STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

PROGRAM REPORT FOR

Collier Regional Juvenile Detention Center

Department of Juvenile Justice

(State-Operated)
3315 East Tamiami Trail
Naples, Florida 34112

Review Date(s): November 27-30, 2018

PROMOTING CONTINUOUS IMPROVEMENT AND ACCOUNTABILITY
IN JUVENILE JUSTICE PROGRAMS AND SERVICES

Rating Definitions

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

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

Review Team

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

Marie Lockwood, Office of Program Accountability, Lead Reviewer (Standard 1)
Ell Fance, Miami-Dade Regional Juvenile Detention Center, Superintendent (Standard 2)
Tonya Gittens, Office of Program Accountability, Regional Monitor (Standard 5)
Patrick Morse, Office of Program Accountability, Regional Supervisor (Standard 3)
Joey Nice, DJJ Office of Education, West Region Education Coordinator (Standard 2)
Maryann Sanders, Office of Program Accountability, Deputy Regional Supervisor (Standard 4)

Program Name: Collier Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: Collier County / Circuit 20
Review Date(s): November 27-30, 2018

MQI Program Code: 997
Contract Number: N/A
Number of Beds: 45
Lead Reviewer Code: 165

Methodology

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

Persons Interviewed

☒ Program Director
☐ DJJ Monitor
☒ DHA or designee
☒ DMHCA or designee

_____ # Case Managers
2 # Clinical Staff
1 # Food Service Personnel
1 # Healthcare Staff

1 # Maintenance Personnel
2 # Program Supervisors
3 # Other (listed by title): **JJDO**

Documents Reviewed

☐ Accreditation Reports
☒ Affidavit of Good Moral Character
☒ CCC Reports
☒ Confinement Reports
☒ Continuity of Operation Plan
☐ Contract Monitoring Reports
☐ Contract Scope of Services
☒ Egress Plans
☒ Escape Notification/Logs
☐ Exposure Control Plan
☒ Fire Drill Log
☒ Fire Inspection Report

☒ Fire Prevention Plan
☒ Grievance Process/Records
☒ Key Control Log
☒ Logbooks
☒ Medical and Mental Health Alerts
☒ PAR Reports
☒ Precautionary Observation Logs
☒ Program Schedules
☒ Sick Call Logs
☒ Supplemental Contracts
☒ Table of Organization
☒ Telephone Logs

☒ Vehicle Inspection Reports
☒ Visitation Logs
☒ Youth Handbook
5 # Health Records
5 # MH/SA Records
5 # Personnel Records
5 # Training Records/CORE
_____ # Youth Records (Closed)
5 # Youth Records (Open)
_____ # Other: _____

Surveys

5 # Youth

5 # Direct Care Staff

_____ # Other: _____

Observations During Review

☒ Admissions
☐ Confinement
☒ Facility and Grounds
☒ First Aid Kit(s)
☐ Group
☒ Meals
☒ Medical Clinic
☒ Medication Administration

☒ Posting of Abuse Hotline
☒ Program Activities
☒ Recreation
☒ Searches
☒ Security Video Tapes
☒ Sick Call
☒ Social Skill Modeling by Staff
☒ Staff Interactions with Youth

☒ Staff Supervision of Youth
☒ Tool Inventory and Storage
☒ Toxic Item Inventory and Storage
☒ Transition/Exit Conferences
☒ Treatment Team Meetings
☐ Use of Mechanical Restraints
☒ Youth Movement and Counts

Comments

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

Standard 1: Management Accountability
Detention Rating Profile

Indicator Ratings

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

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

Standard 2: Youth Management
Detention Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Detention Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Detention Rating Profile

Indicator Ratings

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

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Strengths and Innovative Approaches

- The center hosts pot luck gatherings which are held on special occasions such as holidays and are for both youth and staff. The gatherings promote conversation and sharing of ideas.
- The center holds job fairs for youth throughout the year. Vendors from different organizations set up booths at the center and discuss potential career paths with the youth. Mock interviews are conducted to assist youth in preparing for employment.
- The center has developed a voluntary boot camp style fitness program to encourage youth fitness.
- The center hosts a Friday ice cream social for staff and youth. As with the pot luck, the ice cream socials promote communication and sharing ideas.
- The center has worked with the Probation and Community Intervention staff in Circuit 20 to allow youth on probation to report to the center to assist with projects such as gardening, painting, and clean-up projects. They are accompanied by juvenile probation officers and the work completed is credited toward their court-ordered community service hours. Youth in the center can participate in the same activities to complete their court-ordered community service hours.
- Youth in the center are able to assist in creating murals throughout the center. Many of the murals have motivational messages which can be inspirational to other youth. Youth who participate receive positive reinforcement from staff.

Standard 1: Management Accountability

Overview

Collier Regional Juvenile Detention Center is a forty bed, hardware secure facility serving male and female youth detained by various circuit courts. Youth are detained pending adjudication, disposition, or placement to a residential commitment program. The center is located in Naples, Florida and provides twenty-four-hour supervision for youth in a safe, secure, and humane environment. Youth services include intake and orientation, behavior management, transportation, safety, and emergency procedures. Medical, mental health, dental, and substance abuse services are provided to youth. Healthcare services are contracted through Maxim Healthcare Services, Inc. Education services are funded and provided by the Department of Education through the Collier County School District. Youth participate in daily structured activities to include education, exercise, groups, meals, and hygiene. A tour of the center was conducted on the first day of the annual compliance review and found common areas, hallways, dining area, kitchen, youth modules, and classrooms clean and in good repair. A tour of the perimeter found the grounds were well-maintained and the perimeter secure. During the time of the annual compliance review, the program reported eight staff vacancies to include six juvenile justice detention officer I vacancies and two juvenile justice detention officer II vacancies.

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

The center has a policy and procedures to ensure initial background screenings are conducted. A review of the staff roster found eleven staff were applicable for initial background screening since the last annual compliance review. Each applicable staff had an initial background screening completed prior to their date of hire. The criminal history report was reviewed for each staff and all were found eligible for hire. Staff were documented on the Department's Clearinghouse Employment Roster and were reviewed through the Staff Verification System (SVS). Eight of the eleven staff hired were applicable for the pre-employment assessment tool administered to direct care staff. A review of staff records found each of the applicable staff attained a passing score. None of the newly hired staff required an exemption by the Department's Office of Inspector General, Background Screening Unit (BSU) prior to employment or found ineligible for employment. An Annual Affidavit of Compliance with Level 2 Screening Standards (Form IG/BSU-006) was completed and submitted to BSU on January 26, 2018, meeting the annual requirement.

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

The center has a policy and procedures to ensure the completion of a background rescreening for staff every five years, calculated from the date of hire. A review of staff records found one staff was applicable for five-year background rescreening since the last annual compliance review. A rescreening was submitted to the Department's Background Screening Unit (BSU) and was completed on August 7, 2018, in compliance with the requirement for background rescreening at least ten days prior to the staff member's five-year anniversary date. There were no contracted providers, volunteers, educational staff, medical staff, mental health staff, or interns requiring a five-year background rescreening during this annual compliance review period.

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

The center has a policy and procedures detailing staff code of conduct. Staff are required to adhere to the code of conduct which prohibits any type of abuse, profanity, threats, harassment, intimidation, horseplay, or personal relationships with youth. A review of five staff records verified each staff signed the code of conduct form, which was maintained in their employee record. None of the staff were found to have disciplinary actions or code of conduct violations. An interview with the superintendent indicated there were eight violations of code of conduct during the annual compliance review period which involved four staff. A review of documentation supported management took immediate action and provided staff counseling, addressing all noted instances of the violations and performance issues. Three staff members received a verbal reprimand initially and subsequently received a written reprimand for

additional violations. One staff member was terminated. The superintendent indicated none of the staff received commendations since the date of the last annual compliance review. Interviews with five youth indicated staff treat youth respectfully and youth are not threatened by staff. Youth reported feeling safe in the center. Youth indicated staff sometimes curse in general terms not directed toward youth. Interviews with five staff indicated staff have never seen a co-worker using threats, intimidation, or humiliation toward youth.

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

The center has a policy and procedures to ensure whenever a reportable incident occurs, the program notifies the Department's Central Communications Center (CCC) within two hours of the incident, or within two hours of becoming aware of the incident. The program had twenty-seven reportable incidents during the annual compliance review period. A review of five incidents within the past six months indicated incidents were reported to the CCC within two hours, as required. All five incidents documented the incident date, time, and incident type. A review of logbooks found each incident was documented. A review of internal incidents for the past six months found there were no additional incidents which should have been reported to the CCC. An interview with the superintendent indicated there has not been an increase in the number of reportable incidents to the CCC. A review of the grievance log found there were no reported grievances since the last annual compliance review. Interviews with five youth indicated each youth was aware of their right to access the Florida Abuse Hotline, felt safe in the center, and felt staff were respectful. The superintendent indicated staff document incidents in the Department's Juvenile Justice Information System (JJIS) prior to the end of their shift and note the incident in the unit logbooks and master control logbook. Administration and the Protective Action Response (PAR) instructor review the video recordings within seventy-two hours. If abuse is observed, administration contacts the CCC and an investigation is initiated.

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

The center has a policy and procedures to ensure Protective Action Response (PAR) techniques are used in accordance with Florida Administrative Code. 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 Development and Training on January 19, 2018. The program had forty-six PAR incidents during the annual compliance review period. A review of six PAR incidents found each report was completed by the end of the shift, in accordance with the Florida Administrative Code and included statements from all staff involved. None of the youth involved in the reports sustained injuries, required medical attention, or placed an abuse call to the Florida Abuse Hotline. All reports were reviewed by the supervisor and PAR instructor to determine if use of force was consistent with the PAR policy and techniques approved by the Department. Each incident was found to be in compliance. PAR incidents were reviewed by the superintendent/designee within seventy-two hours. Post-PAR interviews with youth were

conducted within thirty minutes of the incidents. Mechanical restraints were not used in any of the PAR incidents. The center's PAR rate during the annual compliance review period was 8.45, which is below the statewide Detention PAR rate of 9.29. Interviews with five staff indicated staff are trained regarding utilization of PAR techniques. Each staff reported they engage youth in conversation prior to using physical restraints. Each staff reported mechanical restraints were not used. An interview with the superintendent indicated there has not been an increase in the use of PARs since the last annual compliance review.

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

The center has a policy and procedures regarding pre-service training. A review of five staff training records indicated three of the five staff completed pre-service certification requirements specified by Florida Administrative Code within 180-days of hire. Required trainings included Protective Action Response (PAR) training, cardiopulmonary resuscitation (CPR), first aid, mental health services, substance abuse services, suicide recognition and intervention, emergency safety and security, Prison Rape Elimination Act (PREA), human trafficking, and detention operations. Staff are assigned to a certified juvenile justice detention officer (JJDO) until they complete training and shadow a certified JJDO for two weeks after training is completed. Two of the five staff reviewed were working toward completing their training and were within their first 180-days of hire. Reviewed training records verified pre-service training was documented in the Department's Learning Management System (SkillPro).

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

The center has a policy and procedures to ensure all detention staff complete twenty-four hours of in-service training each calendar year after completion of pre-service certification training. Supervisors are required to complete an additional eight hours of supervisory training annually. A review of five staff training records found all staff received in-service training in mandatory topics to include Epi-Pen Auto Injector training. Each reviewed staff record indicated staff satisfied hourly requirements for training to include Protective Action Response (PAR) update, cardiopulmonary resuscitation (CPR), first aid, suicide prevention, and professionalism and ethics. Two of the five staff identified were supervisory staff and received eight hours of annual training to include management, leadership, personal accountability, employee relations, communication skills, and medication management. Training was documented in the Department's Learning Management 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 Development and Training on January 19, 2018.

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

The center has a policy and procedures to ensure critical and special alerts are entered, reviewed, and responded to appropriately. The Department's Juvenile Justice Information System (JJIS) alerts are reviewed daily by supervisors and administrators to ensure data correctly reflects the status of each youth. Updates and additional alerts may be entered by medical, detention, supervisory, and administrative staff. Information regarding youth alerts is communicated during daily shift briefings and is communicated during the shift if changes occur. Staff receive a copy of alerts, which they maintain on their person throughout the shift. Alerts are also documented in master control and logbooks. A review of five youth records indicated alerts were documented in JJIS on the date identified, as required. All critical and special alerts are communicated to administration. Three of the five youth records reviewed had open alerts which were closed after the youth were admitted and an assessment was completed. The alerts were closed by appropriately licensed staff. Interviews with five staff indicated staff are advised of youth alerts daily during shift debriefings, through review of alerts entered into JJIS, and through review of logbooks. Each of the staff indicated they are given a copy of daily alerts upon beginning their shift and are advised of any changes to alerts while on shift.

Standard 2: Assessment and Performance Plan

Overview

All youth admitted to the center are admitted by the juvenile justice detention officers (JJDOs) utilizing the Department's Juvenile Justice Information System (JJIS) Admission Wizard. When the JJDO conducting the admission identifies any significant medical, mental health, or substance abuse issues, allergies, and/or the youth is identified as having a critical alert or special need, the appropriate alert is placed in the center's Facility Management System (FMS), as well as JJIS. The superintendent and applicable professional and administrative staff are immediately notified of the alert. An e-mail alert is automatically generated to all applicable staff including mental health and medical staff, supervisors, the superintendent, and administrative staff. JJDOs of the same gender as the youth are responsible for conducting frisk, electronic, and strip searches. Youth are offered a meal or snack if the next scheduled meal is more than two hours away. JJDOs are also responsible for securing the youth's personal property upon admission. Each youth is provided the opportunity to place a telephone call to their parent/guardian. During the admission process, youth are properly classified for room assignments. Classification information is documented in JJIS, in the FMS Admission Wizard. All admissions are reviewed by the center's contracted licensed clinical social worker (LCSW) to identify youth requiring treatment. The center has three modules; two for male youth and one for female youth. One module is not currently being utilized and is being converted to an honors module. All admitted youth receive an orientation, which explains the center's rules and regulations, the grievance process, the behavior management system (BMS), visitation, telephone procedures, and other available services. The center has a daily and weekend/holiday activity schedule, with separate sections for males and females, observed posted and adhered to. The center conducts weekly detention reviews with the superintendent, Circuit 20 juvenile probation officer supervisory staff, education staff, nursing staff, mental health staff, residential commitment manager, Collier County Sheriff's Office representative, and a detention review specialist. The center utilizes Southwest Florida Regional Juvenile Detention Center's detention review specialist to conduct the weekly reviews and upload the information into FMS. Educational programming is provided by the Collier County School District and is available to all youth. The center's vocational and career component was discontinued and is awaiting the Department of Education and the Department to implement a new program.

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

The center has a written policy and procedures which pertains to admissions, transfers, suicide risk screenings, and chronic or communicable condition processes. A review of five youth case records confirmed the juvenile justice detention officer (JJDO) intake screener completed the Admission Wizard in the Department's Juvenile Justice Information System (JJIS) and screened each youth for possible medical and mental health issues. A review of the Admission Wizard in JJIS verified completion of all required elements concerning admission to include review of arrest affidavit/custody order, Detention Risk Assessment Instrument (DRAI), and Suicide Risk Screening Instrument (SSRI). Observations of a youth admission during the annual compliance review indicated the youth was offered an opportunity to call their parent/guardian and was provided a snack.

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

The center has a written policy and procedures to ensure admitted youth are provided with an orientation within twenty-four hours of admission. A review of five case management records indicated each youth was advised verbally and in writing of the center's staff and roles, rules and regulations of the center, youth rights, grievance process, and how to access mental health/substance abuse services and medical care. Youth were informed of the center's dress code, behavior management system (BMS), hygiene, daily schedule, contraband procedures

and the Prison Rape Elimination Act (PREA), to include viewing of the PREA video. Each youth records maintained a copy of the Department's Juvenile Justice Information System (JJIS) Admission Wizard and youth orientation. Interviews with five youth indicated each youth was provided with information about the center's rules and regulations, daily schedule, education services, visitation, abuse reporting, and the BMS. Observations of a youth admission validated this practice.

2.03 Classification	Satisfactory Compliance

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

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

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

The center has a written policy and procedures regarding classification and orientation to ensure each youth is protected from harm, violence, and victimization. All prior detention information is considered prior to youth placement in a module to include special needs, gang involvement, human trafficking, disabilities, and history of violence or victimization. Youth age and level of aggressiveness, physical characteristics, and suicide risk are also evaluated as part of classifying a youth. A review of five case management records indicated each youth was appropriately classified upon admission. Each record contained a copy of the individual booking classification form, the Department's Juvenile Justice Information System (JJIS) Admission Wizard documentation, and the Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) assessment. Observations of a youth admission validated the practice.

2.04 Classification of Gang Members	Satisfactory Compliance

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

In the event gang involvement is suspected, Detention staff should enter the "other suspected gang affiliation" alert into JJIS along with as much detailed information within the alert note as possible.

Youth admitted to the center are screened by center intake screeners for possible gang involvement or affiliation. As applicable, youth are classified with a special need and an alert is entered into the Department's Juvenile Justice Information System (JJIS). A review of five case

management records found one youth was applicable for gang involvement or affiliation. Staff interviews indicated this was the only applicable youth identified as a gang member and/or gang affiliation. Each reviewed record contained a copy of the JJIS Admission Wizard. A review of training records indicated all staff received training on gang awareness.

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

The center has a written policy and procedures requiring each youth to be screened for possible gang involvement or association. The center has identified a staff member who serves as the gang liaison. When a youth is admitted to the center, the gang liaison notifies the youth's juvenile probation officer (JPO), as well as the gang liaison from law enforcement regarding any suspicions of gang involvement such as gang tattoos, drawings, or related activity. Notification is made through e-mail, telephone, and during the weekly detention review meetings. Detention staff include copies of written statements, drawings, and pictures, as applicable. A review of five youth case management records indicated one youth was applicable for a referral for suspected gang involvement. Staff interviews indicated this was the only applicable youth identified as a gang member and/or gang affiliation.

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

The center has a written policy and procedures for securing, storing, and returning youth property and valuables. Five youth case management records were reviewed, and each contained a personal property form signed by the youth and juvenile justice detention officer (JJDO) receiving the property. Personal property was inventoried and documented upon the youth's admission. Personal property was maintained in a secure room under constant video surveillance. All valuables are placed in a clear and tamper-resistant sealed bag. Youth are advised of the center's procedures for securing, maintaining, and retrieving personal property and valuables. One youth record documented verification of money, personal property, and valuables. The Personal Property Receipt Form and Valuable Property Receipt Form were maintained in the youth's record. Four remaining youth records were not applicable for secured money, personal property, or valuables. Observations of the secure room confirmed compliance with established policy and procedures. An interview with the superintendent indicated the intake officer is responsible for ensuring all youth property and valuables are inventoried in the Department's Juvenile Justice Information System (JJIS) Personal Property Sheet. Youth valuables are placed in a clear tamper-resistant bag, signed by the youth and the intake officer, and placed in the drop safe. Staff are within camera view at all times during this process. Only

supervisors and administration have access to the storage area. Observations of a youth admission validated the practice. Five interviewed youth indicated staff checked their personal property upon arrival to the center and asked them to sign a form verifying the personal property was correct.

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

The center has a written policy and procedures for securing, storing, and returning youth property and valuables. The center maintains youth property throughout the youth's stay at the center. Upon release, youth retrieve and sign for all personal belongings and valuables. If youth property remains, the youth and parent/guardian have thirty days to retrieve the remaining items. There were no reports addressing missing or stolen property to the Department's Central Communications Center in the past six months. An interview with the superintendent verified youth have thirty days to claim personal property left at the center upon their release. After thirty days, a notice of impending Disposal of Property is mailed to the last known address. The superintendent indicated there is no formal policy to address valuables or money. Unclaimed personal property is donated to St. Matthews Church, located in the same parking lot as the center. The superintendent also indicated there has not been any unclaimed property since the last annual compliance review.

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

The center has a written policy and procedures regarding the release of youth from secure detention. The releasing officer verifies the court's authorization to release the youth. Medical staff ensure medication or aftercare instructions are provided to the youth and parent/guardian. A review of five youth case management records indicated they were not applicable for review of release; therefore, three closed applicable youth records were reviewed. Reviewed records indicated the supervisor reviewed all paperwork related to the youth's release. Paperwork received from the court was reviewed by the juvenile justice detention officer supervisor (JJDOS). Youth identification was verified prior to release, as was identification of the parent/guardian. All applicable forms were signed by required individuals. The date of admission

and termination documented in the youth records correlated with the Department's Juvenile Justice Information System (JJIS). A review of the Department's Central Communications Center's reports for the past six months indicated there were no instances of unauthorized releases.

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

The center has a policy and procedures regarding the release of a youth's personal property. All personal property not claimed within thirty days of a youth's release is considered abandoned and a letter is forwarded to the youth and parent/guardian advising them of the property status. Five youth records were reviewed for release of personal property. None of the youth records were applicable; therefore, three closed applicable youth records were. The youth and parents/guardians signed the receipt of property forms which were maintained in the youth record. An interview with the superintendent verified youth have thirty days to claim personal property left at the center upon their release. After thirty days, a notice of impending Disposal of Property is mailed to the last known address. The superintendent indicated there is no formal policy to address valuables or money. Unclaimed personal property is donated to St. Matthews Church, which is located in the same parking lot as the center. The superintendent also indicated there has been no youth property unclaimed since the last annual compliance review.

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

The center has a written policy and procedures regarding the release of medications, ensuring the youth and parent/guardian or person taking custody of the youth is advised of the issues related to the youth's health including medical, mental health, or substance abuse. Five youth case management records were reviewed for release of medication and aftercare instructions. None of the youth records were applicable; therefore, three closed youth records were selected for review. Each reviewed record documented the youth was released to an appropriate person and a copy of the identification was obtained. Two of the three youth were prescribed psychotropic medications at the time of release and all appropriate instructions and release information was provided and signed by the person picking up the youth from the center.

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

The program has a policy and procedures for the review of youth in secure and home detention. Weekly detention reviews are conducted at center and minutes are maintained to verify youth reviewed, as well as comments for follow-up actions. Observations of a detention review meeting during the annual compliance review week confirmed all youth were reviewed. An interview with the superintendent indicated the weekly detention review meeting is staffed by the administrator, mental health provider, medical staff, juvenile probation officer, supervisors,

education staff, and any additional staff required. All relevant information is reviewed to include questionable court orders, length of stay, youth pending placement, youth with mental and medical alerts, any youth under the Department of Children and Families (DCF) custody or supervision and high-profile cases.

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

The center has a written policy and procedures regarding the provision of structured daily activities. Observations during the annual compliance review week confirmed youth are involved in a broad range of educational and group activities daily. Activities are inclusive of personal hygiene, meal time, education, recreation, gender-specific programming, restorative justice programming, life and social skills development. The activity schedule, which delineates the specific activity, time, and location is posted throughout the center. Interviews with five staff indicated gender-specific programming is provided to youth on their assigned modules by detention staff. Five interviewed staff indicated male and female youth participate in activities, such as sports, and in career board. Career board is a discussion with youth regarding potential career opportunities. Staff present their previous work experience to youth and provide youth with an understanding of responsibilities of those and other employment opportunities. Staff print out potential job interview questions and conduct mock interviews with youth. Career board is available to male and female youth. There were no specific curricula identified by staff for gender-specific activities. Interviews with five youth indicated youth participate in structured activities daily and are offered recreational opportunities as well as gender-specific activities. Interview with the superintendent indicated youth are actively engaged in activities throughout the day.

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

The center has a written policy and procedures regarding daily activities. Observations of daily activities, a review of logbooks, and interviews with staff confirmed compliance with the established policy and procedures. Interviews with five youth indicated the daily activity schedule is followed, as written, with rare exception. Interviews with five staff confirmed all activities occur, as scheduled, unless adverse events or inclement weather precludes the scheduled activity. Reviewed logbooks documented and highlighted any changes to the schedule, when applicable.

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

The center has a written policy and procedures regarding educational access. 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. 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 the integration of technology. The district provides additional support for exceptional student education (ESE), as well as a reading coach. A review of the program's daily schedule and logbook ensure minimal interference of educational instruction. All five youth interviews supported school attendance Monday through Friday and adherence to the daily schedule.

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

The center has a written policy and procedures regarding career 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. The career programming provided at the center is a Type 1 program integrating personal accountability skills and behaviors leading to development of work habits to maintain employment and living standards. Career education programming includes communication, interpersonal, decision making, and life skills.

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

The center maintains a written policy and procedures regarding the behavior management system (BMS) which incorporates established rewards, privileges, and consequences for behavior. The center's BMS has three levels for rewarding positive behavior which are posted throughout the center. As the youth progresses and develops an understanding of positive ways to address challenging situations and problems, they earn extra privileges such as extra telephone time, later bed time, additional large muscle activity, participating in the painting project, extra television time, use of video games, and canteen. The center also has a rotating food schedule on Sundays for those youth who maintain level three. Youth also on level three receive name brand body wash, shampoo, conditioner, and a body sponge. In conjunction with

the Collier County School District, the center has incorporated the student of the week award. School teachers vote once a week for youth who display positive behaviors, completes class assignments and participates on a regular basis. Consequences for negative behaviors include earlier bed times and loss of an extra snack. Interviews with five youth indicated each youth felt the BMS was fair and rewards for levels were appropriate. Each interviewed youth indicated clothing, bedding, or meals was not withheld as a consequence for negative behavior. Interviews with five staff indicated each was aware of the BMS and received ongoing supervision and training regarding implementation of the BMS. Each staff confirmed meals, clothing, bedding, and services were not withheld from youth as a consequence for negative behavior.

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

The center maintains a written policy and procedures regarding unauthorized use of punishment. Staff members are responsible for administering the center's behavior management system (BMS) and maintaining professional behavior and relationships when interacting with youth. Corrective actions are implemented in the event the behavior of a group jeopardizes the safety and/or security of the center. Group punishment and disciplinary actions are prohibited at the center. Interviews with five youth indicated group punishment and corporal punishment are not used as part of the center's BMS. Interviews with each youth confirmed youth are not permitted or encouraged to punish other youth. Interviews with five staff confirmed group punishment or corporal punishment is not part of the BMS. Staff confirmed youth have unobstructed access to the Florida Abuse Hotline or the Department's Central Communications Center (CCC) to report suspected abuse. Staff confirmed they have not witnessed staff abusing youth in the center.

2.18 Grievances	Satisfactory Compliance

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

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

The center has a written has a written policy and procedures to ensure a youth's right to file a grievance. During orientation, youth are provided with a copy of the orientation brochure which outlines the grievance process. Grievance forms are available to youth throughout the center and youth may request staff assistance when completing a grievance form. Grievance procedures have three phases to include the informal, formal, and superintendent phases. During the informal phase staff are encouraged to resolve the complaint with youth using ongoing dialogue. If resolution is not attained youth ay continue to pursue their grievance. A review of documentation confirmed there were no grievances filed since the last annual compliance review. Five youth were interviewed and confirmed their understanding of the grievance process. Youth confirmed staff attempt to resolve the issue with the youth before the grievance is filed. Youth indicated negative consequences are not received as a result of filing a grievance. Interviews with five staff verified youth access to file a grievance. Staff confirmed they use ongoing communication with youth to resolve an issue before a grievance is filed.

2.19 Trauma-Informed Care	Satisfactory Compliance

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

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

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

The center has a written policy and procedures to ensure the provision of trauma-informed care. A soft room is available to youth for counseling, de-escalation, and trauma-informed practices. Staff receive training to ensure their awareness and understanding of youth traumatic histories and symptoms, triggers, and expression of trauma. The center ensures daily alerts are entered into the Department's Juvenile Justice Information System (JJIS) for all youth with traumatic histories. Youth are also noted on the center's internal alert system. An interview with the

superintendent indicated youth disclosing a trauma receive a mental health referral documented in the Facility Management System (FMS). Staff attempt to engage the youth and potentially remove them from a situation which may trigger a related response.

Standard 3: Mental Health and Substance Abuse Services

Overview

The center maintains a contract with Maxim Healthcare Services, Inc., who sub-contracts with Camelot Community Care for the provisions of mental health and substance abuse services to all youth in secure detention. Camelot Community Care provides a full-time licensed clinical social worker who serves as the center's designated mental health clinician authority (DMHCA) and is responsible for the overall coordination of mental health and substance abuse services provided at the center. The center has one part-time, non-licensed, master's-level mental health therapist working under the supervision of the DMHCA. Camelot Community Care also provides a part-time psychiatrist who is contracted to provide services for up to two hours each week at the center. The psychiatrist provides psychiatric evaluations and conducts pharmacological evaluations for all youth prescribed psychotropic medications. The DMHCA and the psychiatrist are on-call twenty-four hours a day, seven days a week. The Department's Office of Health Services regional senior behavioral analyst monitors the center's services, provides technical assistance, and completes quarterly reports for mental health and substance abuse services delivered at the center. The center conducts mental health and substance abuse assessments and evaluations, mental health counseling, crisis intervention, and suicide prevention services for all applicable youth. The center utilizes the David Lawrence Center in Naples, Florida for Baker Act crisis stabilization and Marchman Act emergency substance abuse assessment and treatment.

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 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 who serves as the center's designated mental health clinician authority (DMHCA) and holds a clear and active license in the State of Florida with an expiration date of March 31, 2019. The DMHCA is scheduled to be on-site forty hours each week on Monday, Wednesday, Thursday, Friday, and Sunday. The DMHCA is also available seven days a week, twenty-four hours a day, by way of telephone for consultation. A review of the position description for the DMHCA found she is responsible for oversight of all clinical and administrative operations ensuring clinical integrity, quality, contract compliance, utilization, budget/fiscal efficiency, and Council on Accreditation (COA) compliance. An interview with the DMHCA confirmed she is responsible and accountable for ensuring appropriate coordination and implementation of mental health and substance abuse services provided by the center. The DMHCA supervises one non-licensed master's-level clinician. The DMHCA meets with the psychiatrist and nursing staff weekly for mini-treatment team meetings. Observations validated this practice.

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

The center has a licensed clinical social worker to serve as the designated mental health clinician authority (DMHCA). The DMHCA is full-time and provides on-call services twenty-four hours a day, seven days a week. The center also maintains a contract with a licensed osteopathic physician who serves as the psychiatrist. The psychiatrist is scheduled to be on-site one day a week for approximately two hours each visit. The psychiatrist provides psychiatric evaluations and conducts pharmacological evaluations for all youth prescribed psychotropic medications. A review of the licenses for both the DMHCA and the psychiatrist found each was current and active in the State of Florida. The DMHCA's license expires on March 31, 2019 and the psychiatrist's license expires on March 31, 2020. The center's superintendent is responsible for ensuring mental health and substance abuse services are provided by individuals with appropriate qualifications based on education, training, and experience. A review of the center's medical and mental health sign-in logbook reflected the psychiatrist was on-site for approximately two hours each week for the past six months.

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

The center maintains a written policy and procedures to ensure 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's superintendent is responsible for ensuring mental health and substance abuse services are provided by individuals with appropriate qualifications. The center has one non-licensed master's-level mental health and substance abuse clinical staff member who works 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 master's-level clinician holds a degree in social work and is scheduled to work part-time approximately twenty hours a week. Reviewed training records confirmed the non-licensed staff completed the required twenty hours 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 licensed clinical social worker. A review of direct supervision logs verified the DMHCA provided at least one-hour of weekly supervision and reviewed each ASR and crisis assessment 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. *Detention center superintendent has established procedures for a thorough review of preliminary screening conducted by the Office of Probation and Community Intervention.*	

The center maintains a written policy and procedures indicating the mental health and substance abuse needs of youth are identified through a comprehensive screening process which ensures 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 April 3, 2018. An interview with the interim superintendent indicated the juvenile probation officer (JPO) completes the mental health, substance abuse, and suicide risk screenings utilizing the Massachusetts Youth Screening Instrument - Second Version (MAYSI-2) assessment and the Positive Achievement Change Tool (PACT). 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 was completed for each youth upon intake. 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. Four of the five reviewed records documented a history of suicide risk and the youth were placed on precautionary observation until the Assessment of Suicide Risk was completed by the center's clinical staff. Each reviewed record also contained a PACT and MAYSI-2 assessment, which were competed in the Department's Juvenile Justice Information System. The Department's Mental Health/Substance Abuse Referral Summary form was completed for each youth and identified Camelot Community Care as the referral source and the reason for the referral. 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. Youth identified in the JAC as in need of further assessment are referred to a community provider for a comprehensive assessment. The superintendent is responsible for establishing procedures to track the receipt of evaluations at the center. 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. The center utilizes the Department's Positive Achievement Change Tool (PACT) Screening Report and Referral for Mental Health and Substance Abuse Assessment form for a comprehensive mental health and/or substance abuse evaluation or updated evaluation. In addition, the center utilizes the Department's Mental Health/Substance Abuse Referral Summary form for psychiatric evaluations, Assessment of Suicide Risk, crisis assessment and/or intervention, mental health alert status examination, mental health and substance abuse evaluation, and mental health consultation or mental health support services. A review of five youth mental health and substance abuse records reflected each youth was screened and a referral was made for each to receive a comprehensive mental health and substance abuse evaluation. However, each youth was recently admitted and were within the thirty-day time frame of completing the evaluation. A review of three applicable youth mental health and substance records supported each youth received a completed evaluation documented on the Substance Abuse and Mental Health Assessment (SAMH) format. 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 in a detention center, must be assigned to a mini-treatment team.*	

The center maintains a written policy and procedures ensuring mental health and substance 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. Five youth mental health and substance abuse records were reviewed for mental health and substance abuse treatment services. One of the five youth records were applicable for receiving treatment services. A review of two additional applicable youth records validated all three applicable youth were assigned to a mini-treatment team and were referred for services. Each reviewed youth record was applicable for treatment with psychotropic medication and individual therapy. Reviewed documentation confirmed each applicable youth requiring treatment was assigned to

a mini-treatment team consisting of mental health, medical, education, and administrative staff. The 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. Two of the three applicable youth records contained an initial treatment plan while one contained an individualized treatment plan. Treatment notes were documented in accordance with Florida Administrative Code 63N-1, utilizing the Department's Counseling/Therapy Progress Note (MHSA 018). Reviewed sign-in sheets confirmed 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. Groups are conducted in a multi-purpose room. Mini-treatment teams are conducted weekly for youth receiving services. Observations made during the annual compliance review week found the a mini-treatment team was composed of the designated mental health clinician authority (DMHCA), the psychiatrist, medical staff, and the youth. An interview with the DMHCA indicated the center does not maintain a license through the Department of Children and Families for the provision of substance abuse treatment services. Treatment services are provided through her licensed clinical social worker with the State of Florida. Five interviewed youth found three rated the mental health services they were receiving as good and two rated the services as very good.

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

The center 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 one applicable for receiving treatment. Two additional applicable youth records were 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, as required. 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. Each reviewed initial treatment plan was completed within seven days of initiation of treatment and was developed on the Department's form MHSA 015. The plans were completed in full and contained all required elements to include the reason for referral, initial Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, treatment methods, goals, and psychiatric services. Three applicable individual treatment plans were reviewed, and each was completed within the required time frame and included the DSM-5 diagnosis, symptoms, treatment goals, strengths, psychiatric services, and pharmacological interventions. Two of the three youth required one individual treatment plan review and they were conducted as required. No youth was 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. Each reviewed treatment plan was signed by the licensed mental health/substance abuse professional and contained all required elements. Three applicable reviewed youth records supported each youth received mental health and/or substance abuse treatment while in the center had a mental health and substance abuse discharge summary completed on the Department's form MHSA 011. 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 has 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. Psychiatric services provided by the center include initial diagnostic psychiatric interviews, psychiatric evaluations, psychiatric follow-up assessments and consultations, coordination of services, crisis interventions, treatment planning, communication, and emergency procedures. A review of the license for the psychiatrist confirmed the license is clear and active in the State of Florida. The center does not utilize a psychiatric advanced registered nurse practitioner. A review of five mental health and substance abuse records indicated one youth was applicable for receiving psychiatric services. Two additional records were reviewed. 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. One of three youth required the monitoring of Tardive Dyskinesia and it was conducted.

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

The center maintains a written policy and procedures ensuring 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 April 3, 2018. 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.

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. 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 Suicide Risk Screening Instrument (SRSI), Positive Achievement Change Tool (PACT), and Massachusetts Youth Screening Instrument – Second Version (MAYSI-2). When further assessment is indicated by the SRSI, MAYSI-2 suicide ideation subscale, or the PACT Mental Health and Substance Abuse Screening Report and Referral Form – Suicide Category, 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. The non-licensed master'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. A review of five youth mental health and substance abuse records found three youth were identified with an elevated risk of suicide identified during the admission screening process. Each of the three-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 master's-level non-licensed clinical staff and reviewed by the designated mental health clinician authority (DMHCA). A review of the completed ASRs found each youth placed on PO was stepped down to standard supervision. The center utilizes secure observation for potentially suicidal youth.

Interview with the interim 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. The center has had two youth requiring secure observation since the last annual compliance review. One youth was placed on secure observation on two separate occasions. A review of all three-secure observation 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. Both 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 master control logbooks validated each of the youth placed on precautions had documentation regarding the beginning and ending times of their precaution periods. Three 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. In the event a youth expressed suicidal thoughts, staff indicated they would notify the mental health authority, search the youth and their room, maintain constant sight and sound supervision, document supervision, and place the youth in a locked room for observation. Each staff was aware of the location of the suicide kit.

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

The center maintains a written policy and procedures 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 Suicide Precautions Observation Log (MHSA 006). Five reviewed youth mental health records found three were applicable for youth placed on precautionary observation (PO); therefore, two additional youth records were reviewed. Reviewed documentation reflected a Suicide Precautions Observation Log was maintained for the duration each youth was on precautions and each were 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 Assessment of Suicide Risk in the date/time sections.

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 six hours of suicide prevention training annually. Reviewed documentation of mock suicide drills completed since the last annual compliance review reflected the center completed drills on Alpha and Charlie shifts monthly from May through November 2018. Bravo shift documented drills conducted for May, June, July, August, and September 2018. There was no documented drill for October or November 2018. The provision of life saving measures such as cardiopulmonary resuscitation (CPR) and the use of a suicide response kit was documented in April 2018 for Alpha-shift, January and October 2018 for Bravo-shift, and April and June 2018 for Charlie-shift. The program has scheduled a drill to include CPR and use of the suicide response kit in December 2018 for Alpha-shift. Interviews with five staff indicated three staff participated in suicide drills within the last six months.

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

The center maintains a written 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 April 3, 2018. 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.

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

The center maintains a written emergency care plan outlining mental health and substance abuse emergency procedures and 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 April 3, 2018. 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 mental health and substance abuse emergency care plan includes procedures for a suicide attempt, homicide attempt related to mental illness, serious self-injurious behavior, hallucinations, delusions, disorientation, and substance abuse intoxication or withdrawal. The plan is inclusive of immediate staff response, notification procedures, communication, supervision, and staff training. In addition, the plan is inclusive of transportation procedures for emergency mental health and/or substance abuse evaluation and treatment and authorization to transport for emergency mental health and substance abuse services. 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, or under the direct supervision of a licensed mental health professional, to determine the severity of youth's symptoms, and level of risk to self or others. When staff observations indicate a youth's acute psychological distress is extreme/severe and does not respond to ordinary intervention, the superintendent or designee must be notified of the crisis situation and need for Crisis Assessment. A Crisis Assessment is to be utilized only when the youth's crisis (psychological distress) is not associated with suicide risk factors or suicide risk behaviors. If the youth's behavior or statements indicate possible suicide risk, the youth must receive an Assessment of Suicide Risk (ASR) instead of a Crisis Assessment.	

The center maintains a written 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 April 3, 2018. Interviews with the DMHCA and the center's superintendent indicated the center has not conducted a crisis assessment on a youth 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. An informal interview was conducted with the designated mental health clinician authority (DMHCA) and she confirmed the center has had two youth requiring a Baker Act since the last annual compliance review. Reviewed documentation supported each 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 placed on standard supervision. 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 medical clinic and master control. 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

Overview

The Department has a contractual agreement with Maxim Healthcare Services, Inc. for the provision of all medical services at the detention center to ensure quality care, accountability, and rapid response to healthcare needs are provided to each youth admitted to the center. All healthcare staff are employed by Maxim Healthcare Services, Inc. At the time of the annual compliance review, the medical healthcare staff consisted of a medical doctor (MD) serving as the center's designated health authority (DHA), an advanced registered nurse practitioner (ARNP), one full-time registered nurse (RN), one part-time RN, one part-time licensed practical nurse (LPN), and one medical records clerk. Nursing coverage is provided on-site for a minimum of twelve hours on weekdays and for a minimum of eight hours on weekends. The DHA is responsible for the review and approval of the center's facility operating procedures (FOP) and protocols for medical services. The center has a current Modified Class II B Pharmacy Permit, which expires February 28, 2019. Medications are procured through Diamond Pharmacy Services and emergency medications may be procured through a local Publix Pharmacy. The center maintains an agreement with Consultant Pharmacists, Inc. to provide a registered consultant pharmacist, who is scheduled to be on-site once a month. The registered consultant pharmacist is jointly responsible for the disposal of controlled medications and narcotics. The center conducts on-site testing and counseling of youth for human immunodeficiency virus (HIV) by the center's RN who has satisfactorily completed all the requirements for the Florida Department of Health HIV/AIDS prevention counseling, testing, and linkage introduction. Maxim Healthcare Services, Inc. also has a contractual agreement with the Department to provide on-site psychiatric services to youth in the center for at least six hours each week. Psychiatric services include evaluating and monitoring applicable youth and conducting psychiatric evaluations of each referred youth to determine whether psychotropic medications are warranted. The center also provides for female-specific healthcare services for youth girls requesting screenings and examinations to address their unique needs.

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

The center's designated health authority (DHA), a licensed medical doctor, who is employed by Maxim to deliver comprehensive on-site medical services to include primary, and preventative care, sick call, and episodic care, acute and chronic medical treatment, and follow-up care to youth in custody at the center. The DHA is contracted to be on-site two hours a week, and on-call twenty-four hours a day, seven days a week. A review of the medical sign-in and out logbook validated the DHA was on-site during the months of May, June, July, August, September, October, and November 2018 for a minimum of two hours each week, as required. The DHA's designee, a licensed advanced registered nurse practitioner (ARNP), has a collaborative practice protocol in place, signed and dated August 1, 2018. The DHA and the ARNP arrange coverage of the center during the assigned DHA's vacations and scheduled absences. An interview with the ARNP confirmed the ARNP is on-site at least weekly. The DHA communicates with the center's administration and healthcare staff while on-site regarding the youth in custody medical needs, and is available twenty-four hours a day, seven days a week for consultation on acute medical concerns, emergency care, and coordination of off-site care.

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 utilizes the statewide facility operating procedures (FOP) for detention centers. The FOPs include health-related procedures and protocols, which are specific to the detention center. The nursing protocols were reviewed, and a cover page was signed by the designated health authority (DHA) on July 24, 2018, and the nursing staff each with signature dates in July 2018. The DHA signed the non-healthcare protocols on July 24, 2017 for detention staff to utilize when nursing staff are not on-site. All FOPs and protocols were reviewed, updated, and signed annually by the DHA and the superintendent on July 26, 2018. The psychiatrist reviews and signs the FOPs which are psychiatric related to include psychotropic medication procedures.

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

A review of five youth individual healthcare records found each had a current and valid Authority for Evaluation and Treatment (AET) form filed in their record, with a parent/guardian signature along with a witness signature. There were no applicable youth who required a Limited Consent for Evaluation and Treatment for a Department of Children and Families (DCF). Reviewed AETs found each was a copy of a completed AET and contained the word “copy” stamped on each form. Each of the reviewed AET was obtained prior to providing medical services except for emergency care and medical or mental health intake screenings.

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

The program maintains a policy and procedures outlining requirements for parental notification and written consent of the parent/guardian. Nursing interview indicated parental notification is made in a timely manner. Once the order is received from the designated health authority (DHA) and/or the advanced registered nurse practitioner (ARNP), a parental notification is made. A review of five youth individual healthcare records found three youth were applicable for parental notifications. The parental notifications were mailed to the parents/guardians regarding the youth’s need for over-the-counter medications, which are not covered by the parent/guardian signing the Authority for Evaluation and Treatment (AET) form. Three youth were also taken off-site for medical care and each record documented parental notification, as required. There were no youth applicable for newly prescribed medication. In addition, the center’s psychiatrist does not prescribe new medications to youth admitted to the center with psychotropic medications. The psychiatrist maintains the youth’s current or existing medication and dosage, which the parent/guardian is aware of; therefore, a parental notification is not required, due to there not being a change in the medications or a new prescription for medications.

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

The center maintains a written policy and procedures regarding parental consent and notification for the prescription of youth receiving new psychotropic medication, discontinuances, or psychotropic medication adjustments. Parental/guardian consent shall be obtained prior to the initiation of new psychotropic medications and/or changes in a psychotropic medication regimen. Notification includes mailing page three of the Clinical Psychotropic Progress Note (CPPN). The center's contracted psychiatrist's practice is to maintain the youth's same medication regimen (dosage and type) for which the youth was admitted. A review of five youth individual healthcare records found one youth was admitted to the center with psychotropic medication and found the psychiatrist maintained the youth's medication as prescribed prior to admission; therefore, the CPPN was not mailed to the parent/guardian.

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

The center maintains a written policy and procedures for the administration of required and ordered vaccinations. The Authority for Evaluation and Treatment (AET) provides an opportunity for parental consent to be obtained for missing vaccinations. At the time of signing the AET, the parent/guardian is provided with the relevant Vaccine Information Statements (VIS) to inform them of the potential risks and side effects. Nursing staff pull the Florida Certification of Immunization and the immunization history through the Florida Shots website and print a 680form for the designated health authority (DHA) and/or advanced registered nurse practitioner (ARNP) to sign. A review of five youth healthcare records indicated each documented verification of immunizations at the time of the youth's admission into the center. Documentation in each reviewed youth record supported the immunizations were current for each youth. There were no applicable youth in which the parent/guardian provided documentation indicating exemption for religious reasons.

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

The center maintains a written policy and procedures for the administration of required and ordered vaccinations. The Authority for Evaluation and Treatment (AET) provides an opportunity for parental consent to be obtained for missing vaccinations. At the time of signing the AET, the parent/guardian is provided with the relevant Vaccine Information Statements (VIS) to inform the parent/guardian of the potential risks and side effects. Nursing staff pull the Florida Certification of Immunization and the immunization history through the Florida Shots website and print a 680 form for the designated health authority (DHA) and/or advanced registered nurse practitioner (ARNP) to sign. A review of five youth healthcare records indicated each documented

verification of immunizations at the time of the youth's admission into the center. Documentation in each reviewed youth record supported the immunizations were current for each youth. There were no applicable youth in which the parent/guardian provided documentation indicating exemption for religious reasons.

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

The center maintains a written policy and procedures ensuring an alert system is in place to alert staff when mental health, medical, and/or security issues exist which may affect the security and safety of the youth in the center. A review of five youth individual healthcare records found three youth applicable for food and/or environmental allergies, four youth were identified with a chronic medical condition, and one youth taking medications with significant side effects. A review of the medical alerts supported each was clearly documented on the center's internal medical alert system. Nursing staff verify all alerts in the medical alert system daily to ensure each is accurate and up-to-date. An interview with five staff indicated staff are informed of youth alerts upon arrival for their shift and during shift meetings. Youth alerts are discussed with staff to ensure their understanding and each staff is provided with a written list of youth alerts. Staff indicated additional information pertaining to youth alerts is maintained in the juvenile justice information system (JJIS) and the logbook. Staff are alerted to any changes in youth alert status during their shift by radio or in person.

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

The program maintains a written policy and procedures for screening all youth with an elevated risk of suicide. A review of five youth healthcare records found the Department's Suicide Risk Screening Instrument (SRSI) is reviewed by mental health staff and not nursing staff. SRSIs are completed by the mental health staff within twenty-four hours of admission; therefore, this indicator rates as non-applicable.

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

The program maintains a written policy and procedures ensuring all youth are oriented to and have access to all healthcare services. A review of five youth individual healthcare records supported each youth received a healthcare orientation within twenty-four hours of admission to the center. The reviewed orientation form included all required topics as listed in the Department's Rule 63M-2.0046, Health Services. The form was signed and dated by both the nursing staff and the youth.

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

The center has a written policy and procedures in place ensuring the designated health authority (DHA) is notified of all youth admitted into the center identified with chronic health conditions or youth in need of emergency care. The DHA notification is documented in the DHA notification log and a copy of the email is filed. A review of five youth individual healthcare records found four applicable youth admitted with a chronic condition. Documentation on the progress notes filed within each applicable healthcare record supported the DHA was notified within the required time frame. Nursing interviews indicated the DHA is notified within twenty-four hours of each admission

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

The center maintains a written policy and procedures indicating at the time of admission into the center, each youth will receive a facility entry screening by the intake juvenile justice detention officer (JJDO). This screening is conducted utilizing the Medical and Mental Health Admission Screening form in the Department's Juvenile Justice Information System (JJIS) Admission Wizard. A healthcare admission rescreening is conducted each time the physical custody of the youth changes and they are subsequently returned or re-admitted to the center. The center did not have applicable youth in which the physical custody changed, and a new healthcare admission rescreening was required within the past six months, according to interviews with both nursing and administrative staff.

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

The center maintains a written policy and procedures ensuring the Health-Related History (HRH) is completed by nursing staff no later than seven calendar days following the date of admission. A review of five youth healthcare records validated each HRH was completed by licensed medical staff. One HRH was new and four were updated. A review of the HRH documentation supported the designated health authority (DHA) and/or the advanced registered nurse practitioner (ARNP) reviewed each of the five HRHs. All five reviewed healthcare records documented the HRH was completed before or at the same time as the Comprehensive Physical Assessment (CPA).

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

The center maintains a written policy and procedures ensuring the Health-Related History (HRH) is completed by nursing staff no later than seven calendar days following the date of

admission. A review of five youth healthcare records validated each HRH was completed by licensed medical staff. One HRH was new and four were updated. Reviewed HRH documentation supported the designated health authority (DHA) and/or the advanced registered nurse practitioner (ARNP) reviewed each of the five HRHs. All five reviewed healthcare records documented the HRH was completed before or at the same time as the Comprehensive Physical Assessment (CPA).

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

The center maintains a written policy and procedures outlining all female youth over the age of twelve who are sexually active and request testing, will receive a qualitative urine pregnancy screening test with the youth's verbal consent, at the time of admission. Youth will be referred for a gynecological examination for sexually active females if there are medical concerns. A review of three female youth individual healthcare records found each youth was clinically screened for tuberculosis, sexually transmitted infections (STIs), and risk factors. Each youth was offered human immunodeficiency virus (HIV) testing and a qualitative urine pregnancy screening test. None of the reviewed records indicated the youth consented to or were referred for a gynecological examination. All three female youth provided verbal consent for qualitative urine pregnancy screening test. The test results were documented and filed in the youth's individual healthcare records under the laboratory section. Two random female youth were interviewed, and each concurred they could request a female-specific examination.

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

The center maintains a written policy and procedures indicating all youth are required to be screened for tuberculosis. A review of five youth individual healthcare records supported each youth received a tuberculosis screening at the time of admission. There was at least one verified tuberculosis screening test (TST) documented in each of the five reviewed individual healthcare records on the Department's Infectious and Communicable Disease (ICD) form and the Comprehensive Physical Assessment (CPA). In addition, the center maintains a tuberculosis testing log for all youth administered a tuberculin skin test (TST) with the results. There was no indication of any youth requiring further evaluation. Nursing interviews outlined the process for tuberculosis screening if a youth has never been screened. A test is performed during admission intake and read two days later. If the screening has been less than one year since the last test, no test will be required. Youth with a test older than one year will receive a new test. If any youth identified with a positive skin test, the designated health authority (DHA) is notified, and an X-ray and/or blood test is ordered.

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

The center maintains a written policy and procedures ensuring all sexually active youth will be clinically screened and evaluated for sexually transmittable diseases (STIs). After screening, each youth will be referred to the designated health authority (DHA) or advance registered nurse practitioner (ARNP) to determine if further testing is warranted. The test results are documented on the Department's Infectious and Communicable Disease (ICD) form which is filed in the youth's individual healthcare record. A review of five youth healthcare records, Health Related History (HRH), and ICD forms documented each youth received the screenings during admission. There were no applicable youth out of the Department's custody for thirty days or more; therefore, no rescreens were required. The lab results for each of the screenings were found in the laboratory section of the youth individual healthcare records. The center's nursing staff also maintained a human immunodeficiency virus (HIV) and STI testing log.

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

The center maintains a written policy and procedures outlining all youth at risk of human immunodeficiency virus (HIV) will be offered counseling, testing, and referrals for medical treatment. A review of five youth individual healthcare records documented each youth was provided the basic HIV education and offered HIV testing. The youth were given the HIV antibody test consent form to review and sign. Three of the five youth consented for HIV testing. HIV testing and counseling are conducted on-site by the center's registered nursing staff who has satisfactorily completed all the requirements for the Florida Department of Health HIV/AIDS prevention counseling, testing, and linkage introduction. If the HIV test yields positive results, the youth is referred to the Collier Department of Health for further evaluation and testing. HIV results were found securely sealed in an envelope marked confidential and filed in the youth healthcare record for two of the three applicable youth. HIV testing for one youth is pending. The center also maintained a HIV and STI testing log. Five interviewed youth each stated they could request and receive a HIV test.

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

The center maintains a written policy and procedures ensuring all youth are able to make sick call requests and have their complaints treated through the center's sick call system. The center has separate written protocols for the provision of sick call by nursing staff and by non-healthcare juvenile justice detention officer supervisors (JJDOS) for times when a licensed nurse is not on-site. The center has regularly scheduled sick call hours for youth to be evaluated by a licensed nurse. Observation of sick call hours and interviews with nursing staff indicated sick call is conducted seven days a week from 9:00 a.m. to 11:00 a.m. In addition, the center provides for a second sick call Monday through Friday from 1:00 p.m. to 3:00 p.m. Each youth can access the sick call process by notifying a juvenile justice detention officer (JJDO) of any

medical complaint(s) and the JJDO enters the sick call request into the center's Facility Management System (FMS), which electronically generates a notification of the submitted sick call request to the nursing staff. The designated health authority (DHA) and/or advanced register nurse practitioner (ARNP) provides routine sick call and follow-up care when youth are referred to them by nursing staff. When nursing staff are not on-site, the JJDOS reviews the sick call complaints. The JJDOS contacts the DHA for direction if a complaint requires more than a one-time administration of over-the-counter (OTC) medication, or if determination is made by the JJDOS the complaint requires additional consultation with a healthcare professional. Five youth healthcare records were reviewed and three were found to be applicable for sick call requests. One of the three applicable reviewed records were for a youth with three or more similar sick call complaints within a two-week period. The youth was referred to the DHA and subsequently transported to the emergency room for evaluation. The youth returned to the center the same day with specific medical instructions. None of the sick call requests were for complaints in which staff were unfamiliar. Five interviewed youth reported they were seen either immediately or within one day of submitting a sick call request.

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

The center maintains a written policy and procedures ensuring all youth will be able to make sick call requests and have their complaints treated through the program's sick call system. Three applicable youth healthcare records were reviewed including each youth's sick call index, the corresponding Facility Management System (FMS) generated sick call list, and the sick call referral log. In addition, the Department's electronic medical records sick call review documented the sick call event. Each of the three applicable records documented sick calls were conducted by a registered nurse (RN). According to the nursing interview, youth who have presented with repeated similar sick call complaints are referred to the designated health authority (DHA) and/or advanced registered nurse practitioner (ARNP). The sick call is documented in the sick call logbook. There were no sick call visits to observe during the annual compliance review. Five youth were interviewed and four indicated sick call is conducted by either the RN or the DHA. One youth stated staff conducts sick call; however, the youth clarified the statement by indicating staff bring youth to the clinic and medical staff conduct the actual sick call. Interview with five staff indicated when youth submits a sick call request, they are seen on the day of the request or no later than the following day. Staff reported youth sick calls are addressed by the doctor and nurse and on occasionally, by staff if an over-the- counter medication is authorized in the absence of licensed staff and is supervised by non-licensed medically trained staff.

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

The center maintains a written policy and procedures ensuring all youth in the center will be able to access healthcare staff while in restricted housing or confinement. Procedures outline nursing staff are to make a daily visit and complete a detailed narrative entry in the chronological progress notes in the youth's healthcare record for each youth who is treated while in restricted housing. Nursing staff maintains a medical confinement log documenting the youth's name, Department's identification number, date started, date ended, reason for

confinement, and date progress note was made in the youth's healthcare record. All youth in restricted housing shall receive all prescribed medications, as ordered. The center did not have any youth in restricted housing or confinement for more than twenty-four hours or youth requiring medication administration.

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

The center maintains a written policy and procedures for the provision of episodic care and first aid treatment. Emergency medical and dental care, including emergency medical services (EMS), are available twenty-four hours a day, seven days a week. The center tracks all episodic and emergency events utilizing the Department's Episodic Care Log. The center maintained eleven first aid kits located in master control, sub-control, three dormitory laundry rooms, the kitchen, superintendent's office, and four center vehicles; however, only three vehicles were on-site during the annual compliance review. First aid kits, each sealed with a snap tab were inspected in areas frequently used by youth and the transportation vehicles. The contents of the first aid kits were current and documentation confirmed monthly first aid kit inventory inspections were conducted by the medical clerk. In addition, the center maintains documentation of the designated health authority's (DHA) approval of first aid kit contents. The nursing staff inventory and restock each first aid kit monthly. Each first aid kit is resealed with breakaway tabs after each use and restocked by nursing staff. A review of five youth healthcare records found two were applicable for episodic and/or emergency care with one youth having two separate episodes. A review of each applicable healthcare record found the required episodic care is conducted by nursing staff. Reviewed Episodic Care Log found each youth was documented to include the date, name of youth, Department's identification number, injury/emergency/illness, treatment rendered, staff initials, and referral summary to include nursing, DHA, advanced registered nurse practitioner (ARNP), or off-site care facility.

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

The center maintains a written policy and procedures ensuring all healthcare and non-healthcare staff shall know they have the right and responsibility to immediately call 9-1-1 at any time a youth condition appears compromised. All non-healthcare staff who have direct contact with youth maintain current certifications in first aid and cardiopulmonary resuscitation (CPR) with automated external defibrillator (AED). All licensed nursing staff maintains current CPR with AED certification. The center has two AEDs which are located in master control and the medical clinic. The center received the two new AEDs approximately one month prior to the annual compliance review with up to date batteries and pads; therefore, the AEDs were not required to be changed. The new AEDs provided specific instructions not to remove the batteries as to not reset the data in the machine. Nursing staff reported the vendor will inspect the AEDs annually and replace the batteries as needed. Nursing staff demonstrated the operation of the AEDs during the annual compliance review. Reviewed documentation supported medical drills were conducted at least quarterly on each shift for the last twelve months and documented all the required elements. The center maintains a list of emergency phone numbers in the medical clinic and in master control.

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

The center maintains a written policy and procedures ensuring timely referrals and coordination of medical services to an off-site healthcare provider for emergency and non-emergency services. A review of five youth healthcare records contained documentation of services for two applicable youth for off-site care with one youth having two separate incidents. Each applicable reviewed record included a summary of off-site care form. Each of the three reviewed youth incidents applicable for off-site care supported the off-site care findings, instructions, and information for off-site care provided were reviewed by the designated health authority (DHA) or a designee.

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

The center maintains a written policy and procedures ensuring youth who are identified with a chronic illness receive regularly scheduled evaluations and necessary follow-up evaluations. A review of five youth healthcare records found four youth identified with a chronic medical condition and/or taking prescribed medications. The center maintains a chronic conditions roster to document the youth identified with certain medical conditions. Reviewed documentation also found the youth were placed on the center's internal alert system. Documentation reflected one of the youth currently in the detention center was identified with a chronic condition has been in the facility long enough to require a periodic evaluation, which was completed at least once within three months.

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

The center maintains a written policy and procedures ensuring youth admitted with prescribed medications will only accept medications from a licensed pharmacy with a current, patient-specific label intact on the original medication container. A review of five youth healthcare records found three were applicable for youth admitted to the center with current prescribed medications. Reviewed practice supported the center had a prescription verification process. Nursing staff verified the medications youth were prescribed upon admission through a review of each youth's accompanying information and telephone contact with each youth's parent/guardian. The designated health authority (DHA) was notified and consulted regarding the medication. One of the three applicable youth was admitted with psychotropic medication and documentation supported the psychiatrist reviewed the applicable youth on psychotropic medication and conducted an initial psychiatric interview. Nursing staff documented the verification on the Department's Medication Receipt, Transfer, and Disposition form (HS 053) in each applicable youth healthcare record.

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

The center maintains a written policy and procedures ensuring all youth prescribed medications shall have a current, valid order and are given pursuant to a current prescription or practitioner's order. A review of five youth healthcare records found three applicable youth were admitted to the center with current prescribed medications. Progress notes and the designated health authority (DHA) order sections of the healthcare record were reviewed as verification of the center's medication regimen, as well as the Medication Administration Records (MARs) for administration of ordered medications. All three youth were continued their prescribed medication(s) after nursing staff verified the prescription and notified the designated health authority (DHA) and/or psychiatrist. The DHA or psychiatrist provided an order for nursing staff to continue the medication. One youth admitted with prescribed psychotropic medications was maintained on the medications until their initial psychiatric evaluation was conducted. Three of the five reviewed youth healthcare records indicated each was prescribed over-the-counter medications which were not listed on the Authority for Evaluation and Treatment (AET) form documented on the practitioner's order and were administer as outlined in the designated health authority (DHA) approved protocols.

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

The center maintains a written policy and procedures ensuring all medication and pharmaceutical products are stored safely, accurately, and in accordance with state, federal, and industry standards. All prescribed medications, over-the-counter (OTC) medication, and controlled and non-controlled medications are identified and stored in separate and secured areas inaccessible to youth. Observations of the medical clinic during the annual compliance review reflected the center's practice of storing all current prescription medications and current OTC medications in a locked medication cart. Bulk supplies of sharps, prescribed medications, and OTC medications were stored in locked cabinets in the medical clinic. The center currently contracts with Diamond Pharmacy Services for procurement of medication. Reviewed documentation supported the center maintains a current modified Class II Pharmacy Permit (PH21552) with an expiration date of February 28, 2019. The center's current practice is for trained juvenile justice detention officer supervisors (JJDOS) to administer prescribed medications and OTC medications when licensed healthcare staff are not on-site. Medications are accessible only to nursing staff and trained JJDOS staff. The center maintains a secured refrigerator used solely for medications. The center had tuberculosis skin test (TST) medications requiring refrigeration at the time of the annual compliance review. Nursing interviews indicated the center's practice is to return all unused non-controlled prescribed medications to the procuring pharmacy for a credit. Medications not returned to Diamond Pharmacy Services are destroyed by the consultant pharmacist and nurse, utilizing the RX Pill Destroyer and documented in a log. The consultant pharmacist documents a monthly pharmacy audit for the center which include comments and recommendations.

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

The center maintains a written policy and procedures ensuring all medications and pharmaceutical products are inventoried as outlined in Department Rule 63M-2.024, 63M-2.025, and 63M-2.026, Health Services. A review of inventories for the past six months was completed, and the locked medical clinic cabinets designated for the storage of sharps was inspected. Three different sharps, three prescribed stock medications, and three over-the-counter (OTC) medications were randomly selected. Observation of the count of each was completed and documented by the registered nurse (RN). The sample review of documentation for inventory of three prescribed stock medications, three OTC medications, and three different sharps validated the observed perpetual inventories were maintained and accurate. The nursing interview indicated the center's practice for discrepancies in the count is to examine the current medication administration records to locate the error; however, the center reported not experiencing any discrepancies during the annual compliance review period. The shift change nurse report is completed and discussed at the 7:00 a.m. shift briefing and the 3:00 p.m. shift briefing. As an additional means of communicating important medical information to the juvenile justice detention officer supervisor (JJDOS) at shift change, the nurse report is placed on the medication cart when nursing staff leave the center for the day. This is in addition to all required and established notification processes.

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

The center maintains a written policy and procedures ensuring all controlled substances shall be inventoried, stored, and documented as outlined in Department Rule 63M-2.024, 63M-2.026 Health Services and in accordance with the Board of Pharmacy regulations. The center maintained controlled medication in a locked box, within the locked medication cart, which is permanently stored within the medical clinic. There were no youth in the center prescribed a controlled medication at the time of the annual compliance review. The center's practice is for nursing staff to conduct a shift-to-shift count of all controlled medication. The beginning and ending medication count before and after each administered dosage are inventoried, utilizing the Department's Controlled Medication Inventory Records form (HS 008). Youth-specific prescribed medication is inventoried at receipt of the medication by the center and again upon discharge of the youth. A review of the controlled inventory logs for the past six months validated there was one youth taking a prescribed controlled medication. Documentation reflected the inventory was accurate and conducted pursuant to the center's policy.

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

The center maintains a written policy and procedures ensuring each youth receiving either prescription medications on a routine basis or over-the-counter (OTC) medication will be documented on the standard Department Medication Administration Record (MAR). The center

utilized the standard Department MAR, form HS019, to document the administration of prescribed medication, as well as the placement and reading of tuberculosis screening test (TST). A review of Five youth healthcare records found three youth were admitted with medication. Each applicable MAR documented medication was administered as ordered and each contained clear start and stop dates. Staff initialed each administered medication. There were no indications of lapses or errors in medication administration. All three reviewed MARs indicated each was completed to include the youth's name, Department's identification number, date of birth, and assigned medical grade, youth allergies, medical precautions, and medical alerts. The center maintains an active MAR book located on the medication cart. Each youth had a current photograph attached to the MAR and nursing staff documentation of side effect monitoring on the MAR.

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

The center maintains a written policy and procedures ensuring medication administration shall occur as scheduled in a comprehensive, accurate, and organized manner in the program, only by a licensed nurse. The center's practice is to have nursing staff administer medications when they are on-site. Nursing staff are on-site Monday through Friday 6:30 a.m. to 7:00 p.m. and 8:00 a.m. to 4:30 p.m. on the weekends. Nursing staff will flex their hours if a youth in the center required injectable medication such as insulin. At the time of the annual compliance review, the center had one full-time registered nurse (RN), one part-time RN, and one part-time licensed practical nurse (LPN), and a part-time weekend LPN. The part-time LPN and RN work alternate weekends at the center. The advanced registered nurse practitioner (ARNP) was on-site one day each week for six hours and the designated health authority (DHA) was on-site one day each week for two hours and available for consultation twenty-four hours a day, seven days a week. The center also utilized a medical records clerk. Most medications are administered during times nursing staff are on-site; however, evening and weekend medications for youth are administered by seven trained juvenile justice detention officer supervisory (JJDOS) staff, the assistant detention superintendent, and the superintendent which all were trained by a RN. Observation of medication administration was conducted for one youth at a time. The nursing staff verified the five rights of medication administration utilizing the correct Medication Administration Record (MAR). Both the staff and youth initialed the MAR when nursing staff and the JJDOS staff administer medication. Over-the-counter (OTC) medication administration is documented on a patient-specific pro re nata (PRN) Medication Log. Reviewed documentation supported seven JJDOS staff were trained to assist youth with self-administration of medication. Parenteral medications are only administered by licensed healthcare staff; however, there were no youth prescribed a parenteral medication in the center at the time of the annual compliance review. An interview with five youth found four were taking medication. Each of the four youth reported medication is administered by medical staff. One youth stated staff will give OTC medication if medical staff are not on-site.

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

The center maintains a written policy and procedures ensuring trained, non-healthcare staff may assist youth with self-administration of oral prescription medications or over-the-counter (OTC) medication, when licensed nurses are not available on-site. The nurse shall delegate the delivery, supervision, and oversight of youth during self-administration of medications. Youth Medication Administration Records (MARs), staff training records, and center policy and procedures were reviewed. An observation of medication administration was conducted. Reviewed training validated the center identified and trained seven juvenile justice detention officer supervisors (JJDOS), the assistant superintendent, and the acting superintendent to assist youth with self-administration of medications. A review of five youth healthcare records of youth receiving medication found when non-licensed trained supervisory staff administer, both the staff and youth initial the MAR indicating medication was administered in accordance with the center's policy. There were no applicable reviewed MARs where the youth refused the medication. Each of the four youth reported medication is administered by medical staff. One youth stated staff will administer OTC medication if medical staff are not on-site. An interview with five staff indicated if an over the counter medication is authorized in the absence of licensed staff, it may be supervised by non-licensed medically trained staff.

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

The center maintains a written policy and procedures ensuring youth prescribed psychotropic medication administration shall occur as scheduled in a comprehensive, accurate, and organized manner. A review of five youth healthcare records found there was one applicable youth admitted to the center while on prescribed psychotropic medication. Two additional applicable youth healthcare records were requested and reviewed. Progress notes documented notification to the required parties when youth were admitted with psychotropic medication. The center did not maintain any standing orders for psychotropic medications, nor were there emergency treatment or pro re nata (PRN) orders for psychotropic medications. All three reviewed records documented the designated health authority (DHA) was notified upon admission and the psychotropic medications were continued until the psychiatrist conducted an initial diagnostic psychiatric interview. An initial diagnostic psychiatric interview was conducted for all three applicable youth within fourteen days of admission. There were no youth taking psychotropic medication which had been in the center for more than thirty days requiring a follow-up evaluation by the psychiatrist.

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

The center maintains a written policy and procedures ensuring infection control, including prevention, containment, treatment, and reporting requirements related to infectious diseases are in compliance with Occupational Safety and Health Administration (OSHA) federal regulations and with the Centers for Disease Control and Prevention (CDC) guidelines. The center maintains an infection control plan which was last updated and approved by the superintendent and the designated health authority (DHA) on July 5, 2018. Nursing interviews and reviewed documentation validated there were no instances in which the local county health department, CDC, and/or the Department's Central Communications Center (CCC) were notified of an infectious disease during this annual compliance review period. Training records indicated all center staff completed training on universal precautions.

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

The center maintains a written policy and procedures ensuring infection control, including prevention, containment, treatment, and reporting requirements related to infectious diseases are in compliance with Occupational Safety and Health Administration (OSHA) federal regulations and with the Centers for Disease Control and Prevention (CDC) guidelines. The center maintains an infection control plan which was last updated and approved by the superintendent and the designated health authority (DHA) on July 5, 2018. Nursing interviews and reviewed documentation validated there were no instances in which the local county health department, CDC, and/or the Department's Central Communications Center (CCC) were notified of an infectious disease during this annual compliance review period. Training records indicated all center staff completed training on universal precautions.

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

The center maintains a written policy and procedures ensuring proper procedures are followed to prevent the spread of infectious diseases or illnesses. The center has a written policy and procedures detailing their exposure control plan and the related practices which was last updated and signed by the superintendent and the designated health authority (DHA) on July 5, 2018. The plan was written in accordance with the Department of Labor and Occupational Safety and Health Administration (OSHA) requirements to include risk assessment and methods of compliance. Reviewed staff training records reflected each staff received training on the center's exposure control plan. There were no incidents involving a contagious disease

requiring the quarantine or hospitalization of youth or staff during the annual compliance review period.

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

The center maintains a written policy and procedures ensuring the appropriate treatment and consideration is given for pregnant youth admitted to the program. The center had one applicable pregnant youth during the annual compliance review period; however, the healthcare record was not on-site as it was sent with the youth to the residential commitment program. The nursing staff reported prenatal care for pregnant youth begins immediately upon determination of the youth's pregnancy. The designated health authority (DHA) conducts focused medical evaluations every thirty-days and daily monitoring for danger signs of pregnancy complications.

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

The center maintains a written policy and procedures ensuring pregnant youth are provided nutritious foods in sufficient quantities meeting the standards of the minimum daily allowances for pregnant youth. Each pregnant youth shall receive prenatal, post-partum, and parenting education including topics directly related to healthcare issues and medical risk for pregnant adolescents. There were no pregnant youth at the center during the annual compliance review. When a pregnant youth is admitted to the center, nursing staff provide education on alcohol and drug usage, smoking, nutrition, sexually transmitted diseases, contraception, prenatal care, birthing process, postpartum care, basic baby care (feeding, diapering, bathing), child/infant development, and parenting skills. Each pregnant youth is provided with a six-part pregnancy guide entitled, Beginnings.

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

The center maintains a policy and procedures ensuring all non-healthcare staff involved in the supervision or treatment of pregnant youth shall receive appropriate education on female healthcare, annually. A review of five staff training records for in-service training on girls' healthcare was provided to all non-healthcare staff involved in the supervision or treatment of female youth. The training included the topics of monitoring, observation, and emergency care of the pregnant youth and other prenatal healthcare education designed to monitor and foster a healthy environment while the youth are in the Department's care.

Standard 5: Safety and Security

Overview

Collier Regional Juvenile Detention center is a forty-bed secure detention center. The center provides safety and security for all youth admitted into the center. The center is equipped with forty-eight surveillance cameras, two of which experience occasional issues with functionality and are being addressed for resolution. The center has three modules to house youth. At the time of the annual compliance review, only two modules were being occupied; module two and G-mod. Module one was offline as it is being converted into an honors module. During the tour of the center, there were several youth rooms off-line for needed repairs. The sink in two rooms was not working properly and toilets in two other rooms were not functioning. The superintendent confirmed workorders for the repairs were submitted. All other housing areas, the youth had showers and other bathroom facilities in working order. The center was in good repair with minor housekeeping tasks requiring attention, such as cleaning of the carpet in the administration area.

5.01 Active Supervision of Youth (Critical)	Satisfactory Compliance

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

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

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

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

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

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

The center has a written policy and procedures to ensure youth are actively supervised by staff. Staff are responsible for ensuring the care of youth, ensuring youth are in sight and sound of at least one staff at all times. Staff communicate by two-way radio with master control pertaining to all movement within the center including emergencies and drills. A review of the center's master control logbook documented center headcounts are consistently conducted. Headcounts are conducted at the beginning and the end of each shift. Staff are required to account for each youth under their supervision at all times. Observation was conducted of youth movement and supervision, youth transport, school, and lunch. Each staff was observed actively supervising youth in sight and sound of youth at all times with no exceptions. Prior to any youth movement, staff conducted a headcount and reported the count to master control, master control confirmation for movement. An interview with five staff stated they think there has been enough staff to provide for the safety and security of youth and staff at the center. Each staff stated

youth counts are conducted at the beginning and the end of each shift, before and after school, and before and after meals.

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

The center has a policy and procedures in place to ensure ten-minute checks are conducted when youth are in their rooms. The center has forty-eight cameras in which forty-six are operational. An interview with the master control operator reported two cameras are functioning intermittently. The center's video surveillance equipment has a recording capacity of thirty days. The center utilizes Silver Guard electronic system to document room checks. When conducting room checks, staff pause at the door and look into the room to ensure there are no issues with youth. An observation of random video ten-minute checks was conducted for the center's two modules on four different days and two separate shifts. A review of four random days from B and C shift found there were a total of four checks completed late. The checks were three minutes, six minutes, ten minutes, and nineteen minutes late. One of the four days from the hours of 2:30 a.m. to 4:01 a.m. one staff was not conducting the checks within the required ten-minute time frame. Checks were conducted for 2:51 a.m. to 3:04 a.m., 3:04 a.m. to 3:25 a.m., 3:25 a.m. to 3:41 a.m., and 3:41 a.m. to 4:01 a.m. Observation showed three of the four staff were conducting the ten-minute checks as required every ten-minutes or less in real time for all other days and modules. An interview with the superintendent confirmed when youth are secured behind in their rooms, ten-minute checks are to be performed.

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 in place for tracking daily counts and census. A review of the program's master control logbooks and module logbooks for the past six months documented counts are conducted at the beginning and end of each shift, when the population changes with a release or admission, following an emergency, and randomly during the shift. Staff are required to know the number of youth and the exact location of each youth in their area at all times. There shall not be any movement of youth until master control confirms the counts are cleared.

5.04 Logbook Maintenance	Satisfactory Compliance

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

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

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

The center has a policy and procedures in place regarding logbook maintenance. The center has a master control logbook and a logbook on each module. An observation of each logbook was bound with numbered pages and dated at the top of each page. All entries included the time of the event and the name of staff and youth involved. All entries impacting the safety and security of the facility were highlighted. Errors were struck through with a single line, dated and initialed by the person correcting the error. A review of the center's master control logbook and module logbooks for the past six months verified documentation of emergency situations, incidents, drills, mental health and medical alerts, youth counts, admissions and releases, all

youth movements, and population counts at the beginning, end and throughout the shift as counts changed. The center does not use electronic logbooks. An interview the superintendent verified management ensures logbooks are maintained to document all events which occur at the facility in the event other records or sources of information are lost or destroyed.

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 in place addressing logbook reviews. The juvenile justice detention officers (JJDO) are required to document a review of the center's logbook maintained on the module when accepting the responsibility of the living area. The juvenile justice detention officer supervisors (JJDOS) document status checks in each module logbook for all shifts when accepting responsibility for living area daily. The superintendent or designee reviews all logbooks on a weekly basis. A review of master control and module logbooks for the past six months documented the program's practice.

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

The center has a policy and procedures for key control. The center maintains a master key inventory to account for all facility key rings by the ring number, the number of keys on each ring, the capability of each key and to whom the keys are assigned and issued. A review of the center's key control log and observation of distribution and collection of keys confirmed the issuance of facility keys, key rings, and radio numbers were documented on the key log form on each shift to include the date and time of issue, name of person receiving the key ring, time returned, and staff turning in their personal keys in exchange for a center key. During an

observation the key box was left unlocked, and the supervisor was unable to explain why the key box was unlocked and left open. An observation of the issuing of the facility keys to staff confirmed each staff turned in their personal keys and received their facility keys. An interview with the supervisor issuing keys indicated if a staff member does not have their personal keys they will still receive facility keys for their shift. There was inconsistency identifying who signs the key log when issuing facility keys, the staff receiving the facility keys or the supervisor disbursing the facility keys. An interview with master control indicated master control and the supervisor have access to restricted keys located in the supervisor box. Master control staff stated keys are tracked through the key log which documents the staff's name and their assigned facility keys. Five interviewed staff were able to explain the process for tracking keys. Four of the five youth were asked which keys are restricted and stated medical keys mental health records, and case management records keys are restricted. Three of five staff stated youth property area and the kitchen is restricted, and two of five staff stated education, master control, sub-control, and all egress doors are restricted. An interview with the superintendent stated the center does not issue permanent keys to staff.

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

The center has a policy and procedures in place pertaining to vehicle maintenance. Documentation verified the program has three vehicles used to transport youth. All three vehicles had documentation of a completed annual inspection. An inspection of all three vehicles showed all three vehicles had a fire extinguisher, working seatbelts, window punch, and seat belt cutters. Each vehicle had a first aid kit which is stored in intake and placed in vehicles upon transport. Each vehicle had documentation of an inspection prior to and upon return to the center using the Department's approved checklist. Observation of a youth transport returning to the center confirmed each youth and staff were wearing seatbelts. Each youth was searched upon exit. Once youth were secured in the intake area, one staff completed a check of the vehicle and documented the findings on the Department's approved checklist. A check of the center's vehicles indicated each was secured when not in use.

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

The center has written policy and procedures addressing tool inventory and tool management. All tools are stored in a locked portable building outside of the detention center property. Observation of the center's maintenance area was found to be unorganized. The shadow board did not document all tools marked with an identification code, tools were unaccounted for, and no perpetual inventories were maintained in accordance with the center's policy. Monthly inspection of tool areas was unavailable and tool replacement was not verified or documented by the superintendent or designee. An interview with the maintenance staff indicated the staff member began working at the center in September 2018 and did not have the opportunity to locate the missing tools. A review of the center's practice, and an interview with the

superintendent and the maintenance staff confirmed all vendors are escorted in and out the secure area ensuring they are not left alone while on detention center property.

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

The center has a written policy and procedures for the storing of kitchen tools. Kitchen knives and other hazardous utensils are stored in a locked storage cart and a current inventory list is posted. Observation confirmed all kitchen tools were out of reach of youth in the center. Observation of storage indicated the kitchen tools are stored in a locked cabinet when not in use. A review of the inventory list verified all tools listed were contained in the locked cabinet and accounted for. An interview with the kitchen staff confirmed kitchen staff conducts a tool count three times a day which is documented on the itemized inventory list. An interview with the food service director indicated there were no discrepancies of lost or damaged tools since the last annul review.

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

The center has a written policy and procedures for storing tools. Kitchen knives and other hazardous utensils are stored in a locked storage cart with an inventory list posted. All kitchen tools were noted to be out of reach of youth in the center. Observation of storage indicated the tools are stored in a locked cabinet when not in use. An interview with five staff indicated youth are allowed to use brooms and mops for cleaning under the supervision of the center staff.

5.11 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 policy and procedures in place addressing the use, storage, and disposal of flammable, toxic, caustic and poisonous items. The superintendent is responsible for the implementation of the safety plan ensuring all chemicals are located in a locked room, inventoried and properly secured. Observation indicated Safety Data Sheets (SDS) sheets are maintained inside a binder located in the locked room. All chemicals are inaccessible to youth.

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

The center has a written policy and procedures prohibiting youth access or handling of flammable, toxic, caustic, and poisonous items. Youth are restricted from handling flammable, toxic, caustic, and poisonous items or entering the secured area. All items are to be inventoried. If an item is removed it is documented inside a binder located inside the secured area. The center's maintenance mechanic, superintendent, assistant superintendents, and supervisors have access to the locked room. During the annual compliance review, there were no chemicals observed in the secured area of the center. An interview with five staff indicated staff spray chemicals and youth wipe the chemical off to clean areas of the center. Youth do not have direct access to chemicals.

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

The center maintains a written policy and procedure to ensure flammable, toxic, caustic, and poisonous are disposed of according to the material safety data sheet (MSDS). All chemicals are securely stored in a locked room. Youth are not permitted to enter this area. The superintendent and maintenance staff indicated there were no chemical spills and the center did not dispose of any flammable toxic, caustic and poisonous items within the annual compliance review period. The center does not utilize grease for cooking.

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

The center maintains a written policy and procedures addressing confinement under twenty-four hours. The center utilizes the youth's assigned sleeping room for confinement. Youth who are placed in confinement have no contact with other youth. All non-fixed items are removed from rooms. Confinements are documented in the Department's Facility Management System (FMS). A review of five randomly selected confinement reports was reviewed. All five reports documented rooms were searched prior to youth being placed in a room. Each report documented confinement being reviewed within two hours for fairness and appropriateness by a supervisor and reviewed every three hours thereafter, by a supervisor. Each confinement report indicated the superintendent and/or designee reviewed the confinement reports within forty-eight hours. All five confinements were communicated to school personnel. Five staff were interviewed and all five confirmed a confinement report must be completed for youth placed in confinement. The youth's room must be searched, and ten-minute checks must be conducted and documented. An interview with the superintendent stated all youth placed in confinement are documented in the Department's Juvenile Justice Information System (JJIS) and a log for ten-minute checks will be completed.

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

The center has a written policy and procedures to address confinement over twenty-four hours. A review of the Department's Juvenile Justice Information System (JJIS) for the past six months found there were no documented confinements over twenty-four hours.

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

The center has a written policy and procedures in place pertaining to the continuity of operations plan (COOP). The center is required to conduct COOP drills twice a year, and once before hurricane season. The center's COOP was approved by the Department on April 3, 2018 and signed by the superintendent and regional director on April 3, 2018. A review of the center's drills showed documentation of a drill being conducted before hurricane season. A written scenario and staff sign in sheets for each participating staff was observed. Five interviewed staff stated they participated in an escape drill and a fire drill. One staff stated they participated in a weather drill, and four staff stated they participated in a medical and mental health drill.

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

The center has a written policy and procedures regarding drills. The center has an escape prevention plan which requires all staff to remain alert, and attentive to the attitudes and behavior of the youth. The plan addresses procedures to follow when an escape attempt occurs during transportation. The center is required to conduct escape drills quarterly. A review of the

center drills documented the center conducts drills monthly on all three shifts. Drills are kept in a drill binder. A review of the center's logbook documented drills are logged, as required. A review of five staff training records documented all five staff received escape prevention training.

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

The center has a written policy and procedures regarding drills. The center has evacuation egress plans posted throughout the center. Each egress plan defined primary and secondary exit route and the location of emergency equipment to include fire extinguishers and first aid kits. A review of the center's documented drills indicated the program conducted drills on all three shifts monthly. Unannounced drills are documented in the center's logbooks. An interview with five youth indicated all have been instructed on what to do in the event of a fire Five staff were interviewed and each indicated they have participated in monthly fire drills.

Program Name: Collier Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: Collier County / Circuit 20
Review Date(s): November 27-30, 2018

MQI Program Code: 997
Contract Number: N/A
Number of Beds: 45
Lead Reviewer Code: 165

Overall Rating Summary

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

Limited Ratings	Failed Ratings
5.02 * Ten-Minute Checks	5.08 Tool Inventory and Management
5.06 Key Control	