STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Collier Regional Juvenile Detention Center

Department of Juvenile Justice
(State-Operated)
3315 Tamiami Trail East
Naples, Florida 34112

Review Date(s): December 1-4 2020

Promoting Continuous Improvement and Accountability
in Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Camelia Daley, Office of Accountability and Program Support, Lead Reviewer (Standard 1)
Tonya Gittens, Office of Accountability and Program Support, Regional Monitor (Standard 2)
Virgina Jackson, Palm Beach Regional Juvenile Detention Center, Juvenile Justice Detention Officer Supervisor (Standard 5)
Cindy Jones, DJJ Office of Education, Education Coordinator (Standard 2)
Shakela Minns, Office of Accountability and Program Support, Regional Monitor (Standard 3)
Maryann Sanders, Office of Accountability and Program Support, Deputy Regional Supervisor (Standard 4)

Program Name: Collier Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: Lee County / Circuit 20
Review Date(s): December 1-4, 2020

MQI Program Code: 997
Contract Number: N/A
Number of Beds: 40
Lead Reviewer Code: 190

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.

Overall Rating Summary

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

Limited Ratings	Failed Ratings
3.12 Suicide Prevention Training*	5.10 Tool Inventory and Management
5.01 Active Supervision of Youth *	

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	Grievances	Satisfactory
1.09	Entering Alerts(JJIS) and Sharing of Alert Information *	Satisfactory

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

Standard 2: Youth Management
Detention Rating Profile

Indicator Ratings

Standard 2 - Assessment and Performance Plan		
2.01	Admission	Satisfactory
2.02	Orientation	Satisfactory
2.03	Classification	Satisfactory
2.04	Notification of JPO Circuit Gang Rep	Satisfactory
2.05	Admission of Youth Personal Property	Satisfactory
2.06	Storage of Youth Personal Property	Satisfactory
2.07	Release	Satisfactory
2.08	Release of Youth Personal Property	Satisfactory
2.09	Release of Meds, Aftercare Instructions	Satisfactory
2.10	Review of Youth in Secure Detention and Home Detention	Satisfactory
2.11	Daily Activity Schedule	Satisfactory
2.12	Adherence to Daily Schedule	Satisfactory
2.13	Educational Access	Satisfactory
2.14	Career Education	Satisfactory
2.15	Behavior Management System	Satisfactory
2.16	Unauthorized Use of Punishment *	Satisfactory
2.17	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 *	Limited
3.13	Mental Health Crisis Intervention Services *	Satisfactory
3.14	Emergency Care Plan *	Satisfactory
3.15	Crisis Assessments *	Satisfactory
3.16	Baker and Marchman Acts *	Satisfactory

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Standard 4: Health Services
Detention Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Detention Rating Profile

Indicator Ratings

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

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Program Overview

Collier Regional Juvenile Detention Center is a state-owned detention facility, operated by the Department, located in Naples, Florida. The center serves youth in Lee, Hendry, Glades, and Charlotte counties in Circuit 20. Male and female youth who are detained pending adjudication, disposition, or placement in a residential commitment program are housed in the forty-bed center. Youth are provided services which include youth orientation, behavior management, safety and emergency procedures, transportation, mental health, and healthcare services. The center's educational services are provided by the Collier County School District. The center's management team includes the superintendent, assistant superintendent, one administrative assistant, one food service director, and a training coordinator.

The center maintains a contract with Camelot Community Care, Inc. to provide mental health, substance abuse, and psychiatric services. Mental health services are provided by a State of Florida licensed psychiatrist, licensed mental health counselor who serves as the designated mental health clinician authority (DMHCA), and two master's-level non-licensed mental health therapists. Clinical services provided by the center include mental health and substance abuse evaluations, mental health treatment planning, individual, group and family therapy, mental health crisis intervention services, on-site psychiatric services, and availability for substance abuse services for youth with co-occurring disorders.

The center has a current contract with Camelot Community Care, Inc. to assume responsibility for the provision of medical services to all youth. All healthcare staff are employed by Camelot Community Care, Inc. Medical services are provided by the medical doctor (MD) who serves as the center's designated health authority (DHA), advanced practice registered nurse (APRN), two registered nurses, and three licensed practical nurses. The medical clinic maintains nursing coverage Monday through Sunday, from 7:00 a.m. to 7:00 p.m.

Food services are provided by Department staff and include menus, meal planning, meal schedules, special diets, nutritional analysis, daily allowance, food preparation, health certifications, food product standards, sanitation, and cleaning. Staff are responsible for the custody and control of youth in their care, providing youth supervision twenty-four hours a day, seven days a week. The center has three living modules which are divided by male and female. There is one living module designated for the honor mod for youth who are on level three of the behavioral management system (BMS). A tour of the center during the week of the annual compliance review and observations found there are sixty security cameras at the center, of which all were operational.

The center was observed to be clean and free from insect infestation. Common areas, living modules, bathrooms, classrooms, kitchen, and dining areas were observed to be clean, organized, and well maintained. The center had minimal graffiti around the center; however, in one dormitory there was excessive graffiti. An informal interview with the assistant superintendent advised the center will be repainted after the holidays. Outside grounds and the perimeter area appeared to be intact and did not have any observed security issues. At the time of the annual compliance review, the center had eight vacancies, which included five juvenile justice detention officers I (JJDO), two JJDOs II, and one food support worker.

Standard 1: Management Accountability

1.01 Initial Background Screening (Critical)	Satisfactory Compliance
Background screening is conducted for all Department employees and volunteers and all contracted provider and grant recipient employees, volunteers, mentors, and interns with access to youth and confidential youth records. A contracted provider may provide training and orientation to a potential employee before the screening process is completed. However, these individuals may not have contact with youth or confidential youth records until the screening is completed, the determination is "Eligible," a copy of the criminal history report has been reviewed, and the employee demonstrates he or she exhibits no behaviors warranting the denial of employment. An Annual Affidavit of Compliance with Level 2 Screening Standards is completed annually.	

The center maintains a written policy and procedures ensuring all Department employees, contractors, volunteers, mentors, and interns are background screened prior to hire. The center had sixteen newly hired employees and nine contractors since the last annual compliance review. There was a total of one new volunteer obtained since the last annual compliance review. A review of the applicable twenty-six records confirmed background screenings were completed by the Department's Background Screening Unit (BSU)/Clearinghouse prior to each individual's date of hire and/or contact with youth or access to confidential information. Each newly hired staff's Florida Department of Law Enforcement (FDLE), criminal history, Staff Verification System (SVS) module, and Central Communications Center (CCC) Person Involvement Report was reviewed. Each direct-care staff is required to complete a pre-employment assessment and receive a passing score. The program had sixteen direct-care staff who required a pre-employment assessment. Reviewed documentation confirmed a pre-employment assessment was completed by each newly hired direct-care staff and a copy of the passing score was maintained in each staff's personnel record. Two of the newly hired direct-care staff required an exemption from the Department prior to hire due to not having a passing score. Nine contracted employee records were reviewed. All nine contracted staff background screenings were processed and maintained in the Clearinghouse database. An Affidavit of Compliance with Level 2 Screenings Standard was submitted to the BSU and for school board teachers on January 22, 2020, meeting the annual requirement.

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

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

Department staff were applicable for a five-year rescreening since the last annual compliance review. Reviewed documentation confirmed each five-year rescreening was completed and submitted to the BSU/Clearing house at least ten days prior to each staff anniversary hire date. The rescreening results indicated the staff was still eligible for employment.

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

The center maintains a written policy and procedures ensuring all staff adhere to a code of conduct. The center utilizes the Department's employee handbook which contains a code of conduct. Staff are required to adhere to a code of conduct which prohibits any form of abuse, profanity, threats, harassment, intimidations, or personal relationships with youth. Five applicable staff records were reviewed and each contained a signed acknowledgement, receipt, and review of the Department's Code of Conduct which was conducted during phase one of the staff training period. Four personnel records were reviewed for disciplinary action to meet the minimum sample size. Documentation found one staff received an oral reprimand for attendance issues and written reprimand for improper positioning and supervision practice. Another staff received both written and oral reprimands for violation of code of conduct. Two staff received oral reprimands for not adhering to the Department's Code of Conduct. An additional three personnel records were reviewed for commendations. Documentation validated three staff received Employee of the Month, Employee of the Quarter, and Maintenance Mechanic of the Year for outstanding performance and dedication. An informal interview with the superintendent indicated every month staff are recognized for hard work and dedication on each shift and is awarded with a gift card to various establishments. The center's practice confirmed each supervisor on each shift submitted staff names to the superintendent by email on the recommendation of their rising star.

A review of the internal incidents, Department's Central Communications Center, and Protective Action Response (PAR) reports confirmed there were no incidents which should have been documented as a violation of Code of Conduct. An interview with the center's superintendent was conducted and confirmed the center adheres to a strict Code of Conduct, inclusive of youth's confidentiality, prohibiting staff horseplay, verbal or physical abuse, and any personal relationships between staff and youth.

Five staff were interviewed regarding the working conditions of the center. Three of the five staff reported they have never observed a co-worker use profanity when speaking to a youth. One staff reported once witnessing a co-worker use profanity when speaking to a youth. One staff reported occasionally witnessing a co-worker use profanity when speaking to a youth. All five staff reported the working conditions at the center in the past year have been good. Five youth were interviewed and each reported staff are respectful when talking with them and other youth. Two youth reported they witnessed staff using profanity once. One youth reported occasionally hearing staff use profanity. Two youth reported never witnessing staff using profanity. Additionally, each interviewed youth confirmed they have never been threatened by a staff or seen a staff member threaten another youth.

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

The center maintains a written policy and procedures ensuring all incidents are reported to the Department's Central Communications Center (CCC). The center shall notify the CCC within two hours of a reportable incident or within two hours of becoming aware of the reportable incident. The center had twenty-five incidents reported to the CCC since the last annual compliance review. The center indicated thirty-two reportable incidents during the previous year annual compliance review; therefore, demonstrating an increase in reported incidents. An interview with the center's superintendent regarding the increase reported an increase of youth's population; therefore, resulting in an increase in the CCC incidents.

The center had twenty-one incidents reported to the CCC during the previous six months of which five were reviewed. Documentation validated each incident was reported to the CCC within the mandatory two-hour time frame and in accordance with the CCC reporting procedures. The center maintains a master control logbook for documenting reports to the CCC. A review of the logbook validated all five reports were documented. A review of internal incidents and grievances for the previous six months determined there were no incidents which should have been reported to the CCC which were not. An interview was conducted with the center's superintendent and confirmed all staff must contact the Department's CCC within two hours of a reportable incident occurring. Additionally, all staff are mandated reporters and must contact the Florida Abuse Hotline if any abuse or neglect allegations are made. The center's superintendent reported all youth are afforded the opportunity to utilize the telephone to report any abuse or neglect allegations. A telephone is designated on each dorm accessible to youth.

Five staff were interviewed and reported all youth have unhindered access to the Florida Abuse Hotline and CCC. Each interviewed staff confirmed they notify a supervisor when a youth wants to make a call to the Florida Abuse Hotline or CCC. Additionally, each staff can make a call to the Florida Abuse Hotline or CCC if they feel a call is warranted. Five youth were interviewed and each reported they have never had to report abuse but is aware of the process on how to report. Each interviewed youth reported feeling safe at the center.

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

The center maintains a written policy and procedures ensuring Protective Action Response (PAR) is in accordance with Florida Administrative Code. All center administrators and officers shall be trained in PAR. A PAR report will be generated any time a PAR incident occurs. The PAR reports shall include a review by a PAR-certified instructor/supervisory staff, post-PAR interview, and a review of the PAR incident report by the superintendent, or designee, within twenty-four hours of the incident, excluding weekends or holidays.

The center had seventy-four PAR reports completed since the last annual compliance review and seven were reviewed. Reviewed documentation confirmed each report included statements from all staff involved. Six of the seven reports were completed by the end of the staff member's workday. A review of the PAR incident reports found documentation supported each report contained a review by a PAR-certified instructor and documented a post-PAR interview conducted within thirty minutes of the incidents. One PAR report found a post-PAR interview was not conducted with the youth by the administrator or designee, as soon as possible or within thirty minutes of the incident. None of the reviewed reports required a Mechanical Restraint Supervision Log to be completed. None of the reviewed PAR reports alleged any injuries or required a PAR medical review. Documentation confirmed each report was reviewed and processed within the mandated time frame by a juvenile justice detention officer supervisor (JJDOS) and PAR instructor to determine if the use of force was consistent with the center's procedures.

Each post-PAR interview was dated, timed, and signed by the individual conducting the interview. Each post-PAR interview was filed in each youth's individual healthcare record. None of the reviewed reports required a Mechanical Restraint Supervision Log to be completed. Reviewed documentation of seven PAR incident reports contained a review by the superintendent, or designee, within seventy-two hours of the incident. None of the reviewed reports required a call to the Department's Central Communications Center (CCC). There was no documentation to support any involved youth made a report to the Florida Abuse Hotline. Logbooks and internal incident/grievance reports were reviewed, and documentation did not reveal any additional PAR incidents occurred.

The center's PAR rate during the annual compliance review period was 16.60, which is below the statewide Detention PAR rate of 16.56. An interview was conducted with the center's superintendent, who confirmed PAR reports are entered in the Facility Management System (FMS). All PAR reports are reviewed by a JJDOS, the PAR instructor, and an administrator. Additionally, the center reviews logbooks and youth grievances regularly to determine if a reportable incident was not entered into the FMS. Five staff were interviewed and each confirmed they use verbal techniques prior to using physical or mechanical restraints.

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

The center has a written policy and procedures ensuring all newly hired staff are trained in accordance with Florida Administrative Code within 180-days of hire. Pre-service training is divided into two phases. Phase one consists of instructor-led and web-based courses. Phase two consists of 120-hours of academy instructor-led training. Five staff training records were reviewed for pre-service training. All five reviewed records found all staff completed the certification process within 180-days of hire. All reviewed records found each of the five reviewed staff completed the required trainings inclusive of Protective Action Response (PAR), first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), mental health services, substance abuse services, suicide prevention, safety and security emergency plans, human trafficking, Department detention facility operations, supervision, active shooter, and Prison Rape Elimination Act (PREA) prior to having any contact with youth. A review of five staff training records found documentation to support each staff completed phase one and phase two training. All training was conducted by qualified trainers and documented in the Department's Learning Management System (SkillPro).

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

The center has a written policy and procedures ensuring all staff complete at least twenty-four hours of in-service training annually, including mandatory topics specified in Florida Administrative Code. Five applicable staff training records, which included two juvenile justice detention officer supervisors (JJDOS) training records, were reviewed for in-service training. A review of five staff training records revealed each had an excess of the required twenty-four hours of training. All records indicated each staff received re-certification training in Protective Action Response (PAR), cardiopulmonary resuscitation (CPR), first aid, automatic external defibrillator (AED), suicide prevention, professionalism/ethics, and active shooter training. All five records did not have escape prevention training annually as it was not required in the center's in-service plan for 2019. Two JJDOS training records reviewed confirmed the completion of eight or more hours of supervisory training as required by the facility operating procedures (FOP) and the Florida Administrative Code. The center's training coordinator maintains an annual in-service training calendar and enters all training into the Department's Learning Management System (SkillPro). An interview with the superintendent indicated they received training in the Department's Juvenile Justice Information System (JJIS) database for program monitoring and management, Central Communications Center (CCC) database, and leadership training. The superintendent indicated all staff receive in-service and pre-service training in compliance with the FOP and the Florida Administrative Code. The trainings are web-based as well as instructor lead. The superintendent confirmed all completed training is entered into SkillPro.

1.08 Grievances	Satisfactory Compliance

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

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

The center maintains a written policy and procedures ensuring all youth are treated fairly, respectfully, and without discrimination. The center ensures all youth have the right to file a grievance. The grievance process is posted in each module and explained to each youth during the admission and orientation process. The grievance process consists of three phases. The first step in the grievance process is the informal phase which is completed by detention staff whereby the youth and staff attempt to resolve the youth's issue. A written grievance will be submitted to the juvenile justice detention officer supervisor (JJDOS) if the staff is unable to resolve the issue which begins the formal grievance process. Next, the appeal phase requires a response from the superintendent or designee. Grievance forms are electronically retained in the Facility Management System (FMS) for at least one year.

Thirteen grievances were filed in the last twelve months and five were reviewed. All five grievances were resolved at the formal phase. All five grievances were forward to the on-duty JJDOS within the required time frame, through the FMS, and the youth were informed of the findings by the end of the JJDOS shift. An interview with the superintendent explained all youth have the right to file a grievance if they feel their rights have been violated. Five youth were interviewed regarding the grievance process. Three stated they have never submitted a grievance. One youth reported the process as fair. Another youth rated the grievance process as poor and stated no one spoke to the youth when a grievance was filed. An informal interview with the superintendent and records confirmed the youth did not file a formal grievance. An informal interview was conducted with youth, the youth confirmed never formally filing a grievance but was aware of the grievance procedure, the youth spoke verbally to staff but did not want to file a written grievance. Five staff were interviewed and each were able to describe the center's grievance process.

1.09 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 juvenile justice detention officer supervisor (JJDOS) shall ensure the last hard copy of the alerts shall have a written notification or update of the recent admissions or changes to existing alerts on the alert sheet and distribute to all staff within the center immediately.* *Medical and mental health staff shall review alerts to ensure each alert is correctly tracked and managed.* *The responses and updates by medical, mental health, and other staff should be documented in JJIS alerts as they pertain to the specific alert.* *JJDOSs shall inform staff of alerts during shift briefing. When a JJDOS receives changes to the alert list, he/she shall notify the staff affected by changes and add the information to the shift briefing for the oncoming shift upon receipt of the information.*	

The center maintains a written policy and procedures ensuring alerts are entered into the Department's Juvenile Justice Information System (JJIS) and the use of an internal alert system. Critical and special alerts are reviewed, updated, and responded to appropriately. Staff shall always possess a copy of the detailed alert list with them. Five youth's JJIS alerts were reviewed to confirm appropriate entry and closure procedures were followed. All five youth were found to have one or more alerts entered in JJIS and a total of sixteen alerts were reviewed for compliance. All alerts were verified prior to entry into JJIS and all alerts matched the internal alert system. Supervisors and management staff are responsible for updating and downgrading JJIS security alerts. All medical and mental health alerts were entered or updated by the appropriate Department representative. An interview with the superintendent indicated youth alerts are entered in JJIS at the time of admission or when a youth's alert status is changed. Alerts are reviewed daily on each shift by the shift supervisor and the information is shared with staff during the shift briefing. Five interviewed staff indicated they are informed of youth alert status during the shift briefing, review of logbook, alert forms, JJIS, alert board, and they can contact medical. All staff indicated they received pertinent information about the center during the same shift briefings or emails.

Standard 2: Assessment and Performance Plan

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

The center maintains a policy and procedures to ensure the proper screening, evaluation, and documentation is provided for each youth admitted into the center. Five youth case management records were reviewed and each record included the youth's arrest affidavit, court orders, a completed Detention Risk Assessment Instrument (DRAI), and a Suicide Risk Screening Instrument (SRSI). All five youth Admission Wizard forms documented each youth being frisked, full body visual, and/or electronic search by an officer of the same sex as the youth. Each youth record documented all youth received a telephone call, a meal or snack, were evaluated for medical, mental health, and substance abuse needs upon admission. The center did not have any new admissions to observe during the week of the annual compliance review; however, the admission process was discussed with the superintendent and video observation was conducted.

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

The center maintains a policy and procedures to ensure all youth admitted into the center are notified of the center rules and regulations, related consequences for failing to meet behavior expectations, expectations for behavior, and youth rights within twenty-four hours of admission. A review of five youth case management records were reviewed and each reviewed record

included documentation the youth received an orientation within the required twenty fours of admission, which consist of rules and regulations, youth rights, visitation, telephone calls, grievance procedures, access to medical, mental health, and substance abuse services, access to the Florida Abuse Hotline, access to the Department's Central Communications Center (CCC), behavior expectations, behavior-related consequences, and possible new law violations for destruction of property. The orientation was provided to all five youth verbally and in writing. No youth were admitted to the center at the time of the annual compliance review. Observation of an orientation was conducted by videotape. Five youth were interviewed and each reported when they came into the center, they were told about the center's rules and regulations, daily schedule, education services, visitation, abuse reporting, and behavior management system.

2.03 Classification	Satisfactory Compliance

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

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

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

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

The center maintains a policy and procedures regarding classification of youth admitted to the center. A review of five youth case management records included the required classification elements. The center considers several factors prior to placing youth into a room inclusive of height, weight, age, gender, level of aggression, mental illness, development disabilities, physical disabilities, history of violence, gang affiliation, criminal history, history of sexual offenses, vulnerability to victimization, suicide risk, medical and security, and escape risk. Each youth record included a copy of the Secure Detention Admission Wizard form to determine a youth's aggressiveness, mental illness, suicide risk, intellectual and physical disabilities, history of violence, maturity, living arrangements, and gang affiliation. All five reviewed youth case management records contained a Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) assessment which was included in the classification process. All youth were assigned to a room based on their classification. None of the five youth were applicable of being reclassified and none of the five youth had a history of committing a sexual offense. Each of the five reviewed youth case management records documented applicable mental health, medical,

dietary, and suspected gang affiliation classification alerts which were entered into the Department's Juvenile Justice Information System (JJIS) during the youth's admission. An interview with the superintendent confirmed the center's classification process.

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

The center maintains a policy and procedures to ensure youth are screened to determine if the youth are affiliated or identified as gang members and for the purposes of notification to the designated juvenile probation officer circuit gang representative. An interview with the center's superintendent stated the center has a juvenile probation officer (JPO) identified as the circuit gang representative and referrals are submitted by email to the Collier County Sheriff's Office when it has been determined at admission a youth is involved or has affiliation with any street gang for the first time. A review of the Department's Juvenile Justice Information System (JJIS) confirmed the center had no current youth documented as gang members or has affiliation with a street gang. The center's superintendent confirmed the center did not have a youth determined as a gang member or has affiliation with any street gang during admission since the last annual compliance review. The center's practice is once a youth is identified as a gang member, or has a gang affiliation, is to document on the youth's Admission Wizard, enter the alert into JJIS, and send an email to the Collier County Sheriff's Office and the circuit's gang representative.

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

The center maintains a policy and procedures ensuring the proper safe handling and security of each youth's personal property including valuables which are collected and secured at the time of a youth's admission. A review of five youth case management records confirmed each youth had a property form which itemized personal property, valuable property, and youth and staff signature. One of the five youth had valuable property which was placed in a clear tamper-proof bag with youth's name, Department of Juvenile Justice identification number (DJJID), date, staff name, and signatures of the youth and staff. The property is placed in a drop safe which is under video surveillance twenty-four hours a day. The center maintains a drop safe logbook to document the time, youth's name, name of the officer securing the property, and the officer's initials. Five youth case management records were reviewed and each youth record confirmed documentation of the youth signing a letter of acknowledgement regarding unclaimed property. The center had no admissions during the week of the annual compliance review.

Five interviewed youth confirmed when the youth arrived at the center, staff checked their personal property and the youth had to sign a Personal Property Receipt form stating the personal property was correct. An interview with the superintendent confirmed youth personal property is always under video surveillance and all youth property is located in the intake property room. In the event a youth's property is not claimed, the superintendent or designee will ensure all money and property are counted and inventoried. A money order shall be sent to the regional fiscal manager. The regional fiscal manager will then forward the money order to the headquarters' designee. A record must exist for any property disposed of or cash forward to headquarters.

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

The center maintains a policy and procedures to ensure the youth's personal property is inventoried, maintained securely, and returned to the youth in a timely manner upon release from the center. Observation of the center's storage area during the annual compliance review confirmed youth valuable property was secured in a locked safe under video surveillance in a clear tamper-proof plastic bag. The center maintains a drop safe logbook to document the time, youth's name, name of the officer securing the property, and the officer's initials. Youth clothing and shoes are placed in a black zip bag along with a copy of the Personal Property Receipt form. A review of the Department's Central Communications Center (CCC) logbook and CCC incident reports since the last annual compliance review, found there were no incidents of lost or stolen property during the annual compliance review period. The center had no admissions during the week of the annual compliance review.

An interview with the superintendent validated the center's practice in which only administration staff have access to the youth property room, youth personal property is always under video surveillance, and all youth property is located in the intake property room. In the event a youth's property is not claimed, the superintendent or designee will ensure all money and property are counted and inventoried. A money order shall be sent to the regional fiscal manager. The regional fiscal manager will then forward the money order to the headquarters' designee. A record must exist for any property disposed of or cash forwarded to headquarters.

2.07 Release	Satisfactory Compliance

When releasing youth from the center, the releasing officer shall verify the court's authorization to release the youth. Care must be taken to ensure all case file information is reviewed to prevent the negligent release of a youth.

All releases from the center are court-ordered, with the exception of deaths, escapes, and expirations of detention time period. In the absence of a written order, documentation of a verbal order in open court may be used for release.

The on-duty JJDO Supervisor reviews all paperwork prior to a youth's release. The JJDO Supervisor is responsible for ensuring there are no holds, court orders, or other legal reasons not to release the youth.

Questions concerning release are presented and addressed by the superintendent, or designee, prior to release.

The releasing officer shall verify the identification of the youth.

The center maintains a policy and procedures to ensure all releases from the center occur promptly and accurately. A review of three youth closed case management records indicated each record had the appropriate documentation including the Release Wizard signed by the youth's parent/guardian or person taking custody of the youth, the court authorization to be released, and a copy of photo-identification of the parent/guardian or person taking custody of the youth. A review of the Department's Juvenile Justice Information System (JJIS) confirmed each youth record had the admission and termination date correlated within JJIS. A review of the Department's Central Communications Center (CCC) reports confirmed there were no unauthorized releases. The center had no releases during the annual compliance review week.

2.08 Release of Youth Personal Property	Satisfactory Compliance

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

The center maintains a policy and procedures ensuring youth property is maintained securely during admission and released to the youth or the youth's parent/guardian. Three youth closed case management records were reviewed and each record contained a Property Receipt form signed by youth and parent/guardian upon release. An interview with the superintendent confirmed the center did not have property held in the center more than thirty days. The center's policy indicates if property is not claimed during release, it is secured and an acknowledgment is sent to the parent/guardian notifying of the unclaimed property. If the property is not picked up, it is donated to a local charity. There were no releases to observe during the annual compliance review week.

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

The center maintains a policy and procedures to ensure prescribed medication, along with medication instructions, are provided to the parent/guardian or responsible adult at the time the youth is released. A review of three closed youth case management records, had documentation of youth being released to an appropriate person with valid identification. Each closed youth record contained a signed medication receipt with the name and signature of the youth's parent/guardian who took possession of the medication upon the youth's release from the center. The form documented the type of medication, instructions, and any applicable pending appointments.

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

The center maintains a policy and procedures to address detention reviews of youth held in secure detention or who are awaiting placement to a residential program. Detention reviews are held on a weekly basis to address the status of each youth. Updates are provided as to the youth's behavior while in detention, the youth's education status, the next court date, residential placement status, and/or release status. Documentation from the meetings including notes taken for the past six months along with weekly sign-in sheets, confirmed meetings are conducted and each youth in secure detention and home detention are reviewed according to the Department's policy.

Observation of a weekly detention review was conducted, staff in attendance included the mental health, medical staff, education, juvenile probation officer supervisor (JPOS), and detention review specialist. Each youth's status was reviewed individually and included a review of behavior, projected release date, medical status, and other pertinent information relevant to keep youth and staff safe. The superintendent reported detention review meetings are held in the conference room on Wednesday's at 2:00 p.m. by the detention review specialist, who oversees the meetings and documents weekly case notes on each youth.

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

The center maintains a policy and procedures to address the daily activity schedule. Youth are provided the opportunity to participate in constructive activities benefiting the youth in the center. The center's daily schedule documents the days and times of youth activities, personal hygiene, mealtime, visitation, education, recreation indoor/outdoor, shift change, bedtime, groups, and open programming times. A tour of the center validated the daily schedule is posted on each module visible to all youth. Five interviewed youth confirmed the center has a daily schedule.

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

The center maintains a policy and procedures which outlines adherence to a daily schedule. A review of the center's logbooks and shift reports for the past six months validated the center follows the daily schedule. Observations of the youth in school and mealtime confirmed the center's daily schedule was followed during the annual compliance review week. Five youth were interviewed regarding the daily activity schedule. Each youth confirmed the daily activity schedule is followed each day. Five staff were interviewed regarding the daily activity schedule and each staff reported the daily activity schedule is followed every day.

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

The center has a policy and procedures to provide for educational access for the youth. Educational services are provided by the Collier County School District, who approves the 250-day school calendar which incorporates ten teacher planning in-service days. The youth are enrolled in credit bearing courses and continue with their coursework aligned with the district. The daily schedule reflects six fifty-minute class periods fulfilling the minimum twenty-five hours of instruction each week. The superintendent was interviewed and stated there is minimal interference of the school day. Five interviewed youth indicated the daily schedule is followed and they attend school daily. One of the five interviewed youth stated even though the youth graduated, the youth still attends classes and focuses on history and current events. All five youth indicated they are being well prepared for either a General Equivalency Diploma (GED) or continuing their education with one youth indicating they felt very well prepared. A review of the center's logbook for a two-week period of time confirmed youth being in school. The center's practice validated youth are attending school according to the daily schedule. An observation during the annual review week confirmed youth were in school and received educational access.

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

The center has a policy and procedures to address career education for youth at the center. The center provides career education programming which incorporates communication, interpersonal skills, decision-making skills, and goal setting skills. The lead educator indicated the center is providing the requirements for Type One Career Education to include life skills groups, activities, and instruction for the youth in résumé writing, filling out job applications, interviewing skills, and the importance of being a successful student. These activities are incorporated into each teachers' weekly lesson plans. The three teachers have incorporated activities to share their own personal career and job experiences, which have proven to be quite inspirational to the youth. As part of the initial assessment, each youth is given a career

assessment which allows the engagement of each youth to explore positive interests they may have. Guest speakers are a part of the career education development program; however, this component has currently been put on hold due to the COVID-19 pandemic.

2.15 Trauma-Informed Care	Satisfactory Compliance

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

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

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

The center maintains a policy and procedures for trauma-informed care. Observation found the center's soft room is decorated with comfortable furniture and carpeting, along with teddy bears, and a soothing wall color. The soft room is utilized to help calm youth down, therapists sometimes utilize the room to have meetings with youth. A review of five in-service and five pre-service training records indicated all staff are trained on trauma-informed care. All training is completed and documented in the Department's Learning Management System (SkillPro). An interview with the superintendent stated the center has implemented trauma-informed practices by adding additional staff training, making the center's physical appearance more softening, allowing mental health to lead youth groups and activities, conducting projects, advocacy groups weekly, yoga, arts and crafts, and motivational speaker groups.

Standard 3: Mental Health and Substance Abuse Services

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

The center has a written policy and procedures to ensure there is a licensed mental health professional appointed as the designated mental health clinician authority (DMHCA). The policy was approved and signed by the superintendent and the DMHCA on July 15, 2020. The Department maintains a contract with Camelot Community Care, Inc. to provide mental health and substance abuse services to all applicable youth in the center. The DMHCA is responsible for the coordination and implementation of mental health and substance abuse services provided at the center. The center's DMHCA is provided through Camelot Community Care, Inc. The DMHCA is a licensed clinical social worker (LCSW) who holds a clear and active license in the State of Florida with an expiration date of March 31, 2021.

The DMHCA is full-time and scheduled to be on-site forty hours each week, Monday through Friday from 9:00 a.m. to 5:00 p.m. A review of sign-in sheets confirmed the DMHCA is on-site as required. The DMHCA is available seven days a week, twenty-four hours a day by way of telephone for consultation. A review of the DMHCA's job description determined the DMHCA is responsible for overseeing all clinical and administrative operations of the assigned center to ensure clinical integrity, quality, contract compliance, utilization, budget/fiscal efficiency, and Council on Accreditation (COA) compliance. During an interview, the DMHCA reported being responsible for ensuring all youth are assessed within twenty-four hours of being in secure detention. The DMHCA assess all youth by completing an Assessments of Suicide Risk (ASR), Suicide Risk Screening Instrument (SRSI), and a brief mental status check. Youth are provided supportive services, crisis management services, individual/group therapy, and substance abuse treatment if warranted. The center has one back-up DMHCA in the event of scheduled leave and/or absences. The back-up DMHCA is a LCSW under Chapter 491 in the State of Florida, with an expiration date of March 31, 2021.

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

The center maintains a written policy and procedures ensuring services are provided by individuals with appropriate qualifications. The designated mental health clinician authority (DMHCA) ensures the center's non-licensed master's-level therapists are working under direct supervision and providing services they are qualified based on education, training, and experience. The policy was approved by the superintendent and the DMHCA on August 20, 2020.

The center's contract with Camelot Community Care, Inc. provides for a full-time regional mental health director to provide detention center-specific technical assistance to each center, one full-time DMHCA, and a part-time psychiatrist. The psychiatrist is scheduled to provide services for approximately two hours each week. Since April 7, 2020, the psychiatrist has been providing weekly tele-psychiatry services. The center has a contract with an additional psychiatrist to serve as back-up. The regional mental health director conducts weekly video-teleconference meetings with all of the detention center's DMHCAs and conducts an individual weekly call with the DMHCA to discuss youth receiving services. The regional mental health director is a licensed clinical social worker (LCSW), the DMHCA is a licensed mental health counselor, and the back-up DMHCA is a regional mental health director. A review of licenses found each was clear and active in the State of Florida with an expiration date of March 31, 2021. The psychiatrist license was clear and active in the State of Florida with an expiration date of January 31, 2022 and the back-up psychiatrist license was clear and active with an expiration date of January 31, 2022. Both psychiatrists had education backgrounds in child and adolescent psychiatry and were members of the American Board of Psychiatry and Neurology.

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

The center has a written policy and procedures to ensure mental health and substance abuse services are provided by individuals with appropriate qualifications. The clinical supervisor ensures the clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience. The center is licensed through the Department of Children and Families under Chapter 397 to provide substance abuse outpatient services with an expiration date of April 1, 2021.

The center has one non-licensed bachelor's-level mental health and substance abuse clinical staff who works under direct supervision of the licensed clinical social worker (LCSW). The LCSW serves as the center's designated mental health clinician authority (DMHCA). The non-licensed bachelor's-level clinician holds a degree in psychology and is scheduled to work part-time approximately ten hours a week. Reviewed documentation reflected the non-licensed clinician received twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. The training included the administration of five Assessments of Suicide Risk (ASR) or Crisis Assessments conducted on-site in the physical presence of a licensed mental health professional and documented on non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form.

The DMHCA provided the completed fifty-two additional hours of required pre-service training for the non-licensed clinical staff. Reviewed documentation supported the clinician completed the required training, as described in Rule 63N-1 F.A.C., prior to working with youth. The fifty-two hours of pre-service training included sixteen hours of documented clinical training in their duties and responsibilities. The DMHCA provides on-going training in mental disorders and substance-related disorders, counseling theory and techniques, group dynamics and group therapy, treatment planning, and discharge planning.

A review of the supervision logs for the past six months reflected the DMHCA provided at least one-hour of weekly face-to-face supervision documented on the Department's Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log form. In the event weekly supervision was not provided, the center was able to provide documentation to justify the reason supervision was not conducted.

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

The center has written policy and procedures ensuring the mental health and substance abuse needs of youth are identified through a comprehensive screening process in which referrals are made when youth are identified with mental health and/or substance abuse needs or identified as a possible suicide risk. The policy was approved by the superintendent and the designated mental health clinician authority (DMHCA) on July 15, 2020. The superintendent established procedures for a thorough review of each youth's preliminary screening conducted by the juvenile probation officer (JPO) 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.

A review of five youth mental health and substance abuse records found documentation of each having a mental health, substance abuse, and suicide risk screenings utilizing the SRSI and the Massachusetts Youth Screening Instrument - Second Version (MAYSI-2) assessment completed during the admission process in the Department's Juvenile Justice Information System (JJIS). Each of the five SRSIs were reviewed by a mental health clinical staff member and documented their recommendation. Each of the SRSIs had completed entries which had a summary and recommendations included in the screening results section. Five youth were applicable for positive "yes" responses on the SRSI form and were placed on suicide precautions and a mental health referral was completed. Five reviewed SRSIs and MAYSI-2 assessments indicated the need for further assessment and the center notified mental health staff and the superintendent, as required. 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. During an interview, the superintendent reported the mental health, substance abuse, and suicide risk screenings are completed by mental health staff.

3.05 Mental Health and Substance Abuse Evaluation [Detention Staff/Contract Provider]	Satisfactory Compliance
The probation and JAC intake/detention screening process ensures youth identified through preliminary screening with 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 has a written policy and procedures ensuring youth who are identified through preliminary screening or during intake and admission, with mental health and/or substance

abuse issues or needs are referred for a further in-depth mental health and/or substance abuse evaluation. All youth identified by screening or by staff observations or behavior after admission are referred for further in-depth mental health and substance abuse evaluation. The center utilizes the Department's Mental Health/Substance Abuse Referral Summary form. Youth identified in the juvenile assessment center (JAC) as in need of further assessment are referred to a community provider for a comprehensive assessment.

The center maintains a contract with Camelot Community Care, Inc. to ensure youth identified during the preliminary screening process receive an in-depth mental health and/or substance abuse assessment shortly after intake. A review of five youth mental health and substance abuse records reflected each youth was referred for an assessment. Three youth were admitted prior to the annual compliance review and the time frame of fourteen days had not expired. One additional record was requested and reviewed to meet the sample size requirement of three records. All three applicable youth records included an assessment/evaluation provided by a community provider. Each of the assessments/evaluations were completed in full and contained all required elements within thirty days of each youth's admission. When applicable, clinical staff emailed the juvenile probation officer (JPO) requesting an evaluation/assessment which were completed within fourteen days of each youth's admission.

3.06 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/substance abuse treatment in the center. *All youth who receive mental health and/or substance abuse treatment while in at the center shall have a discharge summary completed documenting the focus and course of the youth's treatment and recommendations for mental health and/or substance abuse services upon youth's release from the center.*	

The center has a written policy and procedures ensuring all youth who receive mental health and/or substance abuse treatment while in the center shall have a discharge summary completed documenting the focus and course of the youth's treatment recommendations for mental health and/or substance services upon the youth's release.

Five youth mental health and substance abuse records were reviewed for mental health and substance abuse treatment services. None of the selected records were applicable for requiring an initial treatment plan completed within seven days of initiation of treatment. Three additional closed records were provided by the center for review. All three applicable youth were assigned to a mini-treatment team and were referred for services utilizing the Department's Mental Health and Substance Abuse Referral Summary form. Two of the three reviewed records had a treatment plan in place within seven days of initiation of treatment. One applicable record had a treatment plan in place on the eighth day. All three youth had an Initial Treatment Plan developed within seven days of initiation of treatment. Each reviewed youth record was applicable for treatment with psychotropic medication management, individual therapy, and supportive counseling. Each plan contained the reason for referral for treatment, initial Diagnostic and Statistical Manual of Mental Disorders, initial treatment methods and goals, and psychiatric services. Each was signed by the youth and the mini-treatment team members. Reviewed documentation confirmed the designated mental health clinician authority (DMHCA) maintained documentation of weekly treatment team meetings.

Reviewed documentation and an interview with the DMHCA confirmed each youth received services as identified on their initial treatment plan and/or individual treatment plan. In addition, the DMHCA reported since the onset of the COVID-19 pandemic, the center has not conducted groups; however, the center has increased individual therapy in place of groups. None of the applicable youth were at the center long enough to be due for an individualized treatment plan. None of the applicable youth were an alleged victim of a Prison Rape Elimination Act (PREA) event. All three youth records supported a Mental Health/Substance Abuse Treatment Discharge Summary was completed for each youth. Reviewed documentation supported a copy was provided to the youth, parent/guardian, and assigned juvenile probation officer (JPO).

3.07 Mental Health and Substance Abuse Treatment [Detention Staff/Contract Provider]	**Satisfactory Compliance**
Mental health and substance abuse treatment planning in Department facilities focuses on providing mental health and/or substance abuse interventions which will reduce or alleviate a youth's symptoms of mental disorder and/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 at the center, must be assigned to a mini-treatment team.*	

The center has 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. The policy was approved by the superintendent and the designated mental health clinician authority (DMHCA) on July 15, 2020.

Five youth mental health and substance abuse records were reviewed for mental health and substance abuse treatment services and none were applicable for receiving treatment services. Three additional records were requested and reviewed to meet the sample size requirement. Each applicable youth requiring treatment was assigned to a mini-treatment team consisting of mental health, medical, education, direct-care staff, and administrative staff. Each reviewed youth record was applicable for treatment with psychotropic medication management, individual therapy, supportive counseling, and family therapy sessions. The DMHCA reported since the onset of the COVID-19 pandemic, the center has not conducted groups; however, the center has increased individual therapy in place of groups. The DMHCA maintained documentation of weekly treatment team meetings. All three youth records included a signed Authority for Evaluation and Treatment (AET) form. Treatment notes were documented on the Department's Counseling/Therapy Progress Note form and in the Mental Health Chronological Notes.

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 written policy and procedures ensuring psychiatric services are provided to youth in need to include psychiatric evaluation, consultation, medication management, and medical supportive counseling. Psychiatric services are provided to youth in need of services as indicated by symptoms of mental disorder or substance-related disorder, or to youth who are treated with psychotropic medication subsequent to their admission to the center. The center maintains a contract with Camelot Community Care, Inc. for the provisions of a licensed psychiatrist to provide psychiatric services for applicable youth in the center. The center's psychiatrist is an osteopathic physician with a clear and active license in the State of Florida under Chapter 459 which expires on March 31, 2022. The center has one back-up psychiatrist who is a medical doctor with a clear and active license in the State of Florida with an expiration date of January 31, 2022. The center does not utilize a psychiatric advanced practice registered nurse (APRN).

Reviewed documentation and the Tele-Psychiatry Log validated the psychiatrist is providing weekly services, as required, through tele-psychiatry. Due to the COVID-19 pandemic, the center began utilizing tele-psychiatry on March 17, 2020 and will continue until further notice. The center utilizes the Department's Mental Health/Substance Abuse Referral Summary form to request a psychiatric evaluation. The psychiatrist signs and dates the referral form.

Five youth mental health and substance abuse records were reviewed and none of the five youth were applicable for psychiatric services. Three additional records were requested and reviewed to meet the sample size requirement. 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. None of three youth required the monitoring of Tardive Dyskinesia. Each applicable record contained a current Authority for Evaluation and Treatment (AET) form.

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

The center has a suicide prevention plan, which was approved and reviewed by the designated mental health clinician authority (DMHCA) and superintendent on July 15, 2020. 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 (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, Collier County Sheriff's Office, psychiatrist, designated health authority, emergency room, crisis stabilization unit, and Poison Control. The plan is located in the superintendent's office, medical clinic, DMHCA's office, and is accessible to all staff on the center's network drive and SharePoint.

3.10 Suicide Prevention Services [Detention Staff/Contract Provider] (Critical)	Satisfactory Compliance
Suicide Precautions are the methods utilized for supervising, observing, monitoring, and housing youth identified through screenings, available information, or staff observations 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 at a minimum of constant supervision.* *All youth 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 (ASR).*	

The center has a written policy and procedures regarding suicide prevention services. Suicide precautions are the methods utilized for supervising, observing, monitoring, and housing youth identified through screenings, available information, or staff observations as having suicide risk factors or identified through assessment as a potential suicide risk. The policy was approved by the superintendent and the designated mental health clinician authority (DMHCA) on July 15, 2020. All youth identified as having suicide risk factors by screening, information obtained from the youth, or staff observations must be placed on suicide precautions and receive an Assessment of Suicide Risk (ASR). Youth placed on suicide precautions are maintained on one-to-one or constant supervision. The superintendent has a review process in place for every serious suicide attempt or serious self-inflicted injury and a mortality review for a completed suicide, which includes all required elements.

Four of the five reviewed youth records were applicable for suicide prevention services. The four applicable youth's mental health and substance abuse records validated each youth was screened upon admission for suicide risk factors. All four applicable youth were placed on precautionary observation (PO) until the ASR was completed. A review of the Department's Juvenile Justice Information System (JJIS) confirmed the appropriate alerts were entered and closed, as required. Reviewed documentation reflected staff observations were included on the suicide precaution observation logs including documentation of safe housing areas. An ASR was completed for each youth in the required time frame. The superintendent or designee was notified immediately of each applicable youth's suicide risk. Two ASRs were completed by a non-licensed clinical staff under the supervision of the DMHCA. Two ASRs were completed by the DMHCA. The non-licensed bachelor's-level clinicians' training record was reviewed and supported the completion of the required twenty hours of training to complete an ASR, which included five ASRs completed under the direct supervision and within the physical presence of the licensed mental health staff member. A review of the completed ASRs found two youth were placed on PO and each was stepped down to standard supervision and two youth remained on constant supervision. The mental health staff conducted a Follow-Up ASR prior to the removal of PO and stepped down to Close Supervision. The conference with the superintendent and the

DMHCA was documented and the discontinuation of Close Supervision was documented in accordance with the center's approved Suicide Prevention Plan.

A review of the center's logbooks validated the youth placed on precautions had documentation regarding the beginning and ending times of their precaution periods. The center utilizes secure observation for potentially suicidal youth. The DMHCA reported 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 JJJIS such as the health checklist, producing a secure observation log, and a JJIS incident report. Administration is notified of the incident. None of the youth in the sample were applicable for secure observation; however, the DMHCA provided three examples to confirm the superintendent/designee and DMHCA authorized the placement. 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. Each youth was removed from secure observation within twenty-four hours of placement.

The center maintains four suicide response kits. Observations found the kits located in master control, medical clinic, and two are in the administration office. Five youth were interviewed regarding being placed on suicide precaution in the center. Four of the five youth reported being placed on suicide precaution and three of the four applicable youth indicated staff watched them the entire time. One youth reported during their admission screening, staff did not watch the youth and the youth was "treated like someone in general population". The youth reported not being placed on suicide precaution. On December 3, 2020, the annual compliance review team reviewed the recorded surveillance video from the date the youth was admitted in order to follow-up on the youth's statement. Observation of the video surveillance confirmed one staff was present with the general population of youth. However, the center's policy 5.07, indicates "If a PO youth is present, two staff are required."

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

The center has a written policy and procedures outlining staff supervision of youth placed on suicide precautions, one-to-one supervision, or when constant supervision must be maintained including documenting the youth's behavior on the Department's Suicide Precautions Observation Log. The policy was approved by the superintendent and the designated mental health clinician authority (DMHCA) on July 15, 2020. Five reviewed youth mental health records found four youth were placed on precautionary observation (PO). One youth was not applicable. All four applicable Suicide Precaution Observation Logs were maintained for the duration of each youth's placement on PO. Each applicable log was reviewed and signed by the shift supervisor and mental health clinical staff. One of three youth displayed warning signs while on observation. 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.

3.12 Suicide Prevention Training [Detention Staff] (Critical)	Limited 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 has a written policy and procedures outlining all staff will receive at least six hours of suicide prevention and implementation of suicide precautions training annually. All staff who work with youth must be trained in suicide precautions and emergency response procedures and participate in mock suicide drills quarterly, on each of the three shifts. Suicide prevention trainings are completed and documented in the Department's Learning Management System (SkillPro). Camelot Community Care, Inc.'s designated mental health clinician authority (DMHCA) assists in training juvenile justice detention officers (JJDO) throughout the fiscal year on suicide prevention including verbal and behavioral cues indicating a suicide risk. The mock drills are designed to practice responses to a suicide attempt or incident of serious self-injury. A review of five staff training records validated each staff completed at least two hours of suicide prevention training in SkillPro and four hours of instructor-led suicide prevention training.

Reviewed documentation of mock suicide drills completed since the last annual compliance review reflected the center completed drills on Alpha, Bravo, and Charlie shifts at least quarterly. However, all staff did not participate in at least one quarterly drill within the past twelve months. The center's policy MH-9 on page four, indicates "all staff will participate in drills". In addition, reviewed documentation found staff documented the automated external defibrillators (AED) in the scenario. However, the AED is not being utilized. The scenario only indicates staff bringing the AED to the scene; however, a demonstration of the AED was not conducted or documented. A review of the mock drills found the provision of life saving measures such as cardiopulmonary resuscitation (CPR) was demonstrated on Charlie shift on March 13, 2020. All staff did not participate in the CPR demonstration. This information was communicated to the administration team during the annual compliance review week. An informal interview with the superintendent reported staff who are not present during a drill have the opportunity to review the drill.

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

The center has 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 July 15, 2020. The plan addressed the notification and alert system, means of referral to include youth self-referral, communication, supervision levels, documentation, and review as required.

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 center, requires emergency care to be provided in accordance with the center's Emergency Care Plan. The Crisis Intervention Plan and Emergency Care Plan may be combined into an integrated crisis intervention and emergency services plan which contains all the elements specified in Rule 63N-1, Florida Administrative Code.	

The center maintains a written Emergency Care Plan outlining mental health and substance abuse emergency procedures and ensuring youth who are believed to be an imminent danger to themselves or others because of mental illness or substance abuse impairment receive emergency mental health or substance abuse services. The plan was approved by the superintendent and the designated mental health clinician authority (DMHCA) on October 7, 2020. The plan addressed immediate staff response, notifications, communication, supervision of youth, authorization to transport for emergency services, transportation for emergency mental health and/or substance abuse evaluation and treatment, documentation, training, and review.

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

The center has 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 July 15, 2020. An interview with the DMHCA confirmed the center has not conducted a crisis assessment since the last annual compliance review.

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

The center has a written policy and procedures ensuring staff immediately respond to youth who are believed to be an imminent danger to themselves or others due to mental illness or substance abuse impairment requiring emergency mental health or substance abuse services to protect the youth and others from harm. Five youth mental health and substance abuse records were reviewed for youth requiring Baker Act. One youth was applicable and two additional closed records were provided. Reviewed documentation supported all three applicable youth were placed on suicide precautions upon re-admission from the Baker Act. A mental health

referral was completed for each youth and the mental status examination was completed by a licensed mental health professional. Each youth were placed on constant observation upon returning from the Baker Act. Suicide risk alerts were updated and discontinued, as required in the Department's Juvenile Justice Information System (JJIS). The center had no youth applicable for Marchman Acts since the last annual compliance review.

Standard 4: Health Services

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

The center maintains a written policy and procedures ensuring there is a contract agreement with a licensed physician. The center maintains a contract with Camelot Community Care, Inc., who subcontracts with an osteopathic physician (DO) who holds an unrestricted license which expires on March 31, 2022 and meets all requirements for independent and unsupervised practice in the State of Florida. The DO has specialty training in family medicine. The DO serves as the center's designated health authority (DHA) and is clinically responsible for the medical care of all youth. A review of the contract with Camelot Community Care, Inc., indicates the DHA shall provide two hours on-site each week conducting periodic evaluations, Comprehensive Physical Assessments, sick call referrals, and administrative duties. An interview with the DHA supported this practice. The DHA is on-site on Fridays from approximately noon to 2:00 p.m. and is available twenty-four hours a day, seven days a week for consultation.

In addition, the center utilizes an advanced practice registered nurse (APRN) who is on-site each Thursday for approximately two hours. The APRN holds a clear and active license in the State of Florida which expires on April 30, 2021. Reviewed attendance logs for the past six months found the DHA and the APRN were on-site weekly, as required. The APRN and the DHA both signed the Collaborative Practice Protocol agreement on November 28, 2020. On-site nursing coverage is provided seven days a week from 7:00 a.m. to 7:00 p.m. The DHA is responsible for communication with center staff regarding youth medical needs and participates in weekly DHA meetings with the center's administration. Reviewed attendance logs supported nursing staff participated in the meetings. An interview with the DHA indicated Camelot Community Care, Inc. provides for back-up coverage when the DHA is on scheduled leave; however, the DHA attendance logs for the past six months did not indicate a need for back-up coverage. The back-up DHA is a DO who holds a clear and active license in the State of Florida with an expiration date of March 31, 2022.

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

The center maintains Facility Operating Procedures (FOP) for all utilized health-related procedures and protocols. Reviewed documentation reflected the designated health authority (DHA) reviewed, signed, and dated the FOP, nursing protocols, and non-healthcare protocols on November 6, 2020. The center's contracted psychiatrist documented a review with signature and date for the applicable FOP. Camelot Community Care, Inc. has an established comprehensive clinical orientation for all newly employed healthcare staff which includes the Department's healthcare policies and procedures. Training records supported all newly employed healthcare staff received the clinical orientation conducted by a registered nurse (RN). Reviewed documentation validated the RN and the center's superintendent documented their review of the center's healthcare FOP and protocols on a cover page on October 30, 2020. The DHA documented their review of the center's healthcare FOP and protocols on a cover

page on November 6, 2020 and the remaining clinical staff documented their reviews on October 30, 2020 and October 31, 2020.

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

The center maintains a written policy and procedures ensuring parent/guardians are afforded the right to give or withhold consent with regard to the healthcare provided to the youth. A review of five youth individual healthcare records (IHCR) found all were applicable for requiring a signed Authority for Evaluation and Treatment (AET) and each reviewed IHCR contained the signed AET. The center had no applicable youth eighteen years of age who required a Limited Consent for Evaluation and Treatment. Four of the five youth IHCRs contained a copy of the signed AET and one documented "Copy" on the form. Nursing staff documented "Copy" on the remaining three AETs during the annual compliance review. One of five reviewed AETs was an original form. Each AET was obtained prior to providing medical services.

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

The center maintains a written policy and procedures outlining requirements for parental notification and written consent from the parent/guardian. The center notifies the parent/guardian of significant changes in the youth's condition and to obtain consent when new medications and treatments are prescribed. A review of five youth individual healthcare records (IHCR) found four had significant changes to existing medications and/or changes in chronic conditions or was taking over-the counter (OTC) medication not covered by the Authority for Evaluation and Treatment (AET). None of the reviewed IHCRs required vaccinations/immunizations. An interview with nursing staff indicated there were no Religious Exemption from Immunization forms submitted since the last annual compliance review. Four of the five reviewed IHCRs were applicable for new OTC medication and the chronological notes and the Parental Notification of Health-Related Care form documented the parent/guardian was notified as required. Written parental notices were sent regardless of telephone notifications. None of the five reviewed IHCRs were applicable for new prescription medication, including psychotropic medication. Three additional records were reviewed for off-site care and each IHCR documented each parent/guardian was notified, as required.

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

The center maintains a written policy and procedures ensuring at the time of admission, each youth will receive a healthcare admission screening utilizing the Department's Medical and Mental Health Admission Screening form. A review of five youth individual healthcare records (IHCR) found each contained a Medical and Mental Health Admission Screening form

completed on the date of admission by a juvenile justice detention officer (JJDO) and each indicated the screening was reviewed by a licensed practical nurse (LPN) within twenty-four hours. Each screening form was completed in the Department's Juvenile Justice Information System (JJIS) Admission Wizard. An interview with nursing staff validated this practice. None of the reviewed IHCRs were applicable for a change in physical custody since the youth's admission date. The center reported having no youth applicable for a change in physical custody during the annual compliance review period. In addition, the center had one youth applicable for a qualitative urine pregnancy screening test; however, the youth did not consent to the test. An interview with the center's superintendent reported all healthcare admission screenings are conducted by the doctor or nursing staff.

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

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

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

The center maintains a written policy and procedures ensuring the designated health authority (DHA) is notified when an admitted youth required emergency care or routine notification in accordance with Department requirements. A review of five youth individual healthcare records (IHCR) supported the DHA was notified within twelve hours of admission for each youth regardless of a chronic medical condition, psychotropic medication, or medical concern. Notification was documented on the nursing admission chronological notes for each of the five reviewed IHCRs. The center had no youth who were applicable to be documented on the Chronic Conditions Log of DHA Notification and placed in the Physicians Referral Log for follow-up. One youth reported taking psychotropic medication upon admission and the parent/guardian delivered the medication to the center the following day. Reviewed documentation supported the DHA and the psychiatrist were notified, as required. An interview with nursing staff indicated the DHA is notified within twenty-four hours or less of the youth being admitted either through a telephone call or email.

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

The center maintains a written policy and procedures detailing the process for conducting or reviewing admission history. The center utilizes and completes the standard Department Health-Related History (HRH) form for all youth admitted into the center's physical custody. A review of five youth individual healthcare records (IHCR) found each contained a new or updated HRH form completed electronically by a licensed nurse within seven days or less of the youth's admission. Two of the five HRHs were reviewed by the designated health authority (DHA) or the advanced practice registered nurse (APRN) and were maintained in the youth's IHCR. There was no documentation to support two of the HRHs were reviewed by the DHA or APRN. One of the five youth was scheduled to see the DHA during the week of the annual compliance review. Three of the five HRHs were completed or updated before or at the same time as the Comprehensive Physical Assessment (CPA) and reflected the most current admission into detention. Two of the youth did not have a completed or updated CPA.

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

The center maintains a written policy and procedures ensuring a Comprehensive Physical Assessment (CPA) form will be completed for all applicable youth admitted determining the health and well-being of each youth. The center maintains a written policy and procedures ensuring an alert system is in place to alert staff when medical, mental health, or security issues exist which may affect the security and safety of the youth. The center's policy and procedures for tuberculosis (TB) control and screening addresses the routine screening of all youth for latent and active TB, as well as environmental controls in the case of a youth with active TB. An interview with nursing staff indicated all youth are screened for TB by placing a Tuberculosis Skin Test (TST) in the left forearm once, annually. The test is read by nursing staff within forty-eight to seventy-two hours after placement.

A review of five youth individual healthcare records (IHCR) reflected four youth had a current CPA on file at admission. One youth was a new admission and seven days had not lapsed during the week of the annual compliance review. Reviewed documentation supported two current CPAs documented a review by the designated health authority (DHA) and/or advanced practice registered nurse (APRN) and two did not. Each reviewed CPA was completed in full to include the medical grade, Tanner Stage, body mass index, visual acuity field, and most recent TST. There were no applicable refusals of the examination; therefore, no signed refusal forms were required. Reviewed practice reflected when the CPA was completed, the Department's Problem List was updated. There were no applicable youth with any symptoms of active TB in the center at the time of the annual compliance review. The center's internal alert system coincides with the Department's Juvenile Justice Information System (JJIS) and each applicable alert was updated, as required.

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

The center maintains a written policy and procedures ensuring all youth are evaluated and treated, if necessary for sexually transmitted infections (STI). All sexually active youth will be clinically screened and evaluated for STIs. After the screening, youth will be referred to the designated health authority (DHA) or advanced practice registered nurse (APRN) to determine if further testing is indicated. A review of five youth individual healthcare records (IHCR) indicated each was screened for STIs and each required further evaluation. An interview with nursing staff indicated orders are obtained from the DHA for STI testing and a urine sample is collected and sent to LabCorp for testing.

The center maintains a written policy and procedures ensuring each youth is provided the opportunity to receive counseling, testing, and treatment for human immunodeficiency virus (HIV). All five reviewed youth IHCRs supported each youth was offered testing. Two of the five youth consented and three did not consent as documented on the Department's Human Immunodeficiency Virus Antibody Test Youth Consent form. One additional record was reviewed and documentation supported the additional youth consented to HIV testing. The center's registered nurse is a certified counselor and provides pre-test and post-test counseling. Counseling was documented on each applicable youth's Health Education form. The nursing staff swabs the youth's mouth and sends to LabCorp. If the results are positive, a blood sample is tested and the results are given to the Collier County Health Department. The HIV test results are placed in a sealed envelope marked, "Confidential" and filed in the youth's IHCR. Five interviewed youth reported being able to request a HIV test if they wanted one.

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

The center maintains a written policy and procedures ensuring all youth will be able to make sick call requests and have their complaints treated through the sick call system. The sick call process responds to a youth's complaint of illness or injury of a non-emergent nature which requires a professional nursing assessment and possibly, a nursing intervention. The center provides sick call seven days a week. Sick call is conducted two times daily from 9:00 a.m. to 11:00 a.m. and from 1:00 p.m. to 3:00 p.m. Monday through Friday and one time a day from 9:00 a.m. to 11:00 a.m. on Saturday and Sunday.

A review of five youth individual healthcare records (IHCR) indicated no youth submitted a sick call request; therefore, three additional applicable records were reviewed. Sick calls are documented by direct-care staff electronically and communicated to medical staff. Each applicable youth was seen by the registered nurse (RN) or the advanced practical nurse (APRN) for the sick call within twenty-four hours. None of the sick calls required treatment or a referral for off-site care. There were no instances in which a youth presented a similar sick call complaint three or more times in a two-week period or of a youth complaining of any severe pain with which staff were unfamiliar.

The center maintains treatment protocols appropriate to the level of the provider conducting sick call approved by the designated health authority (DHA) on November 6, 2020. According to an interview with the DHA, the DHA will conduct sick calls while at the center, if necessary. All three applicable sick call events were documented on the Sick Call Index and Sick Call Referral Log. Sick Call forms documented the nature of the complaint, assessment, and plan to include subjective, objective, assessment, and plan format (SOAP). An interview with the RN indicated when a licensed nurse is not on-site, the juvenile justice detention officer supervisor (JJDOS) will review the sick calls to determine the need for intervention. The JJDOS are trained to contact the DHA. Observation of one sick call during the annual compliance review week was conducted by the APRN. The sick call was conducted in the medical clinic and ensured the youth's privacy. The APRN discussed the nature of the sick call and had the youth initial they were seen. The assistant superintendent escorted the youth to the medical clinic; however, allowing medical staff and the youth to maintain privacy during the sick call.

Five interviewed staff indicated sick call is conducted by nursing staff. Each staff stated nursing staff reviews all sick call requests and three indicated the shift supervisor will review the sick call requests if nursing staff is not on-site. Five interviewed youth found three indicated they can be seen immediately should they submit a sick call request and two indicated within one day. Each of the five youth reported sick call is conducted by either the nurse and each stated the sick call process was either very good or good.

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

The center maintains a written policy and procedures ensuring a comprehensive process of episodic care, first aid treatment, and emergency care. The center utilizes an Episodic Care Log to document episodic care and first aid treatment. The log contains information to include the date, name of youth, the youth's Department of Juvenile Justice Identification Number, nature of illness or injury, treatment rendered, staff initials, nurse initials, verification of who provided episodic care, and whether the youth were recommended for off-site care.

A review of five youth individual healthcare records (IHCR) found two youth received episodic care conducted by nursing staff; therefore, one additional IHCR was reviewed. Each applicable IHCR documented problem-oriented elements which were used to capture pertinent information pertaining to the nature of the youth's ailment including identification of the subjective, objective, assessment, and plan (SOAP) to address the complaint for each incident. The center had no applicable episodic care events conducted by non-healthcare staff.

The center maintains eleven first aid kits which are located in master control, sub-control, modules one, two, and three, laundry, the superintendent's office, the kitchen, and four which are used in the center's vans utilized for transportation. A review of three first aid kits found each contained the required items identified on the designated health authority (DHA) inventory list. The center's medical records clerk conducts monthly reviews of the first aid kits and items are replenished upon use and/or expiration date. The medical clerk seals and dates the first aid kits after replenishment and review.

The center has two automated external defibrillators (AED) located in the medical clinic and in master control. The AED procedures were located in the AED box as well as audio instructions.

Nursing staff checks the AED batteries and pads monthly to ensure the AED is operational and document their review on a tracking sheet. Both AEDs were self-tested in front of the annual compliance review team to ensure they were operational. The batteries in both AEDs expire in March 2024 and the pads expire in March 2021. Both AEDs each contained the original batteries and pads.

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

The center's policy and procedures indicated emergency drills are conducted for each shift on a quarterly basis at minimum, and AED/CPR must be demonstrated at least annually. A review of quarterly mock emergency drills since the last annual compliance review supported drills were conducted at least once a month on each shift; however, the demonstration of AED/CPR was only demonstrated one time on one shift. All documented drills included the type of medical event, time the drill/event occurred, time 9-1-1 was called if applicable, name of the juvenile justice detention officer supervisor, healthcare provider in charge, healthcare provider response time, type of medical care rendered, time the event concluded, clinical manager/medical staff review, and critique. Five staff were interviewed to determine if they can call 9-1-1 if necessary and each stated they can call if needed.

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

The center maintains a written policy and procedures to provide for timely referrals and coordination of medical services to ensure youth have timely access to off-site care services. A review of five youth individual healthcare records (IHCR) found none were applicable for off-site medical care; therefore, three additional applicable records were reviewed. The designated health authority (DHA) was notified for each off-site emergency event. Each youth's IHCR contained a Summary of Off-Site Care form, discharge documentation, and instructions. The DHA documented a review of the off-site care findings, instructions, and information. Each youth required an additional referral for follow-up testing or appointment and documentation validated the referral was entered on the Sick Call/Referral Log for tracking and the follow-up was conducted, as recommended.

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

The center has a policy and procedures to ensure youth identified with chronic conditions receive regularly scheduled evaluations and necessary follow-up care. The frequency of the periodic evaluation is determined by the youth's condition, clinical needs, and clinically appropriate medical standards. Youth are screened during the intake process for medical conditions warranting periodic evaluations and follow-up care.

A review of five youth individual healthcare records (IHCR) found none were applicable for the existence of chronic conditions; therefore, three additional applicable records were reviewed. Documentation reflected each applicable youth was classified with a medical grade between two and five. One youth was classified with a body mass index (BMI) greater than thirty. None of the youth were applicable for taking anti-tuberculosis medication or were pregnant. Treatment orders were written so they were clearly distinguishable for clinical staff. There were no indications of lapses in care. None of the three youth were applicable for a periodic evaluation as they each were in the center for less than thirty-days. All three youth were placed on the chronic conditions roster. In addition, reviewed records reflected the Department's Problem List was updated, as required.

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

The center has a policy and procedures ensuring all medication and pharmaceutical products are procured, dispensed, administered, stored safely and accurately in accordance with state, federal, and industry standards. The center's practice is for nursing staff to verify all medications will have a current, valid order and are administered according to a current prescription or practitioner's order. Nursing staff verify medication with the parent/guardian when they deliver the medication to the center. The Medication Receipt, Transfer, and Disposition form is used to document medication received in the original packaging from a licensed pharmacy with a current legible patient-specific label affixed.

A review of five youth individual healthcare records (IHCR) identified one youth was taking prescribed medication upon admission and was applicable for medication management; therefore, two additional records were reviewed. Each applicable IHCR documented verification of prescription medication by the nurse. In each applicable record, the licensed nurse obtained an order from the designated health authority (DHA) or psychiatrist to resume the applicable medication and all orders were signed by the practitioner. There were four youth applicable for over-the-counter (OTC) medications not listed on the Authority for Evaluation and Treatment (AET) form administered. Proper consent was obtained. The center maintains a contract with Diamond Pharmacy Services for procurement of medications and a Modified Class II Type B Pharmacy Permit with an expiration date of August 31, 2021. All medication is delivered to the center in blister packs.

The center utilizes the standard Department Medication Administration Record (MAR) for each youth receiving either prescription medications on a routine basis or OTC medications.

Reviewed documentation reflected the staff initialed each administered medication entry and the four applicable youth documented their initials on the MAR. None of the applicable youth refused the medication administration; therefore, the Department's Refusal of Treatment form was not completed. The center maintains a written policy and procedures to ensure the usage of the MAR by licensed healthcare staff and non-licensed staff. Each reviewed MAR clearly documented the youth's name, Department of Juvenile Justice Identification Number (DDJID), date of birth, youth allergies, precautions, medical grade, medical alerts, and current picture of the youth. The MAR clearly indicated medication start and stop dates and nursing staff documented weekly side-effect monitoring. There were no lapses or errors noted. No youth required parenteral medication.

The center has a secure refrigerator in the medical clinic which contained Tuberculin vaccinations during the annual compliance review. Nursing staff track daily temperatures of the refrigerator. The center has authorized and trained the superintendent, the assistant superintendent, all juvenile justice detention officer supervisors (JJDOS) and one juvenile justice detention officer II (JJDO) to assist youth with self-administration of medication. The center's practice is to have licensed nursing staff on-site until 7:00 p.m. Monday through Friday and until 5:00 p.m. on Saturday and Sunday; therefore, having only nursing staff to administer medication. Trained supervisory non-licensed staff are permitted to provide OTC medications when nursing staff are not on-site.

A review of two applicable JJDOS training records found each received training on the MAR. The center did not have any standing orders for psychotropic medications, pro re-nata (PRN) orders for psychotropic medications, or emergency treatment orders for psychotropic medications. One of the reviewed IHCRs found the youth was admitted on prescribed medication which was a psychotropic medication. The DHA, the psychiatrist, and the designated mental health clinician authority (DMHCA) were notified of the admission. The psychiatrist was notified when the medication was received to obtain an order for continuation. Reviewed documentation supported the applicable youth received an initial diagnostic psychiatric interview conducted less than the required fourteen days of admission which was conducted during the annual compliance review week. Youth receiving psychotropic medications are reviewed weekly each time the psychiatrist is on-site.

Observations of one medication administration validated the assistant superintendent escorted the youth to the medical clinic. The nurse pulled the medication cart up to the door and the youth approached the nurse. The nurse pulled the medication from the secured medication cart and checked it against the MAR. The medication was administered and the MAR was updated accordingly. The center utilizes RX Destroyer for the disposal of medications. The center maintains a contract with Consulting Pharmacist, Inc. and reviewed documentation supported the consultant pharmacist conducted a pharmacy audit monthly. Monthly Audit forms documented whether or not the center required any controlled medications disposal. The center's practice is for the consultant pharmacist and the on-site nurse to dispose the medication(s) which cannot be returned to the contracted Pharmacy for credit and document it on the Medication Disposal form. Disposal of non-controlled medications is documented on the Drug Disposal Form. Five interviewed staff indicated they do not provide medication to youth. Informal interviews with staff indicated only the doctor, nursing staff, and JJDOS staff are trained and permitted to administer medications to youth. Five interviewed staff indicated only medical staff administer prescription medication to youth and two staff stated certain staff are trained to administer OTC medication. Five interviewed youth found three indicated the nurse provides medication to youth and two youth indicated never taking any medication.

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

The center maintains a written policy and procedures ensuring medications and any medical equipment classified as sharps will be secured and inventoried. The dose-by-dose daily administration and documentation of a medication is documented utilizing a perpetual inventory process for the daily distribution of non-controlled prescription medication and over-the-counter (OTC) medication. Documentation of each individual dosage of medication administered to youth is maintained on the Medication Administration Record (MAR) to demonstrate the distribution of medications. Any medical equipment classified as sharps is secured and inventoried utilizing a routine perpetual inventory descending count as each sharp is utilized and disposed.

Observation of the medical clinic during the annual compliance review week found the clinic is secured under lock and key. Medical staff and trained juvenile justice detention officer supervisors (JJDOS), the center's superintendent, assistant superintendent, and one juvenile justice detention officer II have access to the clinic. The identified non-healthcare staff are trained by the registered nurse to assist youth with self-administration of OTC medication. A locked medication cart is located in the medical clinic and stores oral prescription and OTC medications prescribed for youth. Medication in the cart is separated by each youth. A second locked medication box is in the medication cart which stores controlled medication.
The center maintains an inventory of all sharps and medical equipment classified as sharps to include syringes, butterflies, scissors, needles, and suture removal kits. Items designated as sharps are stored in a designated locked cabinet in the medical clinic and are inaccessible to youth. A review of the perpetual inventory for the past six months found sharps inventory counts to be accurate. A review of three sharps found the counts were accurate. A review of three prescription medications and three OTC medications found the counts were accurate. A review of the running daily inventory of all prescription and OTC medications matched the count. The center had one controlled medication on-site during the annual compliance review and documentation supported a shift to shift count is conducted daily by two licensed nursing staff and one JJDOS. If there is only one nurse on-site, the count is conducted with the nurse and the JJDOS.

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

The center maintains a written policy ensuring proper procedures are followed to prevent the spread of infectious diseases or illnesses and provide staff with the knowledge of appropriate prevention, containment, treatment, and reporting requirements of infectious diseases. The center maintains a separate Exposure Control Plan/Infection Control Plan approved by the designated health authority (DHA) on November 16, 2020 and approved by the superintendent

on October 30, 2020. Nursing staff documented a review of the plan on October 30, 2020, October 31, 2020, and November 6, 2020. A review of five youth individual healthcare records reflected each youth received infection control training within twenty-four hours of admission. The infection control training included hand-washing techniques, universal/standard precautions, prevention/transmission of communicable diseases, vaccinations, and the Centers for Disease Control and Prevention (CDC) guidelines for infection control.

Reviewed documentation supported the Exposure Control Plan/Infection Control Plan was written in accordance with Occupational Safety and Health Administration (OSHA) guidelines to include risk assessment and methods of compliance. The plan addressed common childhood infectious diseases, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, tuberculosis, Hepatitis A, B and C, human immunodeficiency virus (HIV), bloodborne pathogens, other outbreaks and epidemics, and outbreaks of pediculosis. In addition, the plan included methicillin resistant staphylococcus aureus (MRSA) and other antibiotic-resistant micro-organisms, food-borne illnesses, bioterrorism agents, chemical exposures in the workplace, and protocols for needlestick post-exposure intervention and treatment. The center ensures Hepatitis B immunization is made available for staff and staff have access to protective equipment. The local county health department, CDC, and the Department's Central Communications Center (CCC) were notified of all incidents related to the COVID-19 pandemic. A review of five staff training records supported each staff received pre-service and in-service training on the center's Exposure Control Plan/Infection Control Plan.

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

The center has a written policy and procedures for the care of pregnant youth to include procedures for medical issues, nutrition, education, and medication. An interview with the nursing staff indicated the center had one pregnant youth since the last annual compliance review. Reviewed healthcare education information supported the pregnant youth received pre-natal education to include alcohol and drug use, smoking, nutrition, sexually transmitted infections, contraception, prenatal care, birthing process, postpartum care, basic baby care, child/infant development, and parenting skills. While at the center, nursing staff monitored the youth for weight and nutritional status. The youth was released prior to thirty-days; therefore, a focused medical evaluation was not conducted post admission. A review of five staff training records verified each staff received Girls Health training specific to working with pregnant youth. Staff training was provided by the registered nurse (RN) at the time of hire and annually, thereafter.

Standard 5: Safety and Security

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

The center maintains a written policy and procedures ensuring youth are actively supervised by staff. Staff communicate by way of two-way radio with master control any issues pertaining to the center and youth supervision. The center utilizes a Daily Population Census by Module and an Alphabetical List of youth currently in detention. This list is generated from the Department's Juvenile Justice Information System (JJIS) to track the daily census of the youth. The center has a dry erase board located in master control to track youth counts, admissions, and releases. During the annual compliance review week, daily observations of youth were conducted throughout the center which confirmed the active supervision of youth by detention staff. Youth are in sight of at least one juvenile justice detention officer (JJDO) at all times, except for when placed in sleeping rooms or in a secure placement. Staff were observed supervising youth during school, line movements, lunch, and in the modules. Five youth were interviewed regarding being placed on suicide watch in the center. Four of the five interviewed youth reported being placed on suicide watch and three of the four applicable youth indicated staff watched them the entire time. One youth reported during their admission screening, staff did not watch the youth and the youth was "treated like someone in general population." The youth reported not being placed on suicide watch. On December 3, 2020, the annual compliance review team reviewed the recorded surveillance video from the date the youth was admitted in order to follow-up on the youth's statement. Observation of the video surveillance confirmed one staff was present with the general population of youth. However, the center's policy 5.07, indicates "If a precautionary observation (PO) youth is present, two staff are required."

In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, no youth transports were observed. Youth court is conducted through video conferencing using Zoom. Youth are always accounted for and accompanied by staff. Each observation found there were always at least one detention staff with each group of youth. Each observation indicated staff were alerted and properly positioned in a manner providing them with full view of youth in the area. Master control authorizes all movement of youth prior to the youth being moved. Staff were observed having positive interactions between youth and staff.

A review of the master control logbooks for the past six months confirmed youth headcounts were conducted consistently at the beginning and end of each shift. Counts were conducted after all admissions and releases, emergencies, and randomly during the shift. During facility counts, there were no youth movement until cleared throughout the facility by master control operator. Five staff were interviewed and each indicated there is enough staff to provide safety and security.

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

The center has a policy and procedures in place ensuring the center provides a system of rewards, privileges, and consequences to encourage youth to promote good behavior and fulfill the program's expectations. The center has a registered behavior technician (RBT). The RBT is primarily responsible for the direct implementation of behavior-analytic services of the behavior management system (BMS) at the center. The center's BMS includes rewards for positive behavior and consequences for inappropriate behavior. The center uses a level card to document youth behavior daily. Youth level can increase up to sixty points daily or can decrease for moderate and major violations. The center has an "Incentive Calendar" and a "Behavior Matrix" which is posted on each module and throughout the facility. The "Behavior Matrix" outlines major problems and give definitions for behaviors and consequences. Once a youth has achieved a level three, the youth will receive the item(s) on the calendar for the day.

The center has a youth advisory board. The board consist of the RBT, chosen youth who have maintained a level three, and other center staff. The board provides youth an opportunity to give feedback and suggestions on how to help improve the BMS. The center uses a "Behavior Intensive Youth" form. This form is utilized for youth who continue to exhibit behaviors preventing them from becoming a level three. The RBT will assist each youth individually to help change specific negative behaviors and become a part of the BMS. Some rewards include extra telephone calls on Saturday and Sunday, hot wings, pizza, and ice cream sundaes. The center is in the process of implementing a sound room for level three youth who are interested in creating music. Five youth interviews were conducted and each confirmed they received fair consequences.

5.03 Unauthorized Use of Punishment (Critical)	Satisfactory Compliance

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

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

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

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

The center has a policy and procedures to address unauthorized use of punishment. The center's behavior management system (BMS) prohibits the use of group punishment, corporal punishment, or use of drugs to control youth behavior. The center's BMS restricts certain types of penalties on youth who demonstrate negative behaviors. All allegations of corporal punishment of any youth by center staff shall be reported to the Florida Abuse Hotline pursuant to Chapter 39, F.S. and the Department's Central Communications Center (CCC).

Five staff and five youth interviews confirmed there is no unauthorized use of punishment. Five youth interviews were conducted. Each youth reported never being sent to a room for punishment and/or being punished by other youth.

5.04 Ten-Minute Checks (Critical)	Satisfactory Compliance

Staff shall visually observe youth on standard supervision at least every ten minutes while they are in their sleeping quarters, either during sleep time or at other times, such as during an illness or room restriction.

Staff conduct observations in a manner ensuring the safety and security of each youth and documents each check in real time, manually or electronically. Documentation must include the actual time of each visual observation and initials of the staff conducting the check; preprinted times are not acceptable.

There shall be no obstructions (e.g., clothing, memos, pictures) over windows and areas where direct line of sight is needed.

If an officer, in the course of completing visual observation, is unable to see the youth or any part of the youth's body, the officer shall, with the assistance of another officer, open the door to verify the youth's presence.

The center has a written policy and procedures ensuring ten-minute checks are conducted when youth are in their rooms for sleeping purposes and confinement. The center has a total of sixty operable cameras with a recording capacity of thirty days. The center utilizes the Guard One Plus which is an electronic system to document ten-minute checks. Staff utilize the electronic Guard One Plus wand by placing on the check point sensor located on the outside of each youth's room door. The data from the wand is downloaded daily to ensure no data is lost.

The juvenile justice detention officer (JJDO) is responsible to visually observe the youth when conducting the ten-minutes checks by looking inside the room and observe the youth behind the closed door before the check point sensor is activated with the wand to ensure there are no issues with the youth. The superintendent was interviewed and validated this practice. Observations of youth living modules and rooms confirmed there were no obstructions over the windows and areas in which direct line of sight is needed. Observations of ten-minute room checks on two different modules and from three different shifts along with the corresponding Ten-Minute Log supported checks were being conducted every ten-minutes or less and in real time. One review of ten-minute checks on the G module on December 2, 2020 found one check was conducted twenty minutes late. The staff conducted the check at 3:57 a.m. and the next check was completed 4:18 a.m. In addition, staff were not wearing their mask, as required.

5.05 Census, Counts, and Tracking	Satisfactory Compliance

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

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

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

The center has a written policy and procedures ensuring staff must know the exact number and aware of the location for all youth under their supervision at all times. The center requires all headcounts to be taken, called into master control at the beginning and end of each shift including following any emergency, prior to and following routine group movement, anytime a population change occurs, randomly on each shift, and documented in the center's master control logbook. A review of master control and module logbooks for the past six months validated the center documented the daily headcounts at the beginning and end of each shift, random counts, any time a population change occurred, youth movement, and inclusive of any mock or emergency drills.

Five interviewed staff reported counts are conducted at the beginning and end of shift, before and after school, and before and after meals. Staff indicated when counts are not correct, all movement is stopped, and a recount is to be conducted. An interview with the center's superintendent validated this practice. A review of the master control module logbooks for the past six months validated all statements to be accurate.

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

The center maintains a written policy and procedures outlining a chronological record of events, incidents, and activities in logbooks maintained in master control and in each living area in accordance with the Florida Administrative Code. There were separate logbooks in master control and in each living area. Provided in master control are logbooks for visitors and contracted staff. Each logbook was a bound book with numbered pages. A review of the logbooks indicated this practice was completed. All entries impacting safety and security of the center including medical/special needs and mental health alerts were highlighted. All errors were struck through with a single line and initialed by the person correcting the error. The master control logbook included emergency counts, drills, medical alerts, population counts at the beginning and end of shift, youth group/individual movement, admissions, releases, and youth who were stepped down from precautionary observation (PO). However, the master control logbook did not document the presence of law enforcement when Protective Action Response (PAR) was used in incidents and the names of youth(s) placed in confinement with the beginning and ending time of confinement. The presence of law enforcement was documented in the visitor's logbook. The center does not utilize an electronic logbook.

5.07 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 maintains a written policy and procedures regarding the reviews of all logbooks. The center's juvenile justice detention officer supervisor (JJDOS) reviews the center's logbooks maintained in master control and in each living module when they accept responsibility for the center's shift. The JJDOS reviews the logbook maintained in their assigned living module before they accept responsibility at shift change. A review was conducted of the living module logbooks

and verified the JJDOS coming on-duty did not consistently document a review of the logbook upon accepting responsibility for the module. The center's practice is to have the JJDOS and the administrative staff conduct regular logbook reviews, and the JJDOS staff documents a daily review and administrative staff documents a weekly review. However, the master control logbook revealed the JJDOS did not document their review daily when assuming responsibility for the center.

5.08 Key Control	Satisfactory Compliance
Each center is responsible for maintaining inventory and control of all facility keys. *All keys shall be placed on a tamper-resistant key ring designed to inhibit the removal of keys.* *Emergency key rings shall be maintained separately from other facility keys, in master control, in a secure location designated by the Superintendent. These keys shall be notched or otherwise identifiable by touch.* *The key(s) on these rings shall provide egress through facility exterior doors providing access to evacuation areas.* *A key inventory shall be maintained by the Superintendent or designee at all times.* *(For the entire indicator statement, please reference the Monitoring and Quality Improvement FY 2020-2021 Detention indicators.)*	

The center maintains a written policy and procedures ensuring the inventory and control of all center keys as well as replacing lost or damaged keys. Center keys are maintained on a tamper-resistant ring with a brass tag identifying the ring number and the number of keys on the ring. All center keys are colored coded for identification. Center keys for education, medical, and mental health staff are stored in master control in a locked key box accessible by the master control operator. Juvenile justice detention officers (JJDO) and juvenile justice detention officer supervisors (JJDOS) keys are maintained in the supervisor's office in a locked box and are only accessible by the JJDOS and administrative staff. Emergency keys providing egress through exterior doors are stored in the module sub-control rooms in which only staff can access. All keys are inventoried in the Department's Facility Management System (FMS). The center maintains a master key inventory which accounts for all key rings by ring number, the number of keys on each ring, the staff assigned to the key, and the capability of each key. Key inventory and issuance of keys is documented during each shift to include the date, time, name of staff receiving the keys, time keys were returned, and name of supervisor issuing the keys. The issuance of staff keys is conducted by the shift supervisor inside the supervisor's office, which is not located on the secure side of the center. Staff personal keys are exchanged for center keys which is secured in a locked box located in the supervisor's office at the beginning of each shift. Upon completion of shift, staff will return the center keys in exchange for their personal keys. Visitor's personal keys are collected by the supervisor and is secured in the supervisor's office. The center's policy states, "if a key becomes lost or missing, a supervisor is notified, if the keys are not located, the Department's Central Communications Center (CCC) is contacted." According to the center's shift commander, the center had no incidents of lost or broken keys since the last annual compliance review.

Five staff were interviewed to verify which center keys are restricted. All five staff indicated the center maintains restricted keys for medical records and mental health records. Interviews with

staff indicated youth do not have access to center keys. Observation of distribution and collection of keys validated the issuance of keys.

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

The center maintains a written policy and procedures for operating and maintaining vehicles used to transport youth. The center has a total of four vehicles which are used to transport youth. Each vehicle is equipped with the appropriate number of seat belts, seat belt cutter, window punch, and fire extinguisher. The first aid kits contained items approved by the designated health authority (DHA) and is maintained in master control. A first aid kit is assigned to each vehicle according to the van number. The first aid kit is signed out prior to departure. Each vehicle contained a vehicle logbook which is maintained in master control and signed out with a cellular telephone prior to departure. Reviewed documentation in each logbook revealed vehicle inspections and contraband checks are conducted by staff before and after each transport. Staff documented the destination and number of youth and staff prior to each transport. All four center vehicles utilized to transport youth were observed and each was found to be secured. The center has a maintenance mechanic who conducts weekly and monthly vehicle inspections. The center utilizes a Vehicle Maintenance Monthly Inspection Checklist, Weekly Vehicle Checklist, Daily Vehicle Checklist, and a Pre-Trip Vehicle Inspection Sheet. Reviewed documentation reflected each of the four vehicles utilized to transport youth received an annual vehicle inspection. Documentation supported the center's maintenance mechanic conducted weekly visual checks of each transport vehicle including the water coolant, lights, oil, emergency equipment, brakes, horn, interior/exterior, and cleanliness. The center conducts a monthly check of each vehicle including the tires, battery, windshield, wipers, windows, mirrors, and damage. Due to the COVID-19 pandemic, court is conducted over Zoom and video call; therefore, transports were not observed.

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

The center maintains a written policy and procedures ensuring tools and equipment are properly maintained, stored, and inventoried. The center's maintenance tools are maintained in a secure locked room only accessible to maintenance staff and administrators. Tools are stored on a shadow board and marked with an identification number. A perpetual tool inventory list of tools is maintained by the center to document what tools are being used by the maintenance staff including the times the tools were checked out, the location of the tools, and times the tools were returned.

An interview with the maintenance mechanic confirmed inventory is conducted monthly by maintenance staff and reviewed by the superintendent or designee. The maintenance mechanic confirmed when there are missing or damaged tools or tools considered surplus, maintenance staff immediately notifies the superintendent or designee. A photo of the tool is taken and a damage tool form or a request surplus form is submitted to the regional office for approval. Observations of the kitchen was conducted. Kitchen knives were maintained in a locked shadow

board outlining each knife along with a pair of scissors. All other kitchen utensils were stored in a drawer. The drawer did not contain an inventory list of the items inside the drawer. It was observed no documentation was present during the annual compliance review. Documentation presented was inconsistent and incomplete. The date of the documentation began on November 4, 2020 and concluded on November 24, 2020 within the time span it was found to be incomplete most days. There was no perpetual inventory list present. Therefore, it was not possible for staff to conduct an itemized inventory of all equipment including knives and other hazardous kitchen implements upon reporting for work duty and to conduct tool inventories monthly. A perpetual inventory list was created during the week of the annual compliance review. An interview with the food service director indicated the director began working with the Department on October 23, 2020 and was not aware of the Facility Operating Procedures (FOP) or Department standards governing tool and inventory management.

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

The center has a written policy and procedures ensuring youth do not have access to any tools including kitchen or medical equipment. The center only allows youth to have access to mops, brooms, and buckets for general cleaning. Staff handles all cleaning solution. Youth are constantly supervised when utilizing these items. Five youth were interviewed and each confirmed they are not allowed to use any tools. Five staff were interviewed and each indicated youth are not to handle any chemicals but can use mops and brooms. All five interviewed staff reported youth do not have access to any tools.

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

The center has a written policy and procedures to address the inventory of flammable, toxic, caustic, and poisonous items. Flammable, toxic, caustic, and poisonous items are maintained in a locked, secure storage area with limited access and not accessible to youth. Safety Data Sheet (SDS) binders are located at the location the chemicals are stored. All items are inventoried weekly by the maintenance mechanic and securely stored when not in use. Each

item observed had an SDS on record for each item stored. Observation of the secure storage area and the inventory list indicated all items matched the inventory list and are stored in the locked storage. The SDS and inventories were compared to the items on-site and were found to be accurate and complete.

5.13 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 ensuring limited access to flammable, toxic, caustic, and poisonous items. Youth are not permitted to access any materials which are flammable, toxic, caustic, and/or poisonous. An informal interview with the center's superintendent confirmed flammable, toxic, and caustic materials are stored in secure storage areas in the janitor's closet and in an outside shed adjacent to the center. The secure storage areas are only accessible to maintenance staff, supervisors, administrators, and the food service director. Observations conducted during the week of the annual compliance review found there were no toxic, flammable, or poisonous materials stored in any place accessible to youth. Five staff were interviewed and each reported youth are not allowed to use any toxic, flammable, or poisonous substances. Five youth were interviewed and each confirmed they are not allowed to use any cleaning agents such as bleach, laundry soap, window, or toilet cleaner.

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

The center has a written policy and procedures which address proper use, storage, and disposal of flammable, toxic, caustic, and poisonous items. The center has a safety plan in place to address any chemical spills or leaks. The plan addressed what procedures to follow in the event of a chemical leak or spill. The maintenance mechanic confirmed materials are disposed of by transport to the Collier County Solid and Hazardous Waste Management Facility. The maintenance mechanic confirmed there were no chemical spills or leaks. The center's practice is if a chemical spill occurs, procedures indicate a staff will notify master control of the location of the spill, a juvenile justice detention officer supervisor (JJDOS) and/or master control shall direct the shutdown of all air handlers, ventilation system, and close all windows and doors. The center will then obtain assistance from outside the center by contacting the necessary emergency contacts. Biohazardous waste disposal is the responsibility of the medical staff.

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

The center maintains a written policy and procedures ensuring confinements under twenty-four hours are used as an immediate, short-term response strategy during volatile situations with a youth's sudden or unforeseen onset of behavior imminently and substantially threatens the physical safety of others or self. The center utilizes the module rooms for confinement. Youth who are placed in confinement have no contact with the general population. A search of the room is conducted prior to the youth being placed in the room and all non-fixed items are removed from rooms. The center documents confinements under twenty-four hours in the Department's Facility Management System (FMS).

A review of eight confinement reports found each youth was afforded the same services as youth in general population. Confinement reports confirmed all rooms were searched prior to youth being placed in confinement and each room was free from any obstructions. Each report supported visual observation which was documented and conducted in accordance with the Department's policy. Each reviewed report indicated the juvenile justice detention officer supervisor (JJDOS) completed reviews within two hours, evaluated the youth every three hours, and documented the need for confinement based on the severity of the rule, violations, and the past disciplinary history of behaviors while in confinement. Each of the eight confinement reports indicated the superintendent, and/or designee, reviewed the confinement report within twenty-four hours. Six of the confinement reports were confined after school and did not need communication with the school board for appropriate record keeping. Two youth were placed in confinement during school hours; however, there was no documentation to support the youth's attendance in school was communicated to school personnel for appropriate record keeping. One youth was placed in confinement on a day visitation was held. There was no documentation in which an effort was made to contact the youth parent/guardian notifying them the youth was in confinement. An informal interview with the superintendent validated this practice. Five staff were interviewed and each reported when a youth is placed in confinement; staff must complete the confinement report, search confinement room, and document room checks.

5.16 Confinement Over 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. *Confinements should not exceed twenty-four hours; however, if a youth continues to exhibit behavior which poses a risk to him or herself, staff, or others, a Confinement Review must be conducted.*	

The center has a written policy and procedures addressing confinement over twenty–four hours, which requires confinement reports to be submitted within one hour of the incident and reviewed within two hours by the superintendent or designee. There were no confinements documented over twenty-four hours since the last annual compliance review.

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

The center has a written policy and procedures ensuring a plan in place to manage various emergencies and disaster events. The center's Continuity of Operations Plan (COOP) was approved by the Department on May 29, 2020 and documentation confirmed there were seven COOP drills conducted since the last annual compliance review. Review of the documentation verified a hurricane drill was conducted in May 2020. There were seven other COOP drills conducted during the annual compliance review period. Observations of the drills indicated each contained written scenarios to include critique and follow-up on instructions, if found necessary on the COOP drill form. All reviewed drills were documented on the drill form and in the logbooks. Five staff were interviewed on the type of drills they participated in within the last six months. Each staff reported participating in a fire, major disturbance, hostage situations, escape, and weather drill. One staff reported participating in a bomb threat and a terrorism drill.

5.18 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 center shall conduct and document quarterly mock escape drills.*	

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

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

The center has a written policy and procedures ensuring fire prevention and safety of the center. The center's fire prevention and safety plans were reviewed and approved by the state fire marshal on February 6, 2020. Annual inspections are conducted by the fire marshal. The center has evacuation egress plans posted throughout the facility. Each egress plan defines primary and secondary exit routes and the locations of emergency equipment, such as fire extinguishers and first aid kits. A review of the emergency drills and logbook documentation did confirm the center conducts fire drills consistently every month as required on both Alpha and Bravo shifts. Bravo shift was missing a fire drill for the month of October 2020. The center superintendent

and juvenile justice detention officer supervisor (JJDOS) confirmed all drills are reviewed during shift briefings. A review of five staff training records validated the annual fire prevention training was completed by each reviewed staff. Five staff were interviewed and each reported fire drills take place monthly and they have participated in at least one monthly drill. Five youth were interviewed and each reported they have been instructed on what to do in the case of a fire.