse Hotline if any abuse or neglect allegations are made. The center's superintendent reported all youth are afforded the opportunity to utilize the telephone to report any abuse or neglect allegations. Five randomly selected staff were interviewed and reported all youth have unhindered access to the Florida Abuse Hotline and CCC. Each interviewed staff confirmed they notify a supervisor when a youth wants to make a call to the Florida Abuse Hotline or CCC. Additionally, each staff can make a call the Florida Abuse Hotline or CCC if they feel a call is warranted. Five youth were interviewed, and each reported they have never been stopped from making a call to the Florida Abuse Hotline or CCC. Each interviewed youth reported feeling safe at the center.

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

The center maintains a written policy and procedures ensuring Protective Action Response (PAR) techniques utilized in the center are in accordance with Florida Administrative Code. All

administrators and officers shall be trained in PAR. A PAR report will be generated any time a PAR incident occurs. PAR reports shall include a review by a PAR certified instructor/supervisory staff, post-PAR interview, and a review of the PAR incident report by the superintendent or designee within twenty-four hours of the incident, excluding weekends or holidays. The center had fifty-eight PAR reports completed within the last six months, of which six reports were reviewed. Reviewed documentation confirmed each report included statements from all staff involved and were completed by the end of the staff member's workday. A review of the PAR incident reports found documentation supported each report contained a review by a PAR-certified instructor and documented a post-PAR interview with the youth conducted within thirty minutes of the incidents. None of the reviewed reports required a Mechanical Restraint Supervision Log to be completed. None of the reviewed PAR reports alleged any injuries or required a PAR medical review. Documentation confirmed each report was reviewed and processed within the mandated time frame by a juvenile justice detention officer supervisor and PAR instructor to determine if the use of force was consistent with the center's procedures in each PAR report. Each post-PAR interview documented the date, time, and signature of the individual conducting the interview. Each post-PAR interview was filed in each youth's Individual Healthcare Record. Each reviewed PAR report contained a review of the PAR incident report by the superintendent or designee within seventy-two hours of the incident. None of the reviewed reports required a report to the Department's Central Communications Center (CCC), and there was no documentation to support any involved youth made a report to the Florida Abuse Hotline. Logbooks and internal incident/grievance reports were reviewed, and documentation did not reveal any additional PAR incidents occurred. The center has experienced in an increase in PAR incidents since the last annual compliance review. An interview with the center's assistant superintendent was conducted. The center's assistant superintendent attributed the increase in PAR incidents to increase in population of youth. The center has been assisting other detention center's with housing which has increased the center's typical youth population. However, the center's PAR rate during the annual compliance review period was 22.60, which is below the statewide Detention PAR rate of 23.40. An interview was conducted with the center's superintendent and confirmed PAR reports are entered in the Facility Management System (FMS). All PAR reports are reviewed by juvenile justice detention officer supervisors, the PAR instructor, and an administrator. The superintendent or designee has seventy-two hours to review the PAR incident report and video footage and ensure the Post-PAR review, supervisory review, and PAR instructor review were all completed correctly. Additionally, the center reviews logbooks and youth grievances regularly to determine if a reportable incident was not entered into FMS. Five staff were interviewed, and each confirmed verbal techniques are used prior to using physical or mechanical restraints. A review of five pre-service and five in-service staff training records found each staff received PAR training approved by the Department's Office of Staff and Development and Training.

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

The center has a written policy and procedures ensuring all newly hired staff are trained in accordance with Florida Administrative Code within 180 days of hire. Pre-service training is divided into two phases. Phase one consists of instructor-led and web-based courses. Phase two consists of 120 hours of academy instructor-led training. Five staff training records were reviewed for pre-service training. Four out of five reviewed records found four staff completed

the certification process within 180 days of hire. One staff has not yet completed the certification process; however, has not been employed 180 days. All reviewed records found each of the five reviewed staff completed the required trainings inclusive of Protective Action Response (PAR), first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), mental health services, substance abuse services, suicide prevention, safety and security emergency plans, human trafficking, Department detention facility operations, supervision, active shooter, and Prison Rape Elimination Act (PREA) prior to having any contact with youth. A review of five training records found documentation to support each staff completed phase one training. Four out of five staff completed phase two training. One staff is currently scheduled to attend the academy January 6, 2020 and will complete phase two training prior to their 180 days of hire. All training was conducted by qualified trainers and documented in the Department's Learning Management System (SkillPro). An interview with the center's superintendent was conducted which confirmed all juvenile justice detention officers are required to complete certification requirements within 180 days of hire date.

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

The center has a written policy and procedures ensuring all staff complete at least twenty-four hours of in-service training annually, including mandatory topics specified in Florida Administrative Code. The center has a written in-service training plan which was submitted to the Department's Office of Staff Development and Training on January 7, 2019 and approved on January 14, 2019. Five staff training records, which included two juvenile justice detention officer supervisor (JJDOS) training records, were reviewed for in-service training. Each staff training record documented staff exceeded the required twenty-four hours of in-service training. Each staff training record had current certifications in Protective Action Response (PAR). Two out of five staff training records were missing annual cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), and first aid training for 2018. However, each staff member had documentation which showed a current certification for CPR/AED and first aid for 2019. Each staff completed training in professionalism and ethics. Three out of five staff did not complete the required six hours of suicide prevention training of which two staff were missing four hours of the instructional led training and one staff was missing three and a half hours of the instructional led training. Each staff completed the active shooter training requirement. Two JJDOS training records were reviewed for completion of the eight hours of management and supervisory training inclusive of management, leadership, personal accountability, employee relations, communication skills, and fiscal. Reviewed documentation supported one out of two JJDOS was missing two of the eight required supervisory training hours. The other JJDOS exceeded the eight-hour training requirement with a total of fifty-two supervisory training hours. All trainings were delivered by qualified trainers and documented in the Department's Learning System (Skillpro). The center maintains an annual training calendar which is updated to reflect any changes. The calendar was last approved by the Department's Office of Staff and Development and Training on January 14, 2019. An interview with the center's superintendent confirmed staff are required to complete PAR, CPR/AED, first aid, active shooter, and suicide prevention training annual.

1.08 Entering Alerts (JJIS) and Sharing of Alert Information (Critical)	Satisfactory Compliance
Superintendents shall ensure Critical and Special Alerts are reviewed and responded to appropriately. *Upon completion of the Admission Wizard, the officer shall ensure all Critical and Special Alerts are listed in JJIS.* *The JJIS alert report shall be reviewed daily by supervisors and administrators to ensure it correctly reflects the status of youth.* *If the electronic system is inoperable, for any reason, the JJDO Supervisor shall ensure the last hard copy of the alerts shall have a written notification or update of the recent admissions or changes to existing alerts on the alert sheet and distribute to all staff within the center immediately.* *Medical and mental health staff shall review alerts to ensure each alert is correctly tracked and managed.* *The responses and updates by medical, mental health and other staff should be documented in JJIS alerts as they pertain to the specific alert.* *JJDOS's shall inform staff of alerts during shift briefing. When a JJDOS receives changes to the alert list, he/she shall notify the staff affected by changes and add the information to the shift briefing for the oncoming shift upon receipt of the information.*	

The center maintains a written policy and procedures ensuring alerts are entered into the Department's Juvenile Justice Information System (JJIS) and the use an internal alert system. Critical and special alerts are reviewed, updated, and responded to appropriately. Staff maintain a copy of the detailed alert list with them at all times. An interview with the center's superintendent was conducted and confirmed medical alerts are entered during admission and updated when necessary. Internal alert reports and the JJIS alert reports are distributed and reviewed during shift briefings daily by the juvenile justice detention officer supervisor (JJDOS) and administration. Alerts are announced at shift briefings and hard copies are distributed to all direct care staff. A current alert list is also maintained in the kitchen and in the medical clinic. During the annual compliance week, an observation of shift briefing was conducted which supported this practice. Five randomly selected staff were interviewed, and each staff reported they are made aware of alerts through shift briefings and the daily alert list. Each staff confirmed management informs staff about issues throughout the center through staff briefings. Additionally, three staff members also stated email communication is utilized for staff communication and one staff reported all staff meetings are utilized as well. A review of five youth records found a total of twenty-two alerts which were required to be entered into the internal alert system and the JJIS alert system. Reviewed documentation supported each youth had the appropriate alert entered in the internal alert system and the JJIS. A review of the center's logbook found each alert was properly documented in the center's logbook as required. The superintendent confirmed only medical staff can remove or downgrade a medical alert, only mental health staff are able to remove or downgrade a mental health alert, and only administrative staff can remove or downgrade safety and security alerts.

Standard 2: Assessment and Performance Plan

2.01 Admission	Satisfactory Compliance

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

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

The center maintains a written policy and procedures to ensure the proper screening, evaluation, and documentation is provided for each youth admitted into the center. Five youth records were reviewed for the admission process. Each youth record included an affidavit/custody order, Detention Risk Assessment Instrument (DRAI), and the Suicide Risk Screening Instrument (SRSI). There was documentation to include youth were searched by a staff of the same gender, and received medical, mental health, and substance abuse screenings. All five youth were offered a telephone call during the intake process. Four of the five youth took the opportunity to make a telephone call to their parent/guardian and one youth record did not have documentation of a telephone call. Three of the five youth were admitted two or more hours prior to the next scheduled meal and were given a brown bagged meal. An observation of a youth admission was made during the annual compliance review. The youth was offered the opportunity to call a parent/guardian during the admission process. The youth watched the Prison Rape Elimination Act (PREA) video and after the video was over, staff asked if the youth had any questions. A picture of the youth was taken and uploaded into the Department's Juvenile Justice Information System (JJIS). During admission, the youth was given a bag meal due to the time of admission and while waiting for mental health staff to conduct an evaluation to determine room placement, the youth was given a hot meal during lunch. The youth was allowed to shower and was escorted by a same gender staff.

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

The center maintains a written policy and procedures to advise youth of center rules and regulations, expectations for behavior and related consequences for failing to meet those expectations, and youth rights within twenty-four hours of a youth being admitted into the center. Five youth records were reviewed and four included orientation documents which were completed within twenty-four hours of admission. One youth orientation documents did not include the date of completion. Each reviewed youth record maintained a copy of the Department's Juvenile Justice Information System (JJIS) Admission Wizard and youth orientation. Documentation indicated orientation was explained to each youth verbally by the staff and they were also given a brochure which included written information. Each youth signed, acknowledging they received the brochure. The orientation brochure included rules and regulations, youth rights, visitation, telephone calls, grievance procedures, access to medical, mental health, and substance abuse services, access to the Florida Abuse Hotline/Central Communications Center (CCC), and behavior related consequences. Destruction of property was included in the consequences section of the center's rules to include youth might receive possible new law violations for destruction of property. An observation of the orientation process was conducted during the annual compliance review. During the observation, staff provided the youth with the orientation brochure and explained the information in the brochure to the youth. The youth signed the paperwork, acknowledging receipt and their understanding of the information. The youth was informally interviewed by a member of the annual compliance review team during the orientation process and stated they understood the process and the information provided in the orientation brochure and did not have any further questions. Five youth were interviewed, and each youth stated when they were admitted to the center, they were provided information about the center's rules and regulations, daily schedule, education services, visitation, abuse reporting, and the behavior management system.

2.03 Classification	Satisfactory Compliance

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

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

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

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

The center maintains a written policy and procedures related to classification to ensure each youth is protected from harm, violence, and victimization, and to alert the center's staff of any special needs a youth may have before the youth is assigned to a room or introduced into the general population. The center considers several factors prior to placing youth into a room inclusive of height, weight, age, gender, level of aggression, mental illness, development disabilities, physical disabilities, history of violence, gang affiliation, criminal history, history of sexual offenses, vulnerability to victimization, suicide risk, medical and security, and escape risk. Five youth records were reviewed, and each included a copy of the Department's Juvenile Justice Information System (JJIS) Admission Wizard documentation results which included documentation of consideration of potential safety and security concerns in room assignment which included the youth's gender, height, weight, age, and level of aggressiveness. Each youth classification form identified any special needs and included all of the required elements. All youth were assessed using the Department's Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB). One of the five reviewed records documented the youth had a history of sexual offenses which was reduced to a lesser offense. The youth was placed in single occupancy cell to include alert of "single room only" due to sexually aggressive behavior or victim of sexual abuse and vulnerability to victimization. All five youth were assigned to a room based on their classification. None of the youth records reviewed were reclassified because of changes in behavior. An observation of the classification process was conducted during the annual compliance review. Staff were observed reviewing the secure detention wizard, completing the VSAB to determine vulnerability to victimization, reviewing alerts entered in JJIS, and the youth's offenses. The staff followed Department protocol regarding youth vulnerability and identifying the youth's type of aggression. An informal interview was conducted with the center's superintendent. The superintendent reported all staff are briefed on all alerts and pertinent information during daily shift briefings and provided an updated list of active alerts

for the youth currently in the center. The superintendent or assistant superintendent will enter an alert in JJIS for all youth which are verified as documented gang members.

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

The center maintains a written policy and procedures to ensure screening of all youth for possible gang involvement or an affiliation with any type of criminal street gang. The center has a juvenile probation officer (JPO) identified as the circuit gang representative, and referrals are submitted by e-mail to Collier County Sheriff's Office when it has been determined at admission, a youth is involved or has affiliation with any street gang for the first time. The center is required to enter "other suspected gang affiliation" alert in the Department's Juvenile Justice Information System (JJIS) if there is a youth suspected to have gang affiliation. Alerts are shared with staff daily at shift briefings. Five youth case management records were reviewed, and none were classified as gang members. An additional three youth records were selected which were identified as possible gang members and/or affiliates. Each youth was screened upon admission and documented on the admission wizard. Each applicable youth's gang information/alert was entered into JJIS. Each reviewed record contained a corresponding email to the Collier County Sheriff's Office and the circuit gang representative. The e-mail included a description of the incident and a copy and/or picture of the depiction of the gang affiliated event.

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

The center maintains a policy and procedures for the handling, storage, and return of youth property to ensure the center's staff is accountable for the security and proper handling of each youth's property. The youth's property is itemized and documented on the personal property form in the Department's Juvenile Justice Information System (JJIS) module. Five youth records were reviewed. Each of the five reviewed youth records contained a Property Receipt form which included the youth's and staff's signatures, letter of acknowledgement for unclaimed property, and a property receipt for the youth's personal property. All of a youth's personal property, such as clothing and footwear, are placed in a bag inside a secured room. One of five reviewed records had documentation of valuable property placed in a clear tamper-proof bag and secured in a locker under video surveillance. An additional two youth records were requested and reviewed for valuable property. Each applicable record reviewed for valuable property had documentation of the Property Receipt form which included the date, time, youth's name, Department identification number, and the signature of the officer who secured the property. The personal property was logged in the logbook and items were placed in a tamper-proof clear bag. Observations of a youth admission was conducted during the annual

compliance review week. Staff were observed following the center's procedures regarding securing the youth's property. The observed youth had personal property including clothing and footwear but did not have any valuable property. The property was placed in a zip bag. The property description was entered on the property receipt form and was printed. The youth reviewed the information and signed the report. The personal property bag was placed inside the secured room. Five youth were interviewed and each stated when they arrived at the center, staff checked their personal property and the youth were given a form to sign stating the personal property was correct. An interview with the center's superintendent reported upon admission, the intake officer is responsible for the inventory of the youth's personal property and valuables. The center's superintendent reported all youth properties are documented on the Department's Property Receipt form. Youth valuables are placed in a clear tamper-proof bag and signed by the youth and the intake officer then placed in the drop safe. A copy of the Property Receipt is placed in the youth's record.

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

The center maintains a written policy and procedures to ensure youth's personal property is maintained securely and returned to each youth in a timely manner upon their release. Observations of the center's storage area during the annual compliance review week found all applicable personal valuable property secured in a locked box under video surveillance in clear tamper-proof bag with the youth's name, date, Department identification number (DJJID), and itemized inventory list documented on the bag. The youth's clothing and footwear are placed in a zip bag along with a copy of the Property Receipt form. Access to the youth's garment property is available by all pertinent staff for a timely distribution upon release. Observations of a youth admission was conducted during the annual compliance review week. Staff were observed following the center's procedures regarding securing the youth's property. The observed youth had personal property including clothing and footwear but did not have any valuable property. The property was placed in a zip bag. The property description was entered on the Property Receipt form and was printed. The youth reviewed the information and signed the report. The personal property bag was placed inside the secured room. An interview with the center's superintendent and observation indicated valuable property is placed in clear tamper-proof plastic bags, locked in a secure room under constant video surveillance which was located inside the room in the intake area. The administration staff are the only staff with key access for the secure valuable safe. The valuable property for three youth was reviewed and was found to be secured in the locker inside of a clear tamper-proof bag. A review of six months of the Department's Central Communications Center (CCC) reports found there were no reports of missing or stolen personal and/or valuable property. An interview with the center's superintendent determined youth's personal properties are in currently stored in the intake area of the center with access to only supervisors and administration. The center's superintendent also explained the process for disposal of property not claimed which include the youth and parent/guardian have thirty days before the items are deemed abandoned. After thirty days, a notice of impending disposal of property will be mailed to the last known address to the youth and parent/guardian.

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

The center has a policy and procedures in place regarding the release of youth from secure detention. A review of three youth closed records documented the on-duty supervisor reviewed all release paperwork prior to youth's release. Each reviewed record contained documentation which confirmed the juvenile justice detention officer supervisor (JJDOS) reviewed all paperwork, inclusive of court paperwork, prior to the youth's release. Each youth's identification was verified prior to release. Each reviewed record included a copy of the identification of the parent/guardian picking up the youth. Each reviewed record contained documentation to support the youth's identification was verified before the release process was started. Each record had documentation which confirmed the youth and parent/guardian were informed of the youth's next court date. Each youth record indicated the staff, youth, and parent/guardian signed the property receipt form upon each youth's release. A review of the Department's Juvenile Justice Information System (JJIS) confirmed each reviewed record's admission and termination date correlated with JJIS. An observation of a youth release process was conducted during the annual compliance review week. Detention staff and the supervisor identified the correct youth, and then the administration staff retrieved the youth's valuable and personal property. The youth changed into personal clothing in the intake area bathroom and was then escorted to the center's lobby to meet with the youth's parent/guardian. The center staff checked the parent's/guardian's identification and made a photocopy for the youth's record. The youth was released in JJIS and all parties signed the release of property form. The youth's parent/guardian was verbally informed of the youth's detention suicide risk, how to schedule assessment of suicide by a mental health professional in the detention center, and was given a written notification of court instructions and future court dates. A review of six months of the Department's Central Communications Center (CCC) reports confirmed there were no unauthorized releases.

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

The center has a policy and procedures which states all youth and their parent/guardian are required to sign the property receipt acknowledging receipt of each youth's personal property. Staff, youth, and the parent/guardian review and sign the property release form at the time of release. A review of three closed youth records indicated each youth and parent/guardian signed the property receipt form upon each youth's release. An interview with the center's superintendent confirmed the center's release of property protocol. The superintendent reported the center ensures youth property is returned safely and the parent/guardian and youth signs a receipt form. In addition, any youth's property left at the center over thirty days is entered into the logbook and placed in the secure room. Furthermore, the center mails out a thirty-day notice of impending disposal of property and, if there is no response regarding the youth's property, it is donated to local charities. The center's superintendent also indicated there has been no youth property unclaimed since the last annual compliance review. Examples of logs and receipts were reviewed, and an observation of a release process was observed during the annual compliance review which confirmed the center's practice.

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

The center maintains a written policy and procedures regarding release of medications and aftercare instructions upon a youth's release from the center. A review of three closed youth healthcare records, in which youth were released with prescribed medication was conducted. Each reviewed record had documentation verifying youth were released to the appropriate parent/guardian with a copy of a valid identification. Each record contained a receipt of medication, signed by the parent/guardian, the type of medication, strength, dosage, quantity, medication instructions, and any pending medical appointments.

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

The center has a written policy and procedures ensuring detention reviews are conducted weekly for youth securely detained, placed on home detention, or electronic monitoring, to ensure proper management of youth and the sharing of information. The status of each youth is addressed, and updates are provided as to the next court date, behavior while in detention, residential placement status, and release status. A review of the center's documentation revealed the weekly meetings were held and updates were noted for each youth at the center for the past six months. There were notes taken on what was discussed, tasks assigned for follow-up, and the identified staff members responsible for those actions. During the annual compliance review, an observation of a weekly detention review meeting was conducted. Staff in attendance included the juvenile probation officer supervisor (JPOS), representatives from

education, mental health staff, medical staff, local law enforcement, and detention review specialist. Each youth's alerts were reviewed which included gang alerts, medical, suicide risk, escape risk, sexual offender alerts, and other pertinent information to keep youth and staff safe. Based on the observation, the detention review meeting process was followed according to the center's policy. An interview with the center's superintendent determined the detention review specialist oversees detention review meetings, as well as documented weekly case notes on each youth record.

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

The center has a written policy and procedures in place regarding the daily activity schedule. A walk-through observation of the center revealed the daily activity schedule is posted on each module for all youth to read. The daily schedule outlines the days and times of youth activities, hygiene, school schedule, visitation, meals, education, shift changes, bed times, groups, open programming times, indoor activities, and recreational activities. Wake up times starts at 6:30 a.m. every day and bedtime at 7:30 p.m., depending on the youth's level. Every activity was appropriately documented with the type of activity and the time frame of each activity. A local community partner, Project Help Recovery Center, visits the center twice a week and conducts groups. During groups, youth are taught subjects including the cycle of abuse violence, teen choices, sexually transmitted infections (STI), pregnancy care and prevention, bullying, and surviving abusive relationships. During the annual compliance review, observations were made of youth in school, recreation activities, meal service, groups, and visitation with juvenile probation officers (JPO). The staff were observed properly supervising the youth, positioning themselves appropriately, and the youth were well behaved. A review of the center's logbooks and observations confirmed the center adheres to the daily activity schedule posted. Five youth were interviewed, and each youth reported the center had a daily activity schedule. Five staff were interviewed, and each staff reported the center had a daily activity schedule.

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

The center has a written policy and procedures in place to ensure daily schedules are followed. The procedures indicate the cancellation of activities may occur due to poor weather conditions, or safety and security concerns, and cancellations are documented in the center's logbooks. A review of logbooks and shift reports for the past six months, as well as observations made during the annual compliance review week verified adherence to the daily activities schedule. The logbooks did not indicate any significant changes in the schedule except when the hurricane disrupted the educational activities. An interview with the center's superintendent verified there are no major disruptions in the center's daily schedule unless there is a natural disaster. Five youth were interviewed, and each stated the center has a daily activity schedule

and it is followed. Five staff were interviewed, and each reported the center had a daily activity schedule and it is followed.

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

The center has a written policy and procedures ensuring educational access to youth in the center. Education services, including the incorporation of career and technical education, are provided by the Collier County School District. The center operates on a calendar providing 250 days of instruction, distributed over twelve months, with a minimum of twenty-five hours of instruction weekly, with ten days used as teacher training/planning. Youth enrolled in the educational program can earn course credit for completion of education and training experience. Education staff provide a variety of instructional methods in the classroom including direct instruction and sunshine standards curriculum. The district provides additional support for Exceptional Student Education (ESE). A review of the program's daily schedule and logbook ensure minimal interference of educational instruction. There were no on-site observations during the annual compliance review week to suggest the educational experience was unduly interrupted or suspended for any length of time. An informal interview with the lead teacher found two of the three teachers are ESE certified. The lead teacher also reported the center staff bring the youth to school on time and actively supervise the youth the during classes. Five youth were interviewed and reported the center offers educational classes. Each interviewed youth reported they attend school Monday through Friday. Each interviewed youth stated they were taking life skills classes, career choices, math, history, science, reading, and social studies classes. Five staff were interviewed regarding educational classes, and each reported there is minimal interference during educational instruction time.

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

The center maintains a written policy and procedures ensuring the development and implementation of a career education competency program. Educational services are provided by the Collier County School District staff and they are providing the requirements for the Type 1 education. The center defines career education programming based on the age, assessed educational abilities, the goals of the youth, and the typical length of stay to which each youth is assigned. Career education programming includes communication, interpersonal, decision making, and life skills. Exceptional Students Education services (ESE) are provided in accordance with each youth's Individual Education Plan (IEP) and specific needs. The center's transition services are provided by the Collier County School District's alternative education transition specialist, to all the youth upon their arrival and discharge from the center.

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

The center maintains a policy and procedures addressing the behavior management system (BMS) to ensure the safety and security of youth and staff. The center provides a system of rewards, privileges, and consequences to encourage youth to fulfill the center's expectations. The system includes rewards for positive behavior and consequences for inappropriate behavior. The behavioral norms and expectations for youth are posted throughout the modules for youth to see. Youth are informed of the BMS during the admission process. The BMS is a three-level system. Each youth enter at a level two when admitted, and their levels can move up or down, depending on their behavior in the center. The center's level two provides each youth with all basic rights and some additional activities and incentives, as determined by center administration. The center incentives and activities include playing games, 9:00 p.m. bed time, and access to television. The youth can progress to level three with positive behavior. The center's level three system provides youth with all basic rights and will receive additional privileges such as a 9:30 p.m. bed time, earn extra snacks weekly, receive haircuts, get an additional ten-minute telephone calls each week, participation on honor module, and participate in work detail. Youth levels are updated daily on their level sheets. Youth can view their status and are able to ask questions, if needed. Inappropriate behavior is also documented in the center's logbook. A review of the level sheets and logbooks confirmed this practice. During the annual compliance review, observations of the youths' behavior in the center were made and staff were giving youth positive reinforcement for appropriate behavior. Documentation showed administration staff rewarded the level three youth for positive behavior which included incentives such as later bed time, earning extra snacks weekly, and additional minutes during weekly calls. Five youth were interviewed, two youth rated the BMS system as "fair," two youth rated it as "good," and one youth rated the BMS as "very good." Each interviewed youth stated the consequences received at the center were fair. Each youth stated the level can be dropped as a consequence and points can also be reduced. Each youth stated youth are not allowed to punish other youth. Each youth stated they were never sent to their room for punishment. Five staff were interviewed, and all staff thought the BMS system was effective. Each staff reported they discussed consequences being imposed, speak with the youth about alternative behaviors, and give the youth the opportunity to explain their behavior. Each staff stated youth will drop a level and/or lose points as a consequence to negative behaviors. Each staff stated they receive feedback from their supervisor regarding the implementation of the BMS system, as needed.

2.16 Unauthorized Use of Punishment (Critical)	Satisfactory Compliance

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

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

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

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

The center has a policy and procedures in place prohibiting the use of group punishment, corporal punishment, and the use of drugs to control the behavior of the youth. All allegations of corporal punishment on any youth by detention center staff shall be reported to the Florida Abuse Hotline and the Department's Central Communications Center (CCC). If a youth is non-compliant and staff have exhausted all opportunities to assist the youth in changing their behavior, then the youth's level will be dropped to level one in which the youth loses special activities and incentives. The center's level one system has an 7:30 p.m. bed time, no additional snacks, and the youth cannot participate in any youth events. Five youth were interviewed, and all stated they had never been sent to their room for punishment. Each youth all stated they are not allowed to punish other youth. Five staff were interviewed, and all stated youth do not lose meals, clothing, snacks, education, or medical care due to inappropriate behavior. Each staff also reported they have never observed any staff encouraging youth to beat up another youth. An interview with the center's superintendent confirmed the center utilizes a three-level reward system to encourage positive behavior.

2.17 Grievances	Satisfactory Compliance

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

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

The center maintains a policy and procedures to ensure each youth has the right to file a grievance and is treated fairly, respectfully, without discrimination, and has their rights protected while at the center. Grievance forms were easily available to the youth in each living module. The grievance process is explained to each youth during the admission process. The center has a three-step grievance process, which includes informal, formal, and appeal phases. The first step of the process is the informal phase in which a youth and juvenile justice detention officer (JJDO) staff attempt to resolve a youth's complaint. Should the complaint be unresolved, it is

then referred to a JJDO supervisor (JJDOS) within two hours, at which time the formal phase begins. The supervisor then has twenty-four hours to attempt to respond. If the youth is unsatisfied with the JJDOS response, he/she can request a review of the grievance by the superintendent, which constitutes the appeal phase. The center's superintendent then has seventy-two hours, excluding weekends and holidays, to respond and then the center superintendent's response is the final decision. The center's superintendent was interviewed and confirmed this practice. Additionally, the superintendent reported grievances forms are located on each module and in the intake area as well. The center had a total of four grievances filed by youth since the last annual compliance review and each grievance was handled in accordance with the Department's policy. Each grievance was entered in Facility Maintenance System (FMS) on behalf of the youth. The center's JJDO attempted to resolve any youth dispute or issue prior to the youth filing a grievance. Each of the four youth grievances were addressed within twenty-four hours and all were resolved. Five youth were interviewed, and each youth denied ever filing a grievance. Five staff were interviewed, and each stated they understood the center's grievance policy and procedures.

2.18 Trauma-Informed Care	**Satisfactory Compliance**

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

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

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

The center maintains a policy and procedures ensuring trauma-informed care is incorporated into current operations and services with youth in custody. Center staff receive training in trauma-informed care as part of their pre-service and in-service requirements. A review of five in-service and pre-service training records indicated all staff are trained in trauma-informed care in the Department's Learning Management System (SkillPro). The center treats all youth as being affected by trauma, recognizes the high prevalence of trauma, assesses for traumatic histories and symptoms, recognizes each youth can be re-traumatized at the center, and uses objective and neutral language when speaking with youth. Informal interviews with administrative staff indicated the center has a soft room which is painted in soothing colors and have positive murals on the walls throughout the center. Observations found the soft room is decorated with comfortable furniture and carpeting. The soft room is utilized by staff to calm youth down and/or for youth to have meetings with the therapists. An interview with the center's superintendent reported when a youth disclose they have experienced trauma, a mental health referral is placed in Facility Maintenance System (FMS). Staff have the ability to remove youth from situations which may trigger past trauma.

Standard 3: Mental Health and Substance Abuse Services

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

The center maintains a policy and procedures ensuring there is a single licensed mental health professional designated as the designated mental health clinician authority (DMHCA) who is responsible for the coordination and implementation of mental health and substance abuse services. The Department maintains a contract with Maxim Healthcare Services, Inc., who sub-contracts with Camelot Community Care to provide mental health and substance abuse services to all applicable youth in the center. Camelot Community Care provides a licensed clinical social worker to serves as the center's DMHCA and holds a clear and active license in the State of Florida with an expiration date of March 31, 2021. The DMHCA is full-time and scheduled to be on-site forty hours each week, Monday through Friday. A review of sign-in sheets confirmed the DMHCA was on-site as required. The DMHCA is also available seven days a week, twenty-four hours a day, by way of telephone for consultation. A review of the Camelot Community Care job description found the DMHCA is responsible for oversight of all clinical and administrative operations ensuring clinical quality and integrity of the therapeutic program. In addition, the DMHCA is responsible for participating in or providing assistance in therapeutic interventions, court hearing, as well as school and community meetings. An interview with the DMHCA confirmed they are responsible and accountable for ensuring the mental health and substance abuse services are provided as it relates to Florida Administrative Code 63N. The DMHCA supervises two non-licensed bachelor’s-level clinicians. Reviewed documentation and observations supported the DMHCA meets with the psychiatrist and nursing staff weekly for mini-treatment team meetings.

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

The center has only one licensed clinical staff serving as the designated mental health clinician authority (DMHCA); therefore, this indicator rates as non-applicable.

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

The center maintains a written policy and procedures ensuring metal health and substance abuse services are provided by individuals with appropriate qualifications. The clinical supervisor ensures the clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience. The center is licensed through the Department of Children and Families under Chapter 397 to provide substance abuse services. The center has two non-licensed bachelor's-level mental health and substance abuse clinical staff who work under the direct supervision of the licensed clinical social worker (LCSW). The LCSW also serves as the center's designated mental health clinician authority (DMHCA). The non-licensed bachelor's-level clinicians hold degrees in psychology and criminal justice, respectively, and are scheduled to work part-time approximately ten to fifteen hours a week. Reviewed training records confirmed one non-licensed staff completed the required fifty-two hours of pre-service clinical training in their duties and responsibilities. The other non-licensed staff was recently hired and has completed twelve hours of pre-service training as of the annual compliance review week. According to the DMHCA, this individual does not have a caseload nor is left alone with youth until the fifty-two hours are completed. Reviewed documentation also supported one non-licensed staff completed the required twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. The training included five Assessments of Suicide Risk (ASR) or crisis assessments conducted on-site in the presence of the DMHCA. A review of direct supervision logs verified the DMHCA provided at least one-hour of weekly face-to-face supervision documented on the Department's Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log form. Reviewed documentation supported each ASR completed by the non-licensed clinician was reviewed by the DMHCA within twenty-four hours of the referral for assessment.

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

The center maintains a written policy and procedures ensuring the mental health and substance abuse needs of youth are identified through a comprehensive screening process in which referrals are made when youth are identified with mental health and/or substance abuse needs or are identified as a possible suicide risk. The superintendent has established procedures for a thorough review of each youth's preliminary screening conducted by the juvenile probation officers and existing documentation of mental health or substance abuse problem needs or risk factors, administration of the Suicide Risk Screening Instrument (SRSI) upon the youth's admission, and referral to the center's mental health and substance abuse clinical staff. The policy was approved by the superintendent and the designated mental health clinician authority

(DMHCA) on October 7, 2019. An interview with the superintendent indicated while the youth is in the juvenile assessment center (JAC), the juvenile probation officer (JPO) completes the mental health, substance abuse, and suicide risk screenings utilizing the SRSI and the Massachusetts Youth Screening Instrument - Second Version (MAYSI-2) assessment. A review of five youth mental health and substance abuse records indicated the center's staff reviewed all prior documentation completed by the JPO when the youth was admitted to the center. The SRSI and MAYSI-2 were completed for each youth upon intake electronically in the Department's Juvenile Justice Information System (JJIS). Each of the five SRSIs were reviewed by a mental health clinical staff member and documented their recommendation. Each of the SRSIs had completed entries which also had a summary and recommendations included in the screening results section. All five reviewed records documented a history of suicide risk and each youth was placed on precautionary observation (PO) and a referral for an Assessment of Suicide Risk (ASR) was submitted. Each youth remained on PO until the ASR was completed by the center's clinical staff. The results of the ASR indicated each youth was placed on standard supervision. The center's staff completed the Department's Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) assessment for each youth upon their intake admission. An interview with the superintendent confirmed the intake officer completes the detention officer portion of the SRSI for each youth.

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

The center maintains a written policy and procedures establishing an intake and admission screening process ensuring youth identified through preliminary screenings in the juvenile assessment center (JAC) or upon admission to the center as having mental health and substance abuse issues or needs are referred for further in-depth mental health and/or substance abuse assessment. All youth identified by screening or by staff observations or behavior after admission are referred for further in-depth mental health and substance abuse evaluation. The center utilizes the Department's Mental Health/Substance Abuse Referral Summary form. Youth identified in the JAC as in need of further assessment are referred to a community provider for a comprehensive assessment. The center maintains a contract with Maxim Health Services, Inc., who sub-contracts services with Camelot Community Care to ensure youth identified during the preliminary screening process receive an in-depth mental health and/or substance abuse assessment shortly after intake. A review of five youth mental health and substance abuse records reflected each youth was screened and a referral was made to Camelot Community Care for each to receive a comprehensive mental health and substance abuse evaluation based on the Massachusetts Youth Screening Instrument - Second Version (MAYSI-2) assessment and/or Suicide Risk Screening Instrument (SRSI). Three youth were also admitted currently prescribed psychotropic medications and a referral for a psychiatric evaluation was submitted. All five youth were recently admitted; therefore, the comprehensive evaluation was not completed as of the annual compliance review week. A review of three separate applicable youth mental health and substance records supported each youth received a completed evaluation documented on the Substance Abuse and Mental Health Assessment (SAMH) form. The assigned juvenile probation officer is responsible for ensuring pre-disposition comprehensive evaluations for detained youth are forwarded to the detention center in a timely manner. Reviewed documented practice did validate the clinical staff contacted the assigned

juvenile probation officer by e-mail, requesting a status update on the comprehensive assessment completed by the community provider. Each reviewed SAMH was completed in full and contained all required information including the diagnostic impression, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, summary of findings, and recommendations.

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

The center maintains a written policy and procedures ensuring mental health and substance treatment planning focuses on providing mental health treatment and/or substance abuse treatment which will reduce or alleviate the youth's symptoms of mental disorder or substance abuse impairment and enable 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, must be assigned to a mini-treatment team. Youth may request to receive mental health and/or substance abuse treatment services. A review of the contract indicated mental health clinical staff are required to be on-site seven days a week. Reviewed schedules support clinical staff are on-site as required. Five youth mental health and substance abuse records were reviewed for mental health and substance abuse treatment services. Two of the five youth records were applicable for receiving treatment services. A review of one additional youth record validated all three applicable youth were assigned to a mini-treatment team and were referred for services utilizing the Department's Mental Health/Substance Abuse Referral Summary form. Each reviewed youth record was applicable for treatment with psychotropic medication management, individual therapy, supportive counseling, and life skills group. Reviewed documentation confirmed each applicable youth requiring treatment was assigned to a mini-treatment team consisting of mental health, medical, education, direct care staff, and administrative staff. The designated mental health clinician authority (DMHCA)maintained documentation of weekly treatment team meetings. Each applicable record had a valid Authority for Evaluation and Treatment (AET) form and proper consent for treatment. Treatment notes were documented on the Department's Counseling/Therapy Progress Note form and in the Mental Health Chronological Notes. Reviewed sign-in sheets confirmed mental health group therapy is limited to ten or fewer youth and group therapy is limited to fifteen or fewer youth with substance abuse diagnoses for substance abuse treatment groups. There were no applicable youth receiving substance abuse treatment; however, three youth were identified as receiving substance abuse education and each signed the Department's Consent for Substance Abuse Treatment and Youth Consent for Release of Substance Abuse Treatment Records. Groups are conducted in a multi-purpose room or the dining hall based on the group size. Mini-treatment teams are conducted weekly for youth receiving services. Observations made during the annual compliance review week found

the mini-treatment team was composed of the DMHCA, the psychiatrist, medical staff, direct care staff, and the youth. Five youth were interviewed and two rated the mental health and substance abuse services provided as good and one indicated very good. Two youth indicated they were not receiving mental health and/or substance abuse services while in the center.

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

The center has a written policy and procedures ensuring all youth who receive mental health and/or substance abuse treatment while in the center shall have a discharge summary completed documenting the focus and course of the youth's treatment recommendations for mental health and/or substance services upon the youth's release. The center ensures all youth who receive mental health and/or substance abuse treatment shall have an initial treatment plan and/or individualized treatment plan, as well as a discharge summary. Five reviewed youth mental health and substance abuse records found two youth were applicable for receiving treatment; therefore, one additional applicable youth record was reviewed. Each applicable youth requiring mental health and/or substance abuse treatment due to observations, youth admission, or indications on their initial assessments were referred for services, utilizing the Department's Mental Health and Substance Abuse Referral Summary form. All three youth had an Initial Treatment Plan developed within seven days of initiation of treatment. Each plan contained the reason for referral for treatment, initial Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, initial treatment methods and goals, and psychiatric services. Each was signed by the youth and the mini-treatment team members. Reviewed documentation and an interview with the designated mental health clinician authority (DMHCA) confirmed each youth received services as identified on their initial treatment plan and/or individual treatment plan.

Since the five youth were recently admitted, there were no applicable individualized treatment plans developed. Three additional youth records were reviewed, and each contained a developed individualized treatment plan. All three reviewed plans were developed within the required time frame and included the DSM-5 diagnosis, symptoms, treatment goals, strengths, psychiatric services, and pharmacological interventions. One of the three youth required one individualized treatment plan review and it was conducted as required. Two additional youth records were reviewed to meet the minimum sample size, and both required one individual treatment plan review, and each was conducted as required. None of the youth were applicable for modifications to their developed plan. An interview with the DMHCA confirmed the center's practice is if they are aware a youth will remain at the center for an extended period beyond thirty days due to a court order, outstanding charges, or a youth being committed pending placement, they will initially create an individualized treatment plan instead of the initial treatment plan. Reviewed progress notes documented in the Department's Facility Management System (FMS) validated each youth received treatment services, as stipulated in their treatment plan.

Three applicable closed youth records were reviewed and supported each youth received mental health and/or substance abuse treatment while in the center and a Mental Health and Substance Abuse Discharge Summary was completed upon discharge from the center. Reviewed documentation supported a copy of each summary was sent to the youth's juvenile probation officer by way of e-mail and a copy was provided to the youth and parent/guardian.

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

The center maintains a policy and procedures ensuring psychiatric services are provided to youth in need as indicated by symptoms of mental disorder or substance-related disorder, or youth who are being treated with psychotropic medication prior to or subsequent to admission. The center maintains a contract with Maxim Health Services, Inc., who subcontracts psychiatric services with Camelot Community Care for the provisions of a licensed psychiatrist to provide psychiatric services for applicable youth in the center. Camelot Community Care provides a part-time psychiatrist who is contracted to provide services for two hours each week. The psychiatrist is an osteopathic physician with a clear and active license in the State of Florida which expires on March 31, 2020. The center does not utilize a psychiatric advanced registered nurse practitioner (ARNP)/advanced practice registered nurse (APRN). Reviewed documentation and the Medical and Mental Health Sign-In Logbook validated the psychiatrist is on-site weekly, as required. The center utilizes the Department's Mental Health/Substance Abuse Referral Summary form to request a psychiatric evaluation. The psychiatrist signs and dates the referral form. Psychiatric services include an initial diagnostic psychiatric interview, psychiatric evaluations, psychiatric follow-up assessments and consultations, coordination of services, crisis interventions, treatment planning, communication, and emergency procedures. A review of five mental health and substance abuse records indicated three youth were applicable for receiving psychiatric services. Each applicable record contained a current Authority for Evaluation and Treatment (AET) form. All three youth were admitted with prescribed psychotropic medications and each youth received an in-depth psychiatric evaluation which included all required elements. Each evaluation was documented on the Department's Clinical Psychotropic Progress Note (CPPN) and completed within fourteen days of the youth's admission. All reviewed mental health and substance abuse documentation was completed utilizing the Department's required forms. The psychiatrist indicated there have been no applicable youth requiring a newly prescribed psychotropic medication or had any changes to the existing psychotropic medication while in the center since the last annual compliance review. None of three youth required the monitoring of Tardive Dyskinesia.

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

The center maintains a written policy and procedures ensuring youth with elevated risk of suicide are safely screening, referred, monitored, and protected in the least restrictive means possible. The plan outlines the center's procedures addressing the use of suicide precautions,

suicide prevention training, and the process by which any youth identified as having suicide risk factors at any time must be placed on suicide precautions and receive an Assessment of Suicide Risk. The suicide prevention plan was approved and signed by the superintendent and the designated mental health clinician authority (DMHCA) on October 7, 2019. The plan includes the identification and assessment of youth at risk of suicide utilizing the Department's Assessment of Suicide Risk (ASR) and Follow-Up ASR. The plan identifies the levels of supervision, referral process, communication, notification, and documentation requirements. In the event of a life-threatening suicide attempt, staff are to call 9-1-1 immediately. Decisions to use extra precautions are determined on a case-by-case basis based upon the individualized risk factors and needs of each youth. Clinical staff assist in training detention officers throughout the fiscal year on suicide prevention, including verbal and behavioral cues indicating a suicide risk. The plan outlined emergency contact telephone numbers to include the superintendent, on-call administrator, DMHCA, Collier County Sheriff's Office, psychiatrist, designated health authority, emergency room, crisis stabilization unit, and Poison Control. The plan is located in the superintendent's office, medical clinic, DMHCA's office, and is also accessible to all staff on the center's K-drive and SharePoint.

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

The center maintains a written policy and procedures addressing the use of suicide precautions, suicide prevention training, and the process by which any youth identified as having suicide risk factors at any time must be placed on suicide precautions and receive an Assessment of Suicide Risk (ASR). Youth placed on suicide precautions are maintained on one-to-one or constant supervision. A review of five youth mental health and substance abuse records validated each youth is screened upon admission for suicide risk factors. Each youth is screened utilizing the Department's Suicide Risk Screening Instrument (SRSI) and Massachusetts Youth Screening Instrument – Second Version (MAYSI-2). When further assessment is indicated by the SRSI or MAYSI-2 suicide ideation subscale, as well as any information obtained during the admission process which may suggest the youth is a possible suicide risk, the youth is placed on suicide precautions and constant supervision until the ASR is completed by the licensed mental health clinician. One of two non-licensed bachelor's-level clinicians' training record was reviewed and supported the completion of the required twenty hours of training to complete an ASR, which included five ASRs completed under the direct supervision and within the physical presence of the licensed mental health clinical staff member. The other non-licensed clinician was recently hired and is in the process of completing the required training.

A review of five youth mental health and substance abuse records found each youth was identified with an elevated risk of suicide identified during the admission screening process.

Each of the five applicable youth was placed on precautionary observation (PO) until the ASR was completed. Each of the ASRs was completed within twenty-four hours by a bachelor's-level non-licensed clinical staff and reviewed by the designated mental health clinician authority (DMHCA) or by the DMHCA. A review of the completed ASRs found each youth placed on PO was stepped down to standard supervision. A review of three additional applicable records of youth placed on PO due to staff observations found an alert was placed in the Department's Juvenile Justice Information System (JJIS) and a referral was made to the clinical staff utilizing the Department's Mental Health/Substance Referral Summary form. The mental health staff conducted a Follow-Up ASR prior to the removal of PO and down to Close Supervision. The conference with the superintendent and the DMHCA was documented and the discontinuation of Close Supervision was documented in accordance with the center's approved Suicide Prevention Plan. Reviewed facility logbook entries supported administrative and supervisory staff provided instructions related to the applicable youth's elevated suicide risk levels and precautions.

The center utilizes secure observation for potentially suicidal youth. An interview with the superintendent indicated when a youth is on precautionary observation and actively trying to harm themselves, the youth will be placed on secure observation. All items are removed from the youth and an officer is assigned to the youth to maintain constant visual observation while the youth is in a secure room. The supervisor then completes the necessary documentation in the Department's Juvenile Justice Information System (JJIS), such as the health checklist, producing a secure observation log, and a JJIS incident report. Administration is notified of the incident. A review of three youth requiring secure observation was conducted. All three secure observations documentation supported each placement was authorized by the superintendent and the DMHCA. The secure room was designated in writing and the Department's Health Status Checklist was completed as required. The center staff completed the suicide precaution observation logs in their entirety and in real time. All three youth were removed from secure observation within twenty-four hours of placement. A review of JJIS indicated appropriate alerts were entered and removed, as required, for all youth placed on suicide precautions. A review of the facility logbooks validated each of the youth placed on precautions had documentation regarding the beginning and ending times of their precaution periods. Five interviewed staff indicated in the event a youth expressed suicidal thoughts, staff indicated they would notify the mental health authority, put in a mental health referral, notify the supervisor. Two staff indicated the youth would be placed on constant sight and sound supervision. Five interviewed staff indicated the suicide response kit is located in master control and one staff indicated there is also one located in the medical clinic.

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

The center maintains a written policy and procedures outlining staff supervision of youth placed on suicide precautions, one-to-one supervision, or when constant supervision must be maintained, including documenting the youth's behavior on the Department's Suicide Precautions Observation Log. Five reviewed youth mental health records found each youth was placed on precautionary observation (PO); however, the mental health clinical staff conducted the Assessment of Suicide Risk (ASR) immediately and subsequently placed the youth on Standard Supervision. Therefore, no Suicide Precaution Observation Logs were required. A

review of three additional applicable youth records found a Suicide Precautions Observation Log was maintained for the duration each youth was on precautions and each was reviewed and signed daily by the shift supervisor, as well as the mental health clinician. Reviewed documentation reflected staff observations did not exceed the required intervals and were documented in real time. Safe housing areas were clearly documented on each log. The licensed mental health clinical staff member conferred with the superintendent prior to revising the supervision level, which was recorded on the ASR in the date/time sections. The program only had two youth detained who have been placed on PO at the time of the annual compliance review. Both interviewed youth indicated when they were on suicide precautions, staff watched them all of the time. Interviews with five staff indicated they received training in suicide prevention. A review of the two incidents of the youth returning to the center from a Baker Act determined the youth PO logs and subsequent Secure Observation Logs were completed as required.

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

The center maintains a written suicide prevention plan outlining the training requirements for all staff who work with youth. Camelot Community Care's clinical staff assist in training juvenile justice detention officers throughout the fiscal year on suicide prevention, including verbal and behavioral cues indicating a suicide risk. The plan outlines all staff who work with youth must receive six hours of annual training on suicide prevention and implementation of suicide precautions. Suicide prevention trainings are completed and documented in the Department's Learning Management System (SkillPro). The plan reflects all staff with direct contact with youth, on a day-to-day basis, must participate in at least one quarterly mock suicide drill semi-annually. The mock drills are designed to practice responses to a suicide attempt or incident of serious self-injury. A review of five staff training records validated each staff completed at least two hours of suicide prevention training in the Department's Learning Management System (SkillPro). Two staff completed the required four hours of instructor-led suicide prevention training. Two staff completed thirty minutes of the required four hours of instructor-led training, and one staff did not have any documented instructor-led training. Reviewed documentation of mock suicide drills completed since the last annual compliance review reflected the center completed drills on Alpha, Bravo, and Charlie shifts monthly from January through October 2019 with the exception of April 2019 for Alpha shift and March 2019 for Bravo shift. Reviewed documentation supported the center ensured each staff participated in at least one mock suicide drill at least semi-annually. Most staff participated on multiple drills. Staff who are not present during a drill have the opportunity to review each drill scenario, procedures, and critique in an effort to understand the process and receive the necessary training to respond to an incident of a suicide attempt or incident of serious self-inflicted injury. The provision of life saving measures such as cardiopulmonary resuscitation (CPR) was demonstrated monthly for the medical drills and the use of a suicide response kit was documented for each suicide drill.

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

The center maintains a written mental health Crisis Intervention Plan ensuring the center will 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 center. The plan was reviewed and approved by the designated mental health clinician authority (DMHCA) and superintendent on October 7, 2019. The plan details crisis intervention procedures including a notification and alert system, means of referral including youth self-referral, communication, supervision, documentation, and review. The center's procedures outline conducting a crisis assessment to evaluate a youth presenting with acute emotional or psychological distress which is extreme and does not respond to ordinary interventions conducted by a mental health clinician to determine the severity of the youth's distressing symptoms, level of risk to self or others, and recommendations for treatment and follow-up care. The Crisis Intervention Plan is placed in the superintendent's office, medical clinic, DMHCA's office, and on the center's K-drive and SharePoint.

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

The center maintains a written Emergency Care Plan outlining mental health and substance abuse emergency procedures and ensuring youth who are believed to be an imminent danger to themselves or others because of mental illness or substance abuse impairment receive emergency mental health or substance abuse services. The plan was last reviewed and approved by the designated mental health clinician authority (DMHCA) and the superintendent on October 7, 2019. The center's plan reflects the superintendent, assistant superintendent, and DMHCA are to review all critical incidents and discuss the circumstances surrounding the incident, center procedures relevant to the incident, and recommendations. The center's plan includes procedures for immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services (Baker Act or Marchman Act), documentation, and training. The center utilizes the David Lawrence Center in Naples, Florida for Baker Act crisis stabilization and Marchman Act emergency substance abuse assessment and treatment. A review of five staff training records supported each was trained on the center's emergency care plan.

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

The center maintains a written mental health crisis intervention plan and services. The plan details crisis intervention procedures including a notification and alert system, means of referral, including youth self-referral, communication, supervision, documentation, and review. The center's plan was reviewed and approved by the designated mental health clinician authority (DMHCA) and superintendent on October 7, 2019. Interviews with the DMHCA and the center's superintendent indicated the center has not conducted a crisis assessment since the last annual compliance review.

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

The center maintains a written policy and procedures for youth determined to be an imminent danger to themselves or others due to mental illness or substance abuse impairment. The program has only had two separate incidents from the same youth requiring a Baker Act since the last annual compliance review. Reviewed documentation supported both times, the youth was placed on suicide precautions upon re-admission from the Baker Act. A mental status examination was conducted and an Assessment of Suicide Risk (ASR) was completed, as required. The completed ASR reflected the youth was maintained on precautionary observation (PO) and subsequently placed in secured observation during both events. The clinical staff completed a Follow-Up ASR and maintained the youth on PO. The youth was then sent to Southwest Florida Regional Juvenile Detention Center on PO. Suicide risk alerts were updated and discontinued, as required in the Department's Juvenile Justice Information System (JJIS). The center maintains two suicide response kits each containing a knife-for-life, wire cutters, and needle nose pliers. Observations found the kits were located in master control and in the medical clinic. The center utilizes the David Lawrence Center in Naples, Florida for Baker Act crisis stabilization and Marchman Act emergency substance abuse assessment and treatment. The center had no youth applicable for Marchman Acts since the last annual compliance review.

Standard 4: Health Services

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

The center maintains a written policy and procedures ensuring there is a contract agreement with a licensed physician. The center maintains a contract with Maxim Healthcare Services who subcontracts with an osteopathic physician (DO) who holds an unrestricted license and meets all requirements for independent and unsupervised practice in the State of Florida. The DO has specialty training in internal medicine. The DO serves as the center's designated health authority (DHA) and is clinically responsible for the medical care of all youth. A review of the contract with Maxim Healthcare Services, indicates the DHA shall be on-site two hours each week conducting periodic evaluations, Comprehensive Physical Assessments, sick call referrals, and administrative duties. An interview with the DHA supported this practice. The DHA is on-site on Tuesdays from approximately 9:00 a.m. to 11:00 a.m. and is available twenty-four hours a day, seven days a week for consultation. In addition, the center utilizes an advanced practice registered nurse (APRN) who is on-site four to six hours each week. The APRN is on-site on Thursdays, from approximately 9:00 a.m. to 1:00 p.m. On-site nursing coverage is provided seven days a week from 7:00 a.m. to 7:00 p.m. The APRP has Collaborative Practice Protocols in place with the DO. Reviewed attendance logs found the DHA and the APRN were on-site weekly with the exception of the week of June 11, 2019. During this week, the APRN was not on-site; however, the DHA was on-site twice during the week. The DHA is responsible for communication with center staff regarding youth medical needs and participates in weekly DHA meetings with the center's administration. Reviewed attendance logs supported nursing staff also participated in the meetings. An interview with the DHA indicated Maxim Healthcare Services provides for back-up coverage when the DHA is on scheduled leave; however, the DHA attendance logs for the past six months did not indicate a need.

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

The center maintains Facility Operating Procedures (FOPs) for all utilized health-related procedures and protocols. Reviewed documentation reflected the designated health authority (DHA) reviewed, signed, and dated the FOPs on April 16, 2019 and the nursing protocols, and non-healthcare protocols on July 23, 2019. The center's contracted psychiatrist documented a review with signature and date for applicable FOPs. Maxim Healthcare Services has an established comprehensive clinical orientation for all newly employed healthcare staff which includes the Department's healthcare policies and procedures. Training records supported all newly employed healthcare staff received the clinical orientation. Reviewed documentation validated the registered nurse, DHA, and superintendent documented their review of the center's healthcare FOPs and protocols on a cover page on April 16, 2019, and the remaining clinical staff documented their reviews on September 16 and September 20, 2019.

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

The center maintains a written policy and procedures ensuring parents/guardians are afforded the right to give or withhold consent with regard to the healthcare provided to the youth. A review of five youth Individual Healthcare Records (IHCR) contained a signed Authority for Evaluation and Treatment (AET). The center had no applicable youth who required a Limited Consent for Evaluation and Treatment (LCET). Each of the five youth IHCRs contained a copy of the signed AET and clearly documented, “Copy” on the form. Each AET was obtained prior to providing medical services.

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

The center maintains a written policy and procedures outlining requirements for parental notification and written consent from the parent/guardian. The center notifies the parent/guardian of significant changes in the youth’s condition and to obtain consent when new medications and treatments are prescribed. A review of five youth Individual Healthcare Records (IHCR) found two had significant changes to existing medications and/or changes in chronic conditions; therefore, one additional record was requested and reviewed. In addition, there was one youth applicable for over-the-counter medication not covered by the Authority for Evaluation and Treatment prescribed. None of the reviewed IHCRs required vaccinations/immunizations. Interviews with nursing staff indicated there were no Religious Exemption from Immunization forms submitted since the last annual compliance review. The center reported having two youth applicable to off-site emergency care and each record supported nursing staff notified the parents/guardians by telephone and, subsequently, in writing. Three reviewed records were applicable for newly prescribed medication and the chronological notes and the Parental Notification of Health-Related Care form documented the parent/guardian was notified as required. Written parental notices were sent regardless of telephone notifications. Three youth were admitted on prescribed psychotropic medications and the medications continued; therefore, parental notification was not required.

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

The center maintains a written policy and procedures ensuring at the time of admission, each youth will receive a healthcare admission screening utilizing the Department’s Medical and Mental Health Admission Screening form. A review of five youth Individual Healthcare Records (IHCR) found each contained a Medical and Mental Health Admission Screening form completed on the date of admission by a juvenile justice detention officer and each indicated the screening was reviewed by a licensed practical nurse (LPN) within twenty-four hours. Each screening form was completed in the Department’s Juvenile Justice Information System (JJIS)

Admission Wizard. Interviews with nursing staff validated this practice. None of the reviewed records were applicable for a change in physical custody since the youth's admission date. The center reported having no youth applicable for a change in physical custody during this annual review period. In addition, the center had no youth applicable for a qualitative urine pregnancy screening test

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

The center maintains a written policy and procedures ensuring all youth are oriented and have access to all healthcare services through discharge. A review of five youth Individual Healthcare Records (IHCR) supported each contained a completed Department of Health Education form documenting youth orientation to the center's healthcare services. Each youth received a general healthcare orientation within twenty-four hours of admission to the center. Reviewed documentation supported each youth's orientation included access to medical care, sick call, what constitutes an emergency and when to notify staff, medication process and side effect monitoring, the right to refuse care and how it is documented, and what to do in the case of a sexual assault or attempted sexual assault. In addition, each youth was oriented to the non-disciplinary role of the healthcare providers, availability of healthcare staff, dental hygiene, sexually transmitted infections, personal hygiene, immunizations, infection control, nutrition, self-examinations, and a review of healthcare contacts.

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

The center maintains a written policy and procedures ensuring the designated health authority (DHA) is notified when youth admitted required emergency care or routine notification in accordance with Department requirements. A review of five youth Individual Healthcare Records (IHCR) supported the DHA was notified within twelve hours of admission of any youth with a chronic medical condition, psychotropic medication, or medical concern. Notification was documented on the nursing admission chronological notes for four of the five records. One youth record left the DHA notification blank; however, the record contained a DHA order within twenty-four hours of admission, inferring notification. None of the five youth were applicable to be documented on the Chronic Conditions Log of DHA Notification and placed in the Physicians Referral Log for follow-up; therefore, three additional records were requested and reviewed. In each instance, the youth was placed in the Chronic Conditions Log of DHA Notification and placed in the Physicians Referral Log for follow-up, and the DHA was notified within twelve hours or less of admission. Three youth were admitted on prescribed psychotropic medications and the DHA was notified as required. Interview with the nursing staff indicated the DHA is notified by any nurse within twenty-four hours or less of the youth being admitted either through a telephone call or email.

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

The center maintains a written policy and procedures detailing the process for conducting or reviewing admission history. The center utilizes and completes the standard Department Health-Related History (HRH) form for all youth admitted into the physical custody of the center. A review of five youth Individual Healthcare Records (IHCR) found each contained an HRH form completed electronically by a licensed nurse within seven days or less of the youth's admission to the center. Each HRH form was reviewed by the designated health authority (DHA) or advanced practice registered nurse (APRN) and was maintained in the youth IHCR. The HRH form was completed before or at the same time as the Comprehensive Physical Assessment (CPA) for each youth.

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

The center maintains a written policy and procedures ensuring a Comprehensive Physical Assessment (CPA) form will be completed for all applicable youth admitted determining the health and wellbeing of the youth. The center also maintains a written policy and procedures ensuring an alert system is in place to alert staff when medical, mental health, or security issues exist which may affect the security and safety of the youth. The center's policy and procedures for tuberculosis (TB) control and screening addresses the routine screening of all youth for latent and active TB, as well as environmental controls in the case of a youth with active TB. Interviews with nursing staff indicated all youth are screened for TB by placing a Tuberculosis Skin Test (TST) in the left forearm once annually. The test is read by nursing staff within forty-eight to seventy-two hours after placement. A review of five youth Individual Healthcare Records (IHCR) validated three youth had a current CPA on file at admission and two youth required the completion of a new CPA. Reviewed documentation supported the three current CPAs documented a review by the designated health authority (DHA) and/or advanced practice registered nurse (APRN). Reviewed CPAs indicated four were completed by the DHA and one was completed by the APRN. Each CPA was completed in full to include the medical grade, Tanner Stage, cardiovascular, body mass index, visual acuity field, and most recent TST. There were no applicable refusals of the examination; therefore, no signed refusal forms were required. Reviewed practice reflected when the CPA was completed, the Department's Problem List was also updated. There were no applicable youth with any symptoms of active TB in the center at the time of the annual compliance review. The center's internal alert system coincides with the Department's Juvenile Justice Information System (JJIS) and each applicable alert was updated as required.

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

The center maintains a written policy and procedures ensuring all youth are evaluated and treated, if necessary, for sexually transmitted infections (STI). All sexually active youth will be

clinically screened and evaluated for STIs. After the screening, youth will be referred to the designated health authority (DHA) or advanced practice registered nurse (APRN) to determine if further testing is indicated. A review of five youth Individual Healthcare Records (IHCR) indicated each youth was screened for STIs and three required further evaluation. Interviews with nursing staff indicated orders are obtained from the DHA for STI testing and a urine sample is collected to be sent to LabCorp for testing. The center maintains a written policy and procedures ensuring each youth is provided the opportunity to receive counseling, testing, and treatment for human immunodeficiency virus (HIV). All five reviewed youth records supported each youth was offered testing and three consented and two did not consent as documented on the Department's Human Immunodeficiency Virus Antibody Test Youth Consent Form. Five interviewed youth each indicated they could request testing for HIV. One of the center's nursing staff is a certified counselor and provides pre-test and post-test counseling. The nursing staff swabs the youth's mouth and sends to LabCorp. If the results are positive, a blood sample is also tested, and the results are given to the Collier County Health Department. The HIV test results were placed in a sealed envelope marked "Confidential" and filed in the youth IHCR. The Youth Education Record was updated with both pre-test and post-test counseling documentation. Five interviewed youth reported being able to request a HIV test if they wanted one.

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

The center maintains a written policy and procedures ensuring all youth will be able to make sick call requests and have their complaints treated through the sick call system. The sick call process responds to a youth's compliant of illness or injury of a non-emergent nature, but which requires a professional nursing assessment and possibly, a nursing intervention. The center provides sick call seven days a week, two times daily Monday through Friday, from 9:00 a.m. to 11:00 a.m. and from 5:00 p.m. to 7:00 p.m. and once daily Saturday and Sunday, from 9:00 a.m. to 11:00 a.m. A review of five youth Individual Healthcare Records (IHCR) indicated one youth a submitted sick call request; therefore, two additional applicable records were reviewed. Sick calls are documented by direct care staff electronically and communicated to medical staff. All three youth were seen by the licensed practical nurse (LPN) for the sick call within twenty-four hours. Each of the three sick calls were reviewed on the same day by the registered nurse. None of the sick calls required treatment or referral off-site. There were no instances in which a youth presented a similar sick call compliant three or more times in a two-week period or of a youth complaining of any severe pain with which staff were unfamiliar. The center maintains treatment protocols appropriate to the level of the provider conducting sick call approved by the designated health authority (DHA) on July 23, 2019. According to an interview with the DHA, they will conduct sick calls while at the center, if necessary. All three applicable sick call events were documented on the Sick Call Index and Sick Call Referral Log. Sick Call forms documented the nature of the complaint, assessment, and plan to include subjective, objective, assessment, and plan format (SOAP). An interview with the RN indicated when there is not a licensed nurse on-site, the juvenile justice detention officer supervisor (JJDOS) will review the sick calls to determine the need for intervention. The JJDOSs are trained to contact the DHA. There were no sick call requests submitted during the annual compliance review week; therefore, there were no sick calls to observe. Five interviewed staff indicated sick call is conducted by nursing staff. Five interviewed youth found two indicated they can be seen

immediately should they submit a sick call request, and one indicated within one day. Two youth reported never having to submit a sick call request. The three applicable youth reported the nurse conducted the sick call and rated the sick call process as good.

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

The center maintains a written policy and procedures ensuring a comprehensive process of episodic care, first aid treatment, and emergency care. The center utilizes an Episodic Care Log to document episodic care and first aid treatment. The log contains information to include the date, name of youth, the youth's Department identification number, nature of illness or injury, treatment rendered, staff initials, nurse initials, verification of who provided episodic care, and whether the youth was recommended for off-site care. A review of five youth Individual Healthcare Records (IHCR) found none of the youth received episodic care conducted by nursing staff; therefore, three additional applicable youth IHCRs were reviewed for episodic care conducted by nursing staff. All three applicable IHCRs documented problem-oriented elements which were used to capture pertinent information pertaining to the nature of the youth's ailment including identification of the subjective, objective, assessment, and plan (SOAP) to address the complaint. The center had no applicable episodic care events conducted by non-healthcare staff.

The center maintains eleven first aid kits, three of which are located in the laundry rooms on each of the modules, one in master control, one in sub-control, one in the kitchen, one in administration, and four which are stored in the intake area for use in the center's vans used for transport. A random review of three first aid kits found each contained the required items identified on the designated health authority (DHA) inventory list. The center's medical records clerk conducts monthly reviews of the first aid kits and items are replenished upon use and/or expiration date. The medical clerk seals and dates the first aid kits after replenishment and review. The center has two automated external defibrillators (AED) located in the medical clinic and in master control. The AED procedures were located in the AED box as well as audio instructions. Nursing staff and the medical records clerk check the AED batteries and pads weekly to ensure the AED is operational and document their review on a tracking sheet. The AED was self-tested in front of the annual compliance review team to ensure it was operational. The batteries in both AEDs expire on March 28, 2021 and the pads also expire on March 28, 2021. Both AEDs were purchased within the year, and each contained the original batteries and pads.

A review of five non-healthcare staff training records found three staff were trained in cardiopulmonary resuscitation (CPR), first aid, and AED in 2018; however, each of the five staff received the required training in 2019 and each held current certifications. All non-healthcare staff and nursing staff are required to maintain certifications. Reviewed documentation supported the DHA, the advanced practice registered nurse (APRN), and all nursing staff maintained current certifications in CPR and AED. Emergency contact numbers were observed posted in the medical clinic, in administration, and in master control to include the number for the statewide Poison Information Center and nursing interviews validated this. Only healthcare and trained supervisory non-healthcare staff can administer the epinephrine auto injector for youth requiring administration, when indicated. A review of five training records supported each staff received the required training on the center's Emergency Care Plan and the supervisory staff received training on epinephrine auto injector. The center's policy and procedures indicated

emergency drills are conducted for each shift on a quarterly basis at minimum, and life saving techniques such as CPR must be demonstrated at least once a quarter each year. A review of quarterly mock emergency drills since the last annual compliance review supported drills were conducted at least once a month on each shift and documented use of life saving techniques such as CPR at least once a quarter on each shift. All documented drills included the type of medical event, time the drill/event occurred, time 9-1-1 was called, name of the juvenile justice detention officer supervisor, healthcare provider in charge, healthcare provider response time, type of medical care rendered, time the event concluded, clinical manager/medical staff review, and critique. Five staff were interviewed to determine if they can call 9-1-1 if necessary and each stated they can call if needed.

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

The center maintains a written policy and procedures to provide for timely referrals and coordination of medical services to ensure youth have timely access to off-site care services. A review of five youth Individual Healthcare Records (IHCRs) found none were applicable for off-site medical care. The center reported there were two youth applicable for off-site medical emergency care during this annual compliance review period, and each record was reviewed. Both youth were taken off-site for emergency care. The designated health authority (DHA) was notified for each emergency event. Each youth IHCR contained a Summary of Off-site Care form, discharge documentation, and instructions. The DHA documented a review of the off-site care findings, instructions, and information. One youth required an additional referral for follow-up testing or appointment and documentation validated the referral was entered on the Sick Call/Referral Log for tracking and the follow-up was conducted as recommended

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

The center has a policy and procedures to ensure youth identified with chronic conditions receive regularly scheduled evaluations and necessary follow-up care. The frequency of the periodic evaluation is determined by the youth's condition, clinical needs, and clinically appropriate medical standards. Youth are screened during the intake process for medical conditions warranting periodic evaluations and follow-up care. A review of five youth Individual Healthcare Records (IHCRs) found none were applicable for the existence of chronic conditions; therefore, three additional applicable records were requested. Reviewed documentation reflected each applicable youth was classified with a medical grade between two and five. One youth was classified with a body mass index (BMI) greater than thirty and two youth were undergoing treatment for a physical health condition. None of the youth were applicable for taking anti-tuberculosis medication or were pregnant. Treatment orders were written so they are clearly distinguishable for clinical staff. There were no indications of lapses in care or missed periodic evaluations. All three youth were placed on the chronic conditions roster. In addition, reviewed records reflected each Department Problem List was updated as required.

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

The center has a policy and procedures ensuring all medication and pharmaceutical products are procured, dispensed, administered, and stored safely, accurately and in accordance with state, federal, and industry standards. The center's practice is for nursing staff to verify all medications will have a current, valid order and are given according to a current prescription or practitioner's order. Nursing staff verify medication with the parent/guardian when they deliver the medication to the center. The Medication Receipt, Transfer, and Disposition Form is used to document medication received in the original packaging from a licensed pharmacy with a current legible patient-specific label affixed. A review of five youth Individual Healthcare Records (IHCRs) identified four youth were taking prescribed medication upon admission and were applicable for medication management. Each applicable IHCR documented verification of prescription medication by the nurse. In each applicable record, the licensed nurse obtained an order from the designated health authority (DHA) to resume the applicable medication and all orders were signed by the practitioner. There were no applicable over-the-counter (OTC) medications not listed on the Authority for Evaluation and Treatment (AET) form administered. The center maintains a contract with Diamond Pharmacy Services for procurement of medications and a Modified Class II Type B Pharmacy Permit with an expiration date of February 28, 2021. All medication is delivered to the center in blister packs. The center maintains a current Drug Enforcement Administration (DEA) Controlled Substance Registration Certificate with an expiration date of June 30, 2020 and a Clinical Laboratory Improvement Amendments Certificate of Waiver with an expiration date of June 7, 2021. The center utilizes the standard Department Medication Administration Record (MAR) for each youth receiving either prescription medications on a routine basis or OTC medications. Reviewed documentation reflected the staff initialed each administered medication entry and the four applicable youth documented their initials on the MAR. When the youth refused the medication administration, the refusal was clearly documented on the MAR and the Department's Refusal of Treatment Form was completed. The center maintains a written policy and procedures to ensure the usage of the MAR by licensed healthcare staff and non-licensed staff. Each reviewed MAR clearly documented the youth's name, Department identification number, date of birth, youth allergies, precautions, medical grade, medical alerts, and current picture of the youth. The MAR clearly indicated medication start and stop dates and nursing staff documented weekly side-effect monitoring. There were no lapses or errors noted. No youth required parenteral medication. The center has a secure refrigerator in the medical clinic which contained Tuberculin vaccinations during the annual compliance review. Nursing staff track daily temperatures of the refrigerator. The center has authorized and trained the superintendent, the assistant superintendent, and all juvenile justice detention officer supervisors (JJDOS) to assist youth with self-administration of medication. The center's practice is to have licensed nursing staff on-site until 7:00 p.m. seven days a week, thereby having only nursing staff to administer medication. Trained supervisory non-licensed staff are permitted to provide OTC medications when nursing staff are not on-site. A review of two applicable JJDOS training records found each received training on the MAR. The center did not have any standing orders for psychotropic medications, no pro re nata (PRN) orders for psychotropic medications, or emergency treatment orders for psychotropic medications. Four of the five reviewed youth records found the youth was admitted on prescribed medications of which three were prescribed psychotropic medications. The DHA and the designated mental health clinician authority (DMHCA) was notified for each admission. The psychiatrist was notified when the medication

was received to obtain an order for continuation. Reviewed documentation supported all three youth received an initial diagnostic psychiatric interview conducted less than the required fourteen days of admission. Youth receiving psychotropic medications are reviewed weekly each time the psychiatrist is on-site. There was one youth with psychotropic medications prescribed subsequent to admission and received the same medication monitoring from the psychiatrist. Observations of four medication administration validated the JJDOS escorted the youth to the medical clinic. The nurse had the medication cart pulled up to the door and each youth approached the nurse one at a time and the nurse pulled the medication from the secured medication cart and checked it against the MAR. The medication was administered, and the MAR was updated accordingly. Observations also included the nursing staff reading the results from the Tuberculosis Skin Test (TST) for two of the four youth. The center utilizes RX Destroyer for the disposal of medications. The center maintains a contract with Consulting Pharmacist, Inc. and reviewed documentation supported the consultant pharmacist conducted a pharmacy audit monthly. Monthly audit forms documented whether or not the center required any controlled medications disposal. The practice is for the consultant pharmacist and the on-site nurse to dispose the medication(s) which cannot be returned to Diamond Pharmacy for credit and document it on the Medication Disposal Form. Disposal of non-controlled medications is documented on the Drug Disposal Form. Five interviewed staff indicated they do not provide medication to youth. Informal interviews with staff indicated only the doctor, nursing staff, and trained juvenile justice detention officer supervisory staff are trained and permitted to give medications to youth. Five interviewed youth found three youth indicated the nurse provides medication to youth and one youth indicated the doctor provides medication. One youth did not take any medication.

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

The center maintains a written policy and procedures ensuring medications and any medical equipment classified as sharps will be secured and inventoried. The dose-by-dose daily administration and documentation of a medication is documented utilizing a perpetual inventory process for the daily distribution of non-controlled prescription medication and over-the-counter (OTC) medication. Documentation of each individual dosage of medication administered to youth is maintained on the Medication Administration Record (MAR) to demonstrate the distribution of medications. Any medical equipment classified as sharps is secured and inventoried utilizing a routine perpetual inventory descending count as each sharp is utilized and disposed. A review of the medical clinic found the clinic is secured under lock and key. Medical staff and trained juvenile justice detention officer supervisors (JJDOS) non-healthcare staff have access to the clinic. The JJDOS non-healthcare staff are trained by the registered nurse to assist youth with self-administration of OTC medication. A locked medication cart is located in the medical clinic and stores oral prescription and over-the-counter (OTC) medications prescribed for youth. Medication in the cart is separated by each youth. A second locked medication box is in the medication cart which stores controlled medication. The center maintains an inventory of all sharps and medical equipment classified as sharps to include syringes, butterflies, scissors, needles, and suture removal kits. Items designated as sharps are stored in a designated locked cabinet in the medical clinic and are inaccessible to youth. A review of the perpetual inventory for the past six months found sharps inventory counts to be accurate. A review of three random sharps found the counts were accurate. A review of three

random prescription medications and three random OTC medications found the counts were accurate. A review of the running daily inventory of all prescription and OTC medications matched the random count. The center had no controlled medications on-site during the annual compliance review.

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

The center maintains a written policy ensuring proper procedures are followed to prevent the spread of infectious diseases or illnesses and provide staff with the knowledge of appropriate prevention, containment, treatment, and reporting requirements of infectious diseases. The center also maintains a separate Exposure Control Plan/Infection Control Plan approved by the designated health authority on July 2, 2019. A review of five youth Individual Healthcare Records reflected each youth received infection control training within twenty-four hours of admission. The infection control training included hand-washing techniques, universal/standard precautions, prevention/transmission of communicable diseases, vaccinations, and the Center for Disease Control and Prevention (CDC) guidelines for infection control. Reviewed documentation supported the Exposure Control Plan/Infection Control Plan was written in accordance with Occupational Safety and Health Administration (OSHA) guidelines to include risk assessment and methods of compliance. The plan also addressed common childhood infectious diseases, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, tuberculosis, Hepatitis A, B and C, human immunodeficiency virus (HIV), bloodborne pathogens, other outbreaks and epidemics, and outbreaks of pediculosis. In addition, the plan included methicillin resistant staphylococcus aureus (MRSA) and other antibiotic-resistant micro-organisms, food-borne illnesses, bioterrorism agents, chemical exposures in the workplace, and protocols for needlestick post-exposure intervention and treatment. The center ensures Hepatitis B immunization is made available for staff and staff have access to protective equipment. There were no reportable incidents for which the local county health department, Centers for Disease Control and Prevention (CDC), and the Department's Central Communications Center (CCC) should have been notified of an infectious disease since the last annual compliance review. A review of five staff training records supported each staff received pre-service and in-service training on the center's Exposure Control Plan/Infection Control Plan.

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

The center has a written policy and procedures for the care of pregnant youth to include procedures for medical issues, nutrition, education, and medication. An interview with the nursing staff indicated the center had no pregnant youth since the last annual compliance review. Reviewed healthcare education information supported each pregnant youth receive pre-natal education to include alcohol and drug use, smoking, nutrition, sexually transmitted infections, contraception, prenatal care, birthing process, postpartum care, basic baby care, child/infant development, and parenting skills. While at the center, nursing staff monitored each

youth for weight and nutritional status. A review of five staff training records verified each staff received Girls Health training specific to working with pregnant youth. Staff training was provided by the registered nurse (RN) at the time of hire and annually, thereafter.

Standard 5: Safety and Security

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

The center maintains a written policy and procedures ensuring youth are actively supervised by staff. Staff communicate by way of two-way radio with master control any issues pertaining to the center and youth supervision. The center utilizes a roster generated in the Department's Juvenile Justice Information System (JJIS) to track the daily census of the youth. During the annual compliance review week, daily observations of youth were conducted throughout the center which confirmed the active supervision of youth by detention staff. Staff were observed supervising youth during school, transport, line movements, lunch, and in the modules. Each observation found there were always at least two or more detention staff with each group of youth. Each observation indicated staff were positioned in a manner providing them full view of youth in the area, were aware of the number of youth being supervised, were in sight and sound of youth, and requested permission from master control prior to any youth movement. No inappropriate actions were observed between youth and staff. Staff were observed having positive interactions with youth. A review of the master control logbooks for the past six months prior to the annual compliance review confirmed youth headcounts have been completed consistently at the beginning and end of each shift, and prior to each youth movement. Five staff were interviewed, and each staff reported they believe there is enough staff at the center to provide for the safety and security of the youth and staff.

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

The center has a written policy and procedures ensuring ten-minute checks are conducted when youth are in their rooms for sleeping or other reasons. The center has a total of sixty-four operable cameras with a recording capacity of thirty days. The center utilizes the Guard One Plus which is an electronic system to document ten-minute checks. Staff utilize the electronic Guard One Plus wand by tapping the want on the check point sensor located on the outside of each youth's room door. The data from the wand is downloaded daily to ensure no data is lost. The juvenile justice detention officer (JJDO) is responsible to pause at the door and observe the youth behind the closed door before the check point sensor is activated with the want to ensure there are no issues with the youth. The superintendent was interviewed and validated this practice. Observations of youth living modules and rooms confirmed there were no obstructions over the windows and areas in which direct line of sight is needed. Observations of ten-minute room checks on three different modules, from three different shifts, and six different days and times along with corresponding ten-minute log supported checks were being conducted every ten-minutes, or less, and in real time. Five staff were interviewed, and each staff reported rooms checks are completed every ten-minutes.

5.03 Census, Counts, and Tracking	Satisfactory Compliance

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

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

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

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

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

The center has written policy and procedures ensuring logbooks are maintained at master control and in each living area in accordance with Florida Administrative Code. The center maintains separate logbooks in master control and for each living module, as well as one for visitors, and one for contracted staff. Logbooks are also maintained to document emergencies and emergency drills. Observations of each logbook confirmed they were bound together with numbered pages. The center does not utilize electronic logbooks. A review of logbooks for the last six months for each living module and master control revealed all entries were legible and written in ink, with no erasures or whiteout areas. Each entry included the date and time of the event or incident with the name of the staff and youth involved, and a brief description of the event and the initials of the staff making the entry. However, 173 out 206 reviewed logbook pages did not include the a.m. or p.m. on the time entry. All entries for the last six months revealed safety and security of the facility, including medical, special needs, and mental health alerts were highlighted. Reviewed logbooks reflected all errors are struck through with a single line and dated and initialed by the person correcting the error. Reviewed master control logbooks included emergency situations, incidents, fire and escape drills, population counts at the beginning and end of each shift, group movements, admissions and releases, presence of law enforcement, and name of youth placed in confinement, including the time confinement began and the time confinement ended, name of youth placed on precautionary/secure observation, including the time precautionary/secure observation began and the time precautionary/secure observation was discontinued.

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

The center has a written policy and procedures ensuring logbook reviews are conducted as required. The superintendent or designee reviews the logbooks on a weekly basis and documents any issues and/or discrepancies. The juvenile justice detention officer supervisor reviews the living module logbooks each shift, including the master control logbook prior to accepting a shift, to document they are aware of all current relevant situations in the center. The juvenile justice detention officer assigned to the living modules reviews the living module logbook when accepting responsibility for the living area at shift change. A review of the master control and living unit logbooks for the past six months supported these practices. The superintendent was interviewed and confirmed this practice.

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

The center maintains a written policy and procedures ensuring the inventory and control of all center keys, as well as replacing lost or damaged keys. Center keys are maintained on a tamper-resistant ring with a brass tag identifying the ring number and the number of keys on the ring. Center keys, including restricted keys, are stored in master control in a locked key box accessible by the master control operator, juvenile justice detention officer supervisors (JJDOS), and administrative staff. Emergency keys providing egress through exterior doors are stored in master control and the module sub control rooms in which only staff can access. All keys are inventoried in the Facility Management System (FMS). The center maintains a master key inventory which accounts for all key rings by ring number, the number of keys on each ring, to the staff assigned to the key, and the capability of each key. Staff must turn in all personal keys to master control prior to entering into the center. All personal keys are stored in a secured

locked box located in the lobby area. The JJDOS are issued keys through the master control operator at the beginning of each shift. A review of the master control logbook and observation of distribution and collection of keys validated the issuance of keys/key rings were documented in the master control logbook on each shift with the date, time, staff name, and initials of staff issuing the keys. Juvenile justice detention officers (JJDO) are issued keys through the JJDOS during shift briefings. Each JJDO is required to sign and enter the date and time on the key control log when issued their keys. Each JJDO turns their keys back into the JJDOS at the end of their shift and must sign, date, and enter the time again on the key log. The JJDOS returns all keys back to master control at the end of their shift and signs, dates, and enters the time in the master control key log. Observations conducted during the annual compliance review week confirmed this practice. A review of the master key control inventory during the annual compliance review validated the inventory report matched the actual keys in use. Observations during the annual compliance review week found staff were carrying their assigned keys on their person at all times, and youth did not have access to any keys. An informal interview with two youth was conducted. Each youth denied having access to any center keys. All center keys were accounted for during the review. An informal interview was conducted with the center's superintendent. The superintendent reported staff are not issued permanent keys. There have been no incidents of lost keys or incidents in which staff have left the center with center keys since the last annual review. The superintendent confirmed if for some reason keys were lost in the center, the center would be locked down and a search would be conducted immediately. A report would be initiated to the Department's Central Communications Center (CCC) if the keys were not found within two hours. Visitor keys are stored in sub-control in a locked box only accessible to supervisors and administrative staff. Five staff were interviewed, and each responded restricted keys included access to medical records, mental health records, and case management records. Each staff reported youth do not have access to center keys. Each interviewed staff could articulate the daily process for tracking keys at the center, including the usage of a key control log.

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

The center has a written policy and procedures ensuring vehicles to transport youth are properly maintained, inspected annually, and in good repair. The maintenance mechanic is responsible for weekly and monthly vehicle inspections. The center has a total of four vehicles used to transport youth. Reviewed documentation validated each vehicle had an annual safety inspection conducted by a certified automobile mechanic. Observations of the four vehicles verified each vehicle was locked when not in use. Inspections of the four vehicles confirmed each vehicle had the appropriate number of seat belts, seat belt cutter, a window punch, up-to-date fire extinguisher, and a first aid kit with approved and up-to-date items. The center's facility operating procedures prohibits tobacco usage in vehicles and is supported by "No Smoking" stickers posted in the driver cabin of each vehicle. Each vehicle was observed to have a binder which contained the vehicle mileage log, mechanical restraint key, gas card, vehicle policy, and vehicle registration. Each vehicle is inspected prior to transporting youth using the Department's approved checklist. Reviewed documentation supported this practice. Weekly visual vehicle inspection checks are conducted on each vehicle as required and documented on the

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

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

The center maintains a written policy and procedures ensuring tools and equipment are properly maintained, stored, and inventoried. The center's maintenance tools are maintained in a secure locked storage building only accessible to maintenance staff and administrators. Tools are stored on a shadow board and marked with an identification number. A perpetual tool inventory list of tools is maintained by the center to document what tools are being used by the maintenance staff including the times the tools were checked-out, the location of the tools, and times the tools were returned. An interview with the maintenance mechanic confirmed inventory is conducted monthly by maintenance staff and reviewed by the superintendent or designee. The center's kitchen tools, inclusive of knives and scissors, are securely stored in a locked box, with an inventory sheet, located in the kitchen. A perpetual inventory of kitchen tools is maintained, and counts are documented three times each day. Any maintenance or kitchen tools in need of disposal or replacement is requested by completing a tool disposal/replacement report which the maintenance or food service manager signs and gives to the superintendent for approval. Additionally, when tools are lost or if there is suspicion a youth may be in possession of a tool, the juvenile justice detention officer supervisor (JJDOS) is notified immediately, and a search is conducted. A review of the monthly inventory sheets confirmed there were no missing maintenance or kitchen tools. An informal interview with the center's superintendent confirmed there have been no missing tools in the past six months. During the annual compliance review week, an observations of interactions with service vendors and staff were completed. Observations found staff accompanied service vendors at all times, and positively identified service vendors prior to allowing vendors access to secure areas. Five staff were interviewed regarding center's practice for lost or damaged tools. Four out of five staff were able to articulate the practice for lost or damaged tools and reported they would notify their supervisor. One out of five staff was not aware of the practice for lost or damaged tools.

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

The center has a written policy and procedures ensuring youth do not have access to any tools, including kitchen or medical equipment. The center only allows youth to have access to mops,

brooms, buckets, cleaning rags, and other common household items for general cleaning. Youth are constantly supervised when utilizing these items. An observation during the annual compliance review supported this practice. Five youth were interviewed, and each confirmed they are not allowed to use any tools. Five staff were interviewed, and four stated youth are only allowed to use mops and brooms. One staff reported youth do not have access to any tools.

5.10 Inventory of all Flammable, Toxic, Caustic, and Poisonous Items	**Satisfactory Compliance**
The Superintendent is responsible for the implementation of a safety plan addressing proper use, storage, and disposal of chemicals, including flammable, toxic, caustic, and poisonous items. *All flammable, toxic, caustic, and poisonous items shall be inventoried and secured when not in use. The use of hazardous material shall be consistent with the manufacturers' instruction and all safety precautions shall be followed.* *All flammable, toxic, caustic, and poisonous items shall have the Material Safety Data Sheets (MSDS) on hand in the facility. Toxic or caustic materials shall not be allowed to enter into the facility unless an MSDS is on file in an MSDS logbook and posted near items. A master copy of the MSDS logbook shall be maintained in an accessible binder for all personnel to review at all times.* *No hazardous chemicals should be mixed, as this could result in an explosion or emission of toxic gas.*	

The center has a written policy and procedure to address the inventory of flammable, toxic, caustic, and poisonous items. Flammable, toxic, caustic, and poisonous items are maintained in a locked, secure storage area with limited access and not accessible to youth. Safety Data Sheets (SDS) logbooks are located at the location the chemicals are stored. All items are inventoried weekly by the maintenance mechanic and securely stored when not in use. Each item observed had a SDS on record for each item stored. Observation of the secure storage area and the inventory list indicated all items matched the inventory list and are stored in the locked storage. The SDS and inventories were compared to the items on-site and were found to be accurate and complete.

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

The center has a written policy and procedure ensuring limited access to flammable, toxic, caustic, and poisonous items. Youth are not permitted to access any materials which are flammable, toxic, caustic, and/or poisonous. The center maintains a list of authorized staff who are allowed access to chemical storage. An informal interview with the center's superintendent confirmed flammable, toxic, and caustic materials are stored in secure storage areas in the kitchen and maintenance storage area, and are only accessible to maintenance staff,

supervisors, administrators, and the food service director. Observations conducted during the annual compliance review found there are no toxic, flammable, or poisonous materials stored in any placed accessible to youth. Five staff were interviewed, and each reported youth are not allowed to use any toxic, flammable, or poisonous substances. Five youth were interviewed, and each confirmed they are not allowed to use any cleaning agents such as bleach, laundry soap, window, or toilet cleaner.

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

The center has a written policy and procedures which address proper use, storage, and disposal of flammable, toxic, caustic and poisonous items. The center has a safety plan in place to address any chemical spills or leaks. The kitchen has an outdoor container outside to store grease for which a contractor provider is maintained with J.C. Drainfield, INC. for disposal. The plan addressed what procedure to follow in the event of a chemical leak or spill. The maintenance mechanic confirmed materials are disposed of by transport to the Collier County Public Utilities Department, Solid and Hazardous Waste Management Facility. The maintenance mechanic confirmed there have been no chemical spills or leaks within the annual compliance review period. If a chemical spill occurs, procedures indicate a staff will notify master control of the location of the spill, a juvenile justice detention officer supervisor and/or master control shall direct the shutdown of all air handlers, ventilation system, and close all windows and doors. The center will then obtain assistance from outside the center by contacting the necessary emergency contacts. Biohazardous waste disposal is the responsibility of the medical staff.

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

The center maintains a written policy and procedures ensuring confinements under twenty-four hours are used as an immediate, short-term response strategy during volatile situations with a youth's sudden or unforeseen onset of behavior imminently and substantially threatens the physical safety of others or self. The center utilizes the youth's assigned sleeping rooms for confinement. Youth who are placed in confinement have no contact with the general population. A search of the room is conducted prior to the youth being placed, and all non-fixed items are removed from rooms. The center documents under confinements under twenty-four hours in the Facility Management System (FMS). A review of five confinements reports found each youth was afforded the same services as youth in general population. Confinement reports confirmed all rooms were searched prior to youth being placed in confinement and each room was free from any obstructions. Each reported supported visual observation was conducted in accordance with the Department's policy. Each reviewed report indicated all reports were completed within one hour. Each reviewed report indicated the juvenile justice detention officer supervisor (JJDOS) completed reviews within two hours, evaluated the youth every three hours, and documented the need for confinement based on the severity of the rule, violations, past disciplinary history of behaviors while in confinement. Each of the five confinement reports indicated the superintended and/or designee reviewed the confinement report within twenty-four

hours. An informal interview with the superintendent validated this practice. Five staff were interviewed, and each staff reported when a youth is placed in confinement staff must document room checks. Two staff also reported a confinement report and a room search must also be conducted.

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

The center has a written policy and procedures addressing confinement over twenty–four hours which requires confinement reports to be submitted within one hour of the incident and reviewed within two hours by the superintendent or designee. Three confinements over twenty-four hours were documented since the last annual compliance review. The three confinement reports stemmed from the same incident report on April 11, 2019. A review of the three confinement reports found each report was approved by the superintendent. The juvenile justice detention officer supervisor (JJDOS) completed reviews within two hours and evaluated the youth every three hours. None of the confinement reports reviewed included a review by the mental health professional or approval by the regional director within twenty-four hours. Each confinement was terminated at twenty-four hours and twenty minutes. Subsequently, after further review of the confinement reports and interview with the superintendent, it does not appear it was the intent of the center to continue the confinements beyond twenty-four hours; therefore, a mental health review and regional director approval was not relevant. None of the reviewed confinements extended beyond three days; therefore, no confinement hearings were required.

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

The center has a written policy and procedures ensuring a plan in place to manage various emergencies and disaster events. The center's Continuity of Operations Plan (COOP) was approved by the Department on August 28, 2019. Center documentation confirmed there were three COOP drills conducted, which is more than the two drills required. Hurricane drills were

conducted in January, May, and September of 2019. One out of three drills was conducted in May, just prior to hurricane season as required. Observations made of the drill forms indicated each contained written scenarios and COOP Drill forms, critique forms, and e-mails used to document the drills. All drills were documented on the drill form and in the logbooks. Five staff were interviewed and asked what drills they have participated in the last six months. Each staff reported participating in a fire drill. Four staff also reported participating in an escape drill. Two also responded they have participated in a weather drill and one stated they participated in a disturbance drill.

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

The center has a written policy and procedures ensuring there is a plan in place to prevent, manage, and address youth escapes. A review of the prevention plan confirmed all required elements outlined in the Department's policy. The center requires escape drills to be conducted at least once a quarter. A review of the center's escape drills since the last annual compliance review, along with corresponding logbook entries, verified the center exceeded the requirements and conducted drills monthly. Drills are reviewed during staff meetings and shift briefings. Reviewed documentation found all drills were documented on drill forms and in the logbook. Additionally, staff signed a roster acknowledging they participated in the drill. An interview with the center's superintendent confirmed this practice. The superintendent reported the center has a safety officer as well. A review of five staff training records validated annual escape training was completed by each reviewed staff. Five staff were interviewed and asked what drills they have participated in the last six months. Four out of five staff stated they have participated in an escape drill. One staff denied participating in an escape drill within the last six months.

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

The center has a written policy and procedures ensuring fire prevention and safety of the center. The center's fire prevention and safety plans were reviewed and approved by the state fire marshal on February 2, 2019. Annual inspections are conducted by the fire marshal. The center has evacuation egress plans posted throughout the center. Each egress plan defined primary and secondary exit routes, and the locations of emergency equipment, such as fire extinguishers and first aid kits. A review of the emergency drills and logbook documentation for the past six months confirmed the center conducts fire drills every moth, one each shift, during different times, as required. Drills are reviewed during staff meetings and shift briefings. A review of five staff training records validated annual fire prevention training was completed by each reviewed staff. Five staff were interviewed, and each staff reported they have participated in at least monthly. Five youth were interviewed, and four reported they have been instructed on what to do in case of a fire. One reported they were never told what to do in case of a fire.