STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Hillsborough Regional Juvenile Detention Center West

Department of Juvenile Justice
(State-Operated)
3948 West Martin Luther King Jr. Blvd.
Tampa, Florida 33614

Review Date(s): April 14-16, 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:

Stephanie Lobzun, Office of Program Accountability, Lead Reviewer (Standard 1)
Marvin Bliss, Office of Program Accountability, Regional Monitor Standard 2
Brenda Comadore, Office of Program Accountability, Regional Monitor Standard 3
Melissa Johnson, Office of Program Accountability, Regional Supervisor Standard 1
Stephanie Shay, Office of Program Accountability, Deputy Regional Supervisor Standard 4
Paul Sheffer, Office of Program Accountability, Regional Monitor Interviews
Jonathan Thompson, Office of Program Accountability, Regional Monitor Standard 5

Program Name: Hillsborough Regional Juvenile Detention Center
Provider Name: State Operated
Location: Hillsborough County / Circuit 13
Review Date(s): April 14-16, 2020

MQI Program Code: 294
Contract Number: N/A
Number of Beds: 93
Lead Reviewer Code: 140

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

Overall Rating Summary

Overall Rating Summary
All indicators have been rated Satisfactory and no corrective action is needed at this time.

Standard 1: Management Accountability
Detention Rating Profile

Indicator Ratings

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

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

Standard 2: Youth Management
Detention Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Detention Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Detention Rating Profile

Indicator Ratings

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

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Program Overview

Hillsborough West Regional Juvenile Detention Center is a state-owned detention center, operated by the Department, located in Tampa, Florida. The center serves youth in Hillsborough county in Circuit 13. Male and female youth who are detained pending adjudication, disposition, or placement in a residential commitment program are housed in the ninety-three 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 Hillsborough County School Board. The center's management team includes the superintendent, two assistant superintendents, two administrative assistants, nine juvenile justice detention officer supervisors (JJDOS), and fifty-nine juvenile justice detention officers (JJDO). Mental health and healthcare services are provided through the contracted provider, Camelot Community Care, Inc. Mental health services are provided by two licensed mental health professionals and one non-licensed clinicians. 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. Medical services are provided by one registered nurse, one physician, one advanced practice registered nurse, two licensed practical nurses, and one medical records clerk. The medical clinic maintains nursing coverage seven days a week, from 7:00 a.m. to 7:30 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 four living modules which are divided by male and female youth. The center has one module for females and three modules for males. The center has one of the male modules off-line for repairs and remodeling. There are sixty security cameras at the center, of which fifty-six were operational. The four inoperable cameras which covered the left side of the recreation field, is not currently utilized by the center; part of male module three, part of portable three, and a secondary camera view of the sally port area. At the time of the annual compliance review, the center had seventeen reported staff vacancies, which included two food service workers, three JJDOS, and thirteen JJDO positions.

Standard 1: Management Accountability

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

The center has facility operating procedures for conducting background screening for all staff, contracted providers, and volunteers prior to hiring or using their services. The center hired twenty-five new staff since the last annual compliance review, and all received an eligible background screening result prior to their hire date. The program had fourteen new volunteers start at the center since the last annual compliance review and all received an eligible screening result prior to working with the youth. The center had four new contracted staff hired during the annual compliance review period and all received an eligible background screening prior to providing services to youth. The center submitted their Annual Affidavit of Compliance with Level 2 Screening Standards to the Department's Background Screening Unit (BSU) on January 21, 2020. The Hillsborough County School Board submitted their Annual Affidavit of Compliance with Level 2 Screening Standards to the Department's BSU on January 22, 2020.

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

The center has facility operating procedures for conducting five-year background rescreening on each staff, contract providers, and volunteers. The center had one staff member who required a five-year rescreening since the last annual compliance review. The center completed the required rescreening prior to the staff's five-year hire anniversary date. The rescreening was submitted to the Background Screening Unit at least ten business days prior to the staff member's five-year anniversary date and the rescreening results received 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 has facility operating procedures regarding staff code of conduct. A review of nine staff records revealed each staff signed the center's code of conduct upon hire. The same staff records revealed two staff violated the code of conduct and received disciplinary action for failure to complete ten-minute room checks on youth. The center provided the annual compliance review team with nine additional staff records which revealed the staff received disciplinary action for violating the center's code of conduct. Five of the staff records revealed the staff were dismissed from their position due to a failure to satisfactorily complete their probationary period. The sixth staff record revealed the staff received an oral reprimand for completing ten-minute room checks late. The seventh record indicated the staff received a verbal reprimand for opening a youth's room door without another juvenile justice detention officer present. The eighth record revealed the staff was dismissed from their position for ineffectively and/or the inability to perform their assigned job duties. The ninth staff record revealed the staff received a verbal reprimand for failure to complete a Protective Action Response (PAR) report after using a PAR technique. The six months prior to the annual compliance review, the center had twelve staff receive commendations. Five staff received recognition for being an active state staff for twenty or more years, one staff received recognition for being a state staff for thirty or more years. Each of the staff members received a gold detention polo shirt in recognition for their years of service. Another staff was recognized for being an active state staff for fifteen years. Three additional staff received recognition as staff of the month. One staff received recognition as the detention center staff of the quarter. One staff was recognized as the assistant superintendent of detention centers for the year and received a plaque. One staff who was recognized for having thirty years of state employment received the Julianna Holt award for Circuit 13 and received recognition at a banquet for their hard work and dedication to the youth in Hillsborough County. During the annual compliance review, five interviewed youth indicate they feel safe while in the center. All interviewed youth indicated staff are respectful when speaking with them and have never heard staff threaten another youth or themselves. Four of the five interviewed youth indicated they have never heard staff curse; however, the fifth youth indicated staff occasionally curse but not at the youth. The youth further indicated staff curse out of frustration and the cursing is not directed toward any youth. All five interviewed youth indicated they have never had to report abuse to the Florida

Abuse Hotline. Five staff were interviewed regarding staff use of profanity when speaking to youth and staff threatening, intimidating, or humiliating youth at the center. Four of the five staff indicated hearing staff curse once and the fifth staff indicated they heard staff use profanity occasionally. The fifth staff clarified their answer to indicate the cursing was done out of frustration after a code and was never directed at the youth. One of staff indicated they heard a staff use profanity once in front of youth in a negative manner, the incident was reported to administration which resulted in the staff's termination. Four of the five interviewed staff indicated they have never seen another staff threaten, intimidate, or humiliate youth at the center. The fifth staff indicated they heard about staff who have threatened, intimidated, or humiliated youth at the center but have never witnessed it. Three of the five interviewed staff indicated the working conditions at the center are good and two indicated it is fair. An interview with the center's superintendent indicated each staff reviews, signs and agrees to the center's code of conduct which includes the expectations set forth for all detention officers while employed by the Department. The superintendent indicated the code of conduct addresses corrective action options and descriptions of violations for the code of conduct.

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 has facility operating procedures regarding compliance with the Department's policy on incident reporting. A review of the Central Communications Center (CCC) database indicated the program had forty-five incidents reported in the six months prior to the annual compliance review Five incidents were reported to the CCC within the required time frame. One was related to youth behavior, two were complaints against staff, and two were medical incidents. Three of the five incidents were required to be documented in the center's logbook. Each of the three incidents were documented in the center's logbook on the date the incident occurred as required. A review of the CCC database revealed forty-five CCC incidents were reported during the annual compliance review period which was a decrease from the previous fiscal year. An interview with the superintendent indicated the decrease is due to a permanent superintendent in place since December 2019, the revised behavior management system, enhancement of the level three incentives, leadership training for supervisory staff, and having staff trained/certified in the center's new behavior management system. A review of the center's internal incident reports and grievances did not reveal any incidents reportable to the CCC. An interview with the superintendent indicated the center ensures all pertinent information about incident and any matter requiring reporting is completed within two hours of the incident or within two hours of becoming aware of the incident.

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

The center has facility operating procedures addressing Protective Action Response (PAR) and physical interventions. There were 234 PAR incidents in the six months prior to the annual compliance review, which is an increase from the previous fiscal year when the center had 111

PAR incidents. The center's PAR rate during the annual compliance review period was 16.54, which is above the statewide average PAR rate of 12.00. An interview with the superintendent indicated the center is trying to reduce the number of PAR techniques used by implementing the new behavior management system (BMS), having staff trained and certified in the new BMS, enhancing level three youth incentives with more attractive available items, and having supervisory staff trained in new leadership skills. The center received a minor deficiency for PAR reports on March 27, 2020. The deficiency was assigned because the superintendent/designee reviews were not conducted within the required seventy-two hour time frame. During the annual compliance review, the team reviewed PAR reports from March 28, 2020 forward; therefore, only seven PAR reports were available for review. Five of the seven PAR reports reviewed were for compliance with the PAR requirements and for verification of the minor deficiency. All reports had narratives from each staff involved and the narratives were completed by the end of the staff's shift. None of the reviewed PAR incidents included the use of mechanical restraints and no allegations of abuse made by the youth or injuries to the youth or staff. All reports were reviewed and signed by a certified PAR instructor, the acting supervisor at the time of the incident and the program director/designee. All PAR techniques were found necessary by the center's staff who reviewed each incident. Four of the five incidents documented a post PAR interview was conducted with each youth within thirty-minutes of each incident and documented on the PAR reports. The fifth incident indicated the post PAR interview was conducted several hours after the PAR incident, however, during the debriefing process the center indicated the post PAR interview was conducted by the supervisor at the time of the incident and the supervisor accidentally documented the time they reviewed the PAR for compliance in the time box for the post PAR interview. None of the reviewed PAR incidents required a medical review. All five PAR incidents were reviewed by the superintendent or designee within the required seventy-two hour time frame. All PAR incidents were found in the Department's Juvenile Justice Information System PAR report database. Five staff were interviewed to determine if staff try to talk to youth prior to using PAR techniques and each indicate they try to verbally deescalate the youth prior to using a PAR physical technique. During the superintendent interview, the center's process for monitoring PAR incidents/reports included the following: to review each incident report and the assistant superintendent reviews the closed-circuit television recording to ensure the use of the PAR technique was appropriate and completed correctly.

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 facility operating procedure addressing pre-service training. A review of five staff training records indicated all staff were certified within 180 days of hire and received all essential skills prior to working with the youth. Each staff member received the following essential skills: Protective Action Response, cardiopulmonary resuscitation, first aid, automatic external defibrillator, suicide prevention, safety, security, emergency procedures, substance abuse services, mental health services, human trafficking, Department detention facility operations, and Prison Rape Elimination Act. All five staff completed phase one detention officer training to also include orientation, information security awareness, legal, Department of Juvenile Justice: the organization, gang awareness, interpersonal/communication skills, detainee behavior and consequences, and active shooter training. All five staff completed phase two training, which consists of the detention officers training academy and 120 hours of

additional training requirements. All training was 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 facility operating procedures (FOP) addressing in-service training. A review of five staff training records revealed each had in excess of the required twenty-four hours of training. All records indicated each staff received re-certification training in Protective Action Response, cardiopulmonary resuscitation, first aid, automatic external defibrillator, suicide prevention, professionalism/ethics, and active shooter training. Three of the five reviewed training records were juvenile justice detention officer supervisors (JJDOS) and each had eight or more hours of supervisory training as required by the 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 database for program monitoring and management, Central Communications Center database, human resources, 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, and the trainings are web-based as well as instructor lead. The superintendent confirmed all completed training is entered into SkillPro.

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

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

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

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

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

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

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

JJDOS's shall inform staff of alerts during shift briefing. When a JJDOS receives changes to the alert list, he/she shall notify the staff affected by changes and add the information to the shift briefing for the oncoming shift upon receipt of the information.

The center has facility operating procedures regarding entering alerts into the Department's Juvenile Justice Information System (JJIS) and sharing of alert information. Five youth's JJIS alerts were reviewed to confirm appropriate entry and closure procedures were followed. Each youth was found to have one or more alerts entered in JJIS and a total of fifteen alerts were reviewed for compliance. Five alerts required entries in the center's logbook and the alerts were documented with the appropriate date. 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 and two of the five interviewed staff revealed they can review the youth alert reports from JJIS. The same five staff all indicated they receive pertinent information about the center during the same shift briefings. Observations during the annual compliance review confirm staff receive youth alert information and other pertinent center information during the shift briefings. During the observed shift briefings, the outgoing shift supervisor, briefed the oncoming shift on any pertinent information. The interviewed staff stated they debrief with outgoing staff when they report to their assigned living module. By reviewing six months of the center's shift briefing reports the review team was able to ensure youth alert information and center information was communicated to staff.

Standard 2: Assessment and Performance Plan

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

The center has facility operating procedure to ensure youth are admitted to the center in accordance with Florida Administrative Code. Five youth records were reviewed for admission and all records contained an arrest affidavit/custody order or courtesy hold order, a Detention Risk Assessment Instrument (DRAI) and Suicide Risk Screening Instrument (SRSI). All records had the Admission Wizard printed and placed. Each Admission Wizard documented each youth was searched, allowed to make a telephone call, electronically searched, and received a medical, mental health, and substance abuse screening. All five Admission Wizards documented each youth were offered a snack or meal. During the annual compliance review, a team member observed a youth admission. The admitting juvenile justice detention officer (JJDO) spoke in a calm voice, explained the admission process, and all paperwork. The youth was electronically searched and given a full body visual search by an officer of the same gender as the youth. The youth made a telephone call to their parent/guardian and was offered a meal. The youth was given an opportunity to shower and was provided with clean detention clothing.

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.*	

Five youth records were reviewed for orientation to the center. Documentation in all five records indicated each youth received orientation to the center within twenty-four hours of their admission and each youth acknowledged they received orientation by signing the orientation

forms. Two of the five reviewed orientation acknowledgement forms were missing the date of the youth's signature. The orientation process included identification of key staff, the daily activity schedule, the center's rules and regulations, youth rights, visitation, telephone calls, grievance procedures, access to medical, mental health, substance abuse services, access to the Florida Abuse Hotline and Central Communications Center, behavior expectations and related consequences, and possible new law violations for destruction of property. At the time of the review the video system in the intake area was broken; therefore, intake videos were viewed on the living modules by the incoming youth. Five youth were interviewed, and each reported they were provided with information about the center's rules and regulations, daily schedule, education services, visitation, abuse reporting, and the behavior management system.

2.03 Classification	**Satisfactory Compliance**

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

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

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

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

The center has facility operating procedures to ensure all youth admitted to the center are classified to provide the highest level of safety and security. Five youth records were reviewed, and each had a completed Admission Wizard containing a review of each youth's criminal history, gender, height, weight, age, level of aggressiveness, identified special needs, history of sexual offenses, the Victimization and Sexually Aggressive Behavior (VSAB) form, medical, suicide risk identified or suspected, escape, gang affiliation, and security. Youth were assigned to a module and room based on the classification screening procedures. An interview with the superintendent indicated all gang and associated gang members are referred to the center's gang liaison to ensure an alert is entered into the Department's Juvenile Justice Information System (JJIS). Youth alerts were entered into JJIS, as required. Of the five reviewed records, one youth was classified as a suspected gang member and one was classified as being vulnerable to victimization. None of the reviewed records reflected the youth were classified as sexually aggressive.

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."*	

A review of five youth records indicated all were screened for gang affiliation during intake and one was found to have been identified as a suspected gang member prior to admission into the center. The center provided two additional records for review for youth who were classified as being a suspected gang member or a documented gang member. All three applicable records indicated each youth's gang affiliation and status was provided to the shift supervisor and forwarded to the center's gang representative. The center's current gang representative is a juvenile probation officer (JPO) from the circuit thirteen probation office.
According to the Department's Juvenile Justice Information System (JJIS), the center has not identified any youth as being gang members or affiliates during the annual compliance review period. An interview with the superintendent confirmed the center shares gang information with the youth's assigned JPO, local law enforcement and gang representative. The center's intake unit maintains a gang binder with copies of each youth's photo, the Department's face sheet, alerts, a completed gang affiliation screening form, and an attached email notification to the gang representative. Gang alerts are entered in JJIS by both detention and probation staff and all reviewed alerts were entered in the system.

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.	

A review of five youth records found documentation the youth's property was inventoried by the admitting juvenile justice detention officer (JJDO) and entered into the Department's Juvenile Justice Information System (JJIS). Each of the five reviewed records contained a property receipt form, printed and signed by each youth and JJDO. Youth's property is placed in a property bag with a copy of the property receipt form and youth information, then sealed and placed in a secured property room. The center provided the annual compliance review team with three additional youth records with valuable property such as cell phones and money requiring to be secured. Three of the reviewed records confirmed each youth's valuable property was placed in a sealed envelope and placed in a drop safe which is under camera surveillance. The sealed envelope was labeled with each youth's name, Department identification number, a listing of the items in the bag, and was signed by the youth and staff. The center maintains a valuable property logbook to document items placed in the drop safe. All reviewed records contained a signed letter of acknowledgement regarding unclaimed property. There were no incidents regarding lost or stolen property since the last annual compliance review. Five youth were interviewed and each stated staff checked their personal property and

they signed a property receipt upon admission to the center. An interview with the superintendent confirmed the process for the collection and storage of youth property.

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 has facility operating procedures addressing the storage of youth personal property. Upon entering the center, youth's personal property is stored within two separate areas in the center. During the annual compliance review, a team member observed the center's two youth property storage areas. Youth clothing is stored in a property room with access restricted to supervisors and intake staff. Valuable property items are secured in a sealed envelope and placed in the drop safe, which is under constant surveillance. Currently, only the superintendent, assistant superintendent, and the administrative assistant have access to the drop safe. Valuable property is removed daily and stored in the main safe, which is also under constant surveillance. Property envelopes are listed in a binder by date order. Property is purged by the administrative assistant after the release of each youth from the center and a thirty-day notice of disposal is sent to the parent/guardian. A review of Central Communications Center (CCC) reports for the past six months indicate no incidents related to youth property. An interview with the superintendent confirmed the center's procedures related to storage of youth's personal property.

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.*	

Three closed youth records were reviewed for required release documentation. Each record confirmed the center was consistent in photocopying the identification (ID) cards of people to whom each youth were released. For youth released to detention transporters, IDs were photocopied, and the center identified the transporter by name. Each of the three reviewed records documented court orders and other paperwork related to the release were reviewed by the juvenile justice detention officer supervisor (JJDOS) prior to the youth's release. Each record documented the youth's identity was confirmed prior to release. During the annual compliance review, a release for one youth was observed. The JJDOS reviewed the release order, related paperwork, and confirmed the youth's ID. Each parent/guardian's ID was

confirmed and copied prior to releasing the youth to their custody. The youth was not on precautionary observation at the time of their release and no notifications of suicide risk were applicable. The youth received their property and each youth and parent/guardian signed the release section of the property receipt.

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

Three closed youth records were reviewed for release of each youth's personal property. All three records contained a copy of the property receipt on file, all were signed by each youth and parent/guardian. The valuable property logbook documented valuable property was released to each youth upon their release from the center. There is a process to purge property which includes sending a letter to the parent/guardian informing them the intent to dispose of any property if it is not picked up after thirty days. An interview with the superintendent confirmed property not picked up is either donated to a non-profit organization, discarded, or maintained on-site for the youth to retrieve.

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.	

A review of five youth records confirmed none were applicable for being released from the center with medications. The center provided the annual compliance review team with three additional records which each youth was released from the center with medication.
A medication receipt form was found in each of the records and was completed in its entirety. All forms were signed and dated by all required parties. Observations and a review of records confirmed the juvenile justice detention officer supervisor advised medical staff when a youth is being released from the center for verification if the youth had any medications. If the youth was currently prescribed medications, the medical staff would then bring the medication to the lobby area, complete a review and count the medication with the parent/guardian. The parent/guardian, medical staff, and a witness sign the medication receipt form, which is then is placed in the youth's record.

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.	

An interview with the superintendent reported the center has designated a juvenile justice detention officer II (JJDO II) to serve as the detention review specialist who coordinates the required weekly detention reviews. The superintendent confirmed the weekly reviews include representatives from mental health, medical, and education services at the center along with circuit probation, community intervention, and residential staff. The superintendent indicated the meetings address youth alerts, confinements/behavior issues, current court status, any issues relative to youth's placement (if committed), education, and medical or mental health concerns. Documentation of detention reviews occurring during the past six months were reviewed and a

detention review meeting was observed. Observations confirm all youth on detention status were reviewed, which included any follow-up information needed from previous reviews, pending court dates, commitment status, release dates, and other pertinent information. The reviews were attended, either in person or by phone, by circuit probation staff and all departments within the center.

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 follows a daily activity schedule. The daily activity schedule is posted in each living area and outlines the days and times for youth activities. A review of logbooks, five youth interviews, five staff interviews, and observations during the annual compliance review indicated the center follows their posted daily activity schedule. The schedule includes times for personal hygiene, meals, visitation, education, indoor and outdoor recreation, shift change, faith-based services, groups, shower time, bed time, and down time for youth. Five staff and five youth were interviewed, and all reported the center's activity schedule is followed.

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 annual compliance review was conducted during the world wide COVID-19 pandemic and due to social distancing procedures, the review team was unable to observe the center's adherence to their daily schedule by video or in person. The center's logbooks were reviewed and confirmed the center documents the daily schedule was followed unless an emergency or disturbance occurred. Any changes to the schedule must be approved by the shift supervisor, superintendent or assistant superintendent. Five staff and five youth were interviewed and all reported the center's activity schedule is followed.

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

The center contracts with the Hillsborough County School Board to provide education services to the youth at the center. During the annual compliance review, the center's educational services were not reviewed because face to face educational services were suspended due to the world wide COVID-19 pandemic. Due to the suspension of face-to-face educational services and the teachers not having been at the center since March 15, 2020, the teachers provide educational packets for the youth to complete weekly. Staff provide packets daily and proctor the youth. Completed daily educational packets are compiled and placed in the superintendent's

office for an education representative to retrieve. The packets are reviewed and graded by the teachers; and then returned to the youth for their review the following week. A review of the center's schedule and logbook for the period prior to March 15, 2020 indicates each youth attended school for five hours each day. Youth are enrolled in educational programs and can earn course credit for completion of the education and training experience. The center provided education on a 250-day calendar over twelve months. The teachers have up to ten days a year for participation in training and educational planning. Five youth were interviewed, and all reported they attended school Monday through Friday and each identified common subjects/classes taught during school such as math, English and social studies. Five staff and the superintendent were interviewed, and all reported there was minimal interference in education activities prior to March 15, 2020.

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 provides career education to all youth. The center provides Type 1 programming, which includes life skills groups, activities, and instruction. The youth at the center receive instruction in the areas of communication, interpersonal, and decision-making skills. Career education is taught within the personal career skills (PCS) classes. The PCS class is facilitated by three teachers and a review of the March master schedule instruction counts list for Hillsborough County Schools indicated PCS classes were completed as required prior to the COVID-19 pandemic and suspension of face-to-face educational services. The curriculum allows the use of the "Creative Living" workbook. The workbook covers life skills, job interviews, proper attire for jobs, as well as good nutrition and hygiene. Youth also learn how to complete job applications, real life mathematics, and life skills/social skills. The workbook is being offered to the youth as part of the weekly packets which were handed out during the pandemic. Videos of 'Dirty Jobs' and 'Undercover Boss' are also being used as teaching tools during the pandemic. The center also has a job board in the hallway so youth can see different job opportunities available within the community.

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

The center has facility operating procedures detailing the center's behavior management system (BMS). The BMS includes youth point cards and a three-tier level system. There are incentives for youth obtaining level three status, such as access to video games, special parties, additional phone calls, sibling visitation, and extra snacks. The incentives can be changed or updated based on the center's needs. The center has an incentive calendar outlining the daily incentives for the month. For the month of April 2020, the daily incentives were UNO card games, ice cream social, ICEE Tuesdays, concessions, candy trivia, movie night, and video

games. A behavior matrix is posted within each living module for youth to view and reference. Details are provided for the three different levels, privileges for each level, and how to move up within the level system to earn additional points, activities, and incentives. Five staff were interviewed, and all reported staff speak with youth to discuss the consequences being imposed for poor behavior. Staff further indicated youth are given the opportunity to explain their behaviors and staff explain alternative acceptable behaviors to the youth. All five staff further indicated they receive input from their supervisors on the implementation of the BMS, with the input being provided weekly or as necessary. All five staff stated they felt the BMS was effective. Five youth were interviewed and asked to rank the center's BMS. Four ranked it "very good" and one ranked it "good." The youth were asked if consequences received were fair or unfair, and three youth indicated consequences were fair, while two youth indicated never receiving a consequence.

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

The center's behavior management system (BMS) prohibits the use of group punishment, corporal punishment, or use of drugs to control youth behavior. Five staff were interviewed, and all advised consequences for inappropriate behavior never include loss of meals, snacks, sleep, school, or other rights afforded to the youth. All interviewed staff further indicated they had never witnessed a co-worker utilize the above listed consequences. All five staff indicated they have never witnessed a co-worker encourage a youth to beat up another youth. Five youth were interviewed and none reported having rights taken away as punishment for inappropriate behavior. Three of the five youth further indicated losing points or having levels reduced due to inappropriate behaviors. Each of the five youth advised they are not allowed to punish other youth.

2.17 Grievances	Satisfactory Compliance

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

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

The center has facility operating procedures regarding each youth's right to report grievances and to be treated fairly, respectfully, without discrimination, and have their rights protected. The center's grievance process includes an informal phase, a formal phase, and an appeal phase. Youth have access to grievance forms within the living modules by asking staff to enter a grievance into the Department's Facility Management System (FMS) database. Completed grievance forms are reviewed by staff and forwarded to the shift supervisor who reviews the grievance. The supervisor reviewing the grievance will either resolve the issue/concern or forward the grievance to the superintendent. A review of five grievances filed since the last annual compliance review indicated the grievance process and appeals were completed within the required time frame. Five staff were interviewed about the center's grievance process and all were able to articulate the process. Five youth were interviewed, and they all indicated they had never had to file a grievance. The superintendent interview confirmed their understanding of the process and indicated the process has three phases. The superintendent also confirmed grievances are entered into and maintained in the Department's FMS database.

2.18 Trauma-Informed Care	Satisfactory Compliance

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

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

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

The center has facility operating procedures indicating how the center is incorporating trauma-informed practices into the daily schedule and acknowledges the role trauma plays in each youth's life. The procedures indicate staff will receive trauma-informed care training. A review of five staff training records were reviewed for both pre-service and in-service training. All records confirmed all staff receive trauma-informed training during the pre-service training and annually

thereafter. The superintendent interview indicated the center has a soft room where youth can relax and calmly reflect on concerns/issues. The center has bulletin boards throughout the center explaining the center's trauma informed process, and murals painted throughout the center to inspire a calming and inspirational atmosphere. The center has painted caulk board squares in each youth room which allows the youth a positive way to express themselves. The superintendent indicated the center is undergoing repainting with softer colors to provide a more soothing environment. The superintendent confirmed staff are trained in trauma-informed care practices annually.

Standard 3: Mental Health and Substance Abuse Services

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

The center has facility operating procedures to address the provision of a designated mental health clinician authority (DMHCA). The center uses the sub-contractor, Camelot Community Care, Inc. who provides the center with a DMHCA. The DMHCA is properly credentialed and is a licensed clinical social worker (LCSW) with a State for Florida license which expires March 31, 2021. The DMHCA provides forty hours of clinical on-sight supervision and is also on call twenty-four hours a day, seven days a week. While on-site the DMHCA attends all mini-treatment team meetings, provides weekly supervision to the non-licensed mental health professionals, acts as the point of contact person for the coordination, and the implementation of mental health services. The DMHCA was interviewed and confirmed, in addition to the responsibilities listed above, duties include conducting and/or reviewing assessments for suicide risk, completing initial and individualized treatment plans, discharge summaries, participating in weekly detention review audits, and conducting weekly mental health groups.

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 contracts with Camelot Care Community Care, Inc. for the provision of mental health and substance abuse services. The mental health department uses a licensed clinical social worker (LCSW) and a licensed mental health clinician (LMHC) to provide regular mental health services at the center. The mental health professionals have current active licenses, within the State of Florida which expire on March 31, 2021. Oversight is provided by the contractor's regional clinical director, who also serves as the backup to the DMHCA. The regional clinical director possesses an active license with an expiration date of March 31, 2021. Mental health credentials were validated by using the Department of Health Medical Quality Assurance website for licensed professionals in the State of Florida.

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 facility operating procedures to ensure metal health and substance abuse staff have the appropriate qualifications. The center uses a contractor for the provision of mental

health and substance abuse services. The center is licensed under Chapter 397, Florida Statues, to provide substance abuse services, which expires on August 31, 2021. The provider employs one non-licensed clinician who provides coverage at the center on the weekdays during the evening shift hours. The non-licensed mental health professional holds a master's degree in rehabilitative counseling. The center provided documentation for twenty hours of on-the-job-training in assessing suicide risk, mental health crisis intervention, and emergency mental health services. The reviewed documentation also validated the administration of five Assessments of Suicide Risk (ASR) or crisis assessments conducted in the physical presence of a licensed mental health professional. A review of direct supervision logs confirmed the designated mental health clinician authority (DMHCA) is assuring the non-licensed clinical staff is working under the direct supervision of a qualified professional, performing services the position is qualified to provide based on education, training, and experience. Additionally, a review of the direct supervision logs confirmed the non-licensed mental health clinical staff also receive at least one hour of on-site face-to-face direct supervision by the DMHCA weekly. All reviewed records confirmed the DMHCA reviewed and signed all comprehensive mental health evaluations, updated comprehensive mental health evaluations, comprehensive substance abuse evaluations, follow-up comprehensive substance abuse evaluations, initial mental health treatment plans, initial substance abuse evaluations, individual treatment plans, and individualized substance abuse treatment plans within ten calendar days of completion by the non-licensed clinical staff. All reviewed records confirmed the DMHCA reviewed and signed all ASR, follow-up ASRs, crisis assessments, and follow-up crisis assessments conducted by non-licensed mental health clinical staff, the next scheduled time they were on-site.

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

The center has facility operating procedures related to mental health and substance abuse admission screenings, which are approved by the superintendent and the designated mental health clinician authority (DMHCA). A review of five youth mental health and substance abuse records confirmed the detention center's staff reviewed all prior documentation completed by the juvenile probation officer (JPO) or the juvenile assessment center screener upon admission. During the admission process, the juvenile justice detention officer (JJDO) reviews the screening documents Massachusetts Youth Screening Instrument - Second Version (MAYSI-2), Suicide Risk Screening Instrument (SRSI), and the Vulnerable to Victimization and/or Sexually Aggressive (VSAB) forms. In all five records reviewed, a SRSI was conducted at intake with all entries completed, including the section completed by the nurse and/or clinical staff, which also include a summary and recommendation under the screening results section. Three of the five youth were applicable for positive responses on the SRSI which resulted in each youth being placed on precautionary observation and referred for further assessment.

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

The center has facility operating procedures which regulates the assessment process of each youth upon entry to the center. All youth shall be referred and have completed a new or updated comprehensive mental health and/or substance abuse evaluation within thirty days of admission. A review of five youth mental health records contained documentation the mental health clinical staff's request for an evaluation which was completed within fourteen days of admission. Four of the five reviewed records were applicable for the completion of a new or updated comprehensive mental health evaluation. One of the four had an updated comprehensive mental health evaluation completed within thirty days of the referral and was completed by the designated mental health clinician authority (DMHCA). The remaining three youth had recently been assessed and referred, between the dates of March 31 and April 2, 2020 for a comprehensive mental health evaluation and the status of the evaluations were pending during the annual compliance review.

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

The program has facility operating procedures which define how the program will provide treatment to youth. Five youth records were reviewed. One of the five reviewed youth records were applicable for receiving services while in the center. Two additional applicable records were provided by the mental health team for review. Each of the three youth were assigned to a mini-treatment team which consisted of the youth, the designated mental health clinician authority (DMHCA), the psychiatrist, medical staff, and the youth's parent/guardian when available. A review of documentation confirmed each youth was receiving individual treatment in accordance with the frequency outlined in their plan. All three applicable youth records had a copy of a valid Authority for Evaluation and Treatment (AET). None of the youth were found to be receiving any specific substance abuse services, therefore, they did not require Substance Abuse Consent and Release forms nor did the youth attend substance abuse groups. The DMHCA confirmed the staff provide individual counseling, behavioral therapy, treatment planning, discharge planning, and evaluations for youth. Five youth were interviewed regarding how they would rate the mental health and substance abuse services they were receiving at the center. Three youth indicated the services were very good, and two indicated they had not received any services while in the center.

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

The center has facility operating procedures which define how treatment planning shall be conducted for youth. Five youth records were reviewed. One of the five reviewed youth were applicable for the completion of an Initial Treatment Plan. Two additional applicable records were provided by the clinical staff for review. Each of the three reviewed youth records were found to include an initial plan which was completed within seven days of admission and signed by the members of the mini-treatment team, including the designated mental health clinician authority (DMHCA). Each of the Initial Treatment Plans reflected each youth would be seen by the psychiatrist for the completion of an initial diagnostic psychiatric interview and would follow through with any recommendations. All three plans were completed on the Department's Initial Treatment Plan form. One of the five reviewed youth records was applicable for the completion of an Individualized Treatment Plan. The center provided two additional applicable records for review. Each of the Individual Treatment Plans were completed within thirty days of admission using the Department's Individualized Treatment Plan form. Each plan included the youth's Diagnostic and Statistical Manual of Mental Disorders-Version 5 (DSM-5) diagnosis and their recommended psychiatric services, which included prescribed psychiatric medications and the frequency of monitoring to be conducted by the psychiatrist. All reviewed Individualized Treatment Plans were signed by the treatment team, and each was completed by the DMHCA. One of the three youth records were applicable for a treatment plan review and the review was completed within thirty days of the completed individualized treatment plan. The same youth required a modification to their existing treatment plan, and it was modified to add the youth's medication. The remaining two records were not applicable for treatment plan reviews because they were recently assessed, and it had been less than fourteen days from the completion of their individualized plans. The reviewed documentation was signed by all members of the mini-treatment team. One of the five reviewed youth records indicated the youth was recently discharged from the center. Two additional applicable youth records were provided for review by the clinical team. Each youth had the Mental Health/Substance Abuse Treatment Discharge Summary completed on the required Department form. Each record contained documentation reflecting these plans were mailed to the youth and parent/guardian and emailed to the assigned juvenile probation officer (JPO). During the annual compliance review, the team observed three mini-treatment team meetings. During these meetings the psychiatrist completed an initial and follow-up diagnostic psychiatric interviews on each youth, while a clinician finalized each youth's individualized treatment plans. In addition to the psychiatrist and licensed clinician, each youth and medical staff were also present during the observed meetings. After each mini-treatment team meeting the youth's parent/guardian were contacted regarding each youth's mental health and substance abuse treatment. Two of the three youth's parent/guardians were reached and provided input to the treatment team and received an update of the youth progress in treatment. Regarding the parent/guardian who was unreachable, it should be noted the treatment team made two attempts of contact by telephone.

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 facility operating procedures outlining the center's process for providing psychiatric services to youth residing at the center. The center contracts with Camelot Community Care, Inc. who provides for the services of a psychiatrist weekly for three hours. The provided psychiatrist is a medical doctor (MD) who is certified by the American Board of Psychiatry and Neurology in child and adolescent psychiatry, with a license expiration date of January 31, 2021. A review of psychiatrist sign-in sheets confirmed the psychiatrist is on-site weekly for up to three hours and is also in compliance with the rule and contract. Additionally, the sign-in sheets confirmed the psychiatrist meets with the designated mental health clinician authority (DMHCA) and other available staff each time they are on-site to review the progress of youth within the center, and those scheduled for treatment team meetings. he psychiatrist communicates with the center as needed to assist in service coordination for new admissions or other situations such as dealing with a youth in crisis or emergencies. An interview with the DMHCA confirmed they met with the psychiatrist weekly to discuss youth receiving psychiatric services. A review of five youth mental health and substance abuse records revealed one of the records was applicable for psychiatric services. The center's clinical team provided the annual compliance review team with two additional applicable youth records to review for psychiatric services. A review of three applicable youth mental health and substance abuse records revealed they all contained an initial psychiatric interview completed within fourteen days of each youth's admission. All three initial psychiatric interviews contained the reason for the referral, historical information, mental status examination, diagnostic and statistical manual of mental disorders (DSM–5), treatment recommendations, prescribed medication, explanation of the need for medication, and the frequency of medication monitoring. A review of the three applicable mental health and substance abuse records revealed all three were applicable for an in-depth psychiatric evaluation. All psychiatric evaluations included the reason and factors leading to the referral, historical information, mental status examination, identification of individual, family and environmental factors, DSM-5, treatment recommendations and interventions for youth to assist in stabilizing psychiatric disorder, prescribed medication, if applicable, and frequency of medication monitoring/management, explanation of the need for psychotropic medications related to the youth's diagnosis, target symptoms, potential side effects, risks, youth's adherence to medication regime and benefits of taking the medication. All three evaluations had the youth's height, weight, and blood pressure documented on the last page of the evaluation. All three evaluations were signed by the psychiatrist. All three evaluations contained page three of the Clinical Psychiatric Progress Notes (CPPN) and two of the records reflected each youth was prescribed medications. One of the three reviewed youth required tardive dyskinesia screening, and each was completed within the required time frame. The second youth record reflected the youth was not in the center long enough to have a follow-up medication management meeting, which would have resulted in the completion of the tardive dyskinesia screening. The third youth record reflected the youth was not prescribed medication and did not require any type of additional screenings. All three reviewed youth records contained a properly executed Authority for Evaluation and Treatment in their medical record.

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 program has a suicide prevention plan which addresses all required elements in accordance with Rule 63N-1, Florida Administrative Code. The plan includes procedures to identify and assess youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral process, communication, notification, documentation, immediate staff response, and a review process of suicide attempts and mortality review. The plan was reviewed and signed by the superintendent and designated mental health clinician authority (DMHCA) on January 14, 2020.

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

The center has a suicide prevention plan which addresses how suicide prevention services will be provided for youth in the center and includes a section for reviews of any serious suicide attempts or incidents of self-inflicted behaviors. Five youth records were reviewed. Three of the five reviewed youth mental health and substance abuse records were applicable for suicide prevention services. All three applicable youth were placed on precautionary observations at the time of their admission due to the findings on their Suicide Risk Screening Instruments and/or Massachusetts Youth Screening Instrument - Second Version (MAYSI-2). Each youth received an Assessment of Suicide Risk (ASR) within twenty-four hours of their admission and were stepped down to standard supervision as a result of the assessments. Observations of each of the three youth's behaviors were documented on the Suicide Precautions Observation form. All reviewed forms were completed in their entirety, to include the identification of safe housing areas. None of the reviewed records reflected the youth were released to their parent/guardian while on suicide precautions. None of the reviewed records required the completion of a Follow-up ASR due to each youth being stepped down to standard supervision after the completion of the initial ASR. All three reviewed ASRs reflected a conference was held with a licensed clinician and superintendent/designee prior to reducing the level of supervision. Each reviewed ASR was done by a licensed mental health professional, or by a clinical staff member working under the supervision of a licensed clinician. A review of the master control logbook found all the three youth's placement on precautionary observation and release from precautionary observation was documented on the appropriate date. A review of the Department's Juvenile Justice Information System (JJIS) validated each youth had an appropriate suicide risk alert opened and closed as required. None of the five reviewed youth records reflected the youth were placed on secure observations. The center has six suicide response kits; one located in

master control, one in medical and the other four are located in sub-control for each of the living modules. Each suicide response kit was found to contain a knife-for-life, wire cutters, needle nose pliers, and basic first aid supplies. Five youth were interviewed and two indicated they had been placed on suicide precautions during their time in the center. Each youth indicated they were with staff at all times. Five staff were interviewed regarding their responsibilities when youth express suicidal thoughts or behaviors. All five staff indicated they would notify the designated mental health clinician authority (DMHCA), place the youth on constant sight and sound supervision, and document the supervision of each youth. All five staff also indicated they would search each youth and the youth's room for sharp objects and would notify the supervisor on duty.

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.	

A review of five youth mental health and substance abuse records confirmed the completion of precautionary observation logs. Three of the five reviewed records were applicable for placement on suicide precautions. The center uses the Department's Suicide Precaution Observation Log form to document each youth's behaviors while on suicide precautions. All precautionary observation logs were reviewed by a juvenile justice detention officer supervisor and a licensed professional. Warning signs were clearly documented on the logs, when applicable. Each of the reviewed logs had safe housing areas identified for each youth while they were maintained on suicide precautions. All the reviewed logs were found to have required thirty-minute observation checks documented legibly with no lapses or missed checks. During the annual compliance review, each of the three youth who were on suicide precautions were interviewed, and all confirmed they had been placed on suicide precautions during their time in the center. Two of the three youth indicated they were with staff the entire time. The third youth refused to answer any further questions regarding placement on suicide precautions.

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

The center maintains facility operating procedures ensuring all staff receive at least six hours of suicide prevention and intervention training annually. A review of five pre-service and in-service staff training records reflected each staff received six hours of training on suicide prevention. The reviewed training information in the Department's Learning Management System (SkillPro), found each staff received four hours of instructor-led training and two hours of web-based training on suicide prevention. The center maintains a drill binder to document all mock suicide drills. In the binder the center also has a tracking form to ensure all staff participate in at least two mock suicide drills semi-annually. A review of all suicide drills indicated they were conducted on each shift and at least once a quarter. Further review of the drill documentation confirmed all direct care staff participated in at least one quarterly mock drill on a semi-annual basis. Five staff were interviewed regarding the location of the center's suicide response kits and all staff indicated there is a kit in master control and one in each of the living module sub control rooms, and a kit in the medical clinic. Three of the five interviewed staff recalled participating in a major disturbance drill and all five staff stated they can make an emergency call to 9-1-1.

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 Crisis Intervention Plan which addresses the notification and alert system, means of referral to include youth self-referral, communication, supervision levels, documentation, and review as required. The plan was reviewed and signed by the superintendent and the designated mental health clinician authority on January 2, 2020.

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

The center has an Emergency Care Plan which addresses immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment, transport for emergency substance abuse assessment and treatment, documentation, and training as required. The plan was reviewed and signed by the superintendent and the designated mental health clinician authority on January 2, 2020.

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 facility operating procedures for the completion of a Crisis Assessment if a youth is in psychological distress. A review of five mental health and substance abuse records revealed none of the youth were applicable for the completion of a crisis assessment. The center provided one additional youth record which was applicable for the completion of a Crisis Assessment. The program used the Department's Crisis Assessment form during completion of the assessment. The Crisis Assessment contained the reason for the assessment, a Mental Status Examination and Interview, determination of danger to self and others, initial clinical

impression, supervision recommendations, treatment recommendations, and recommendations for follow-up. After the completion of the Crisis Assessment, the youth was maintained on mental health alert. The Crisis Assessment was completed by a licensed clinician and completed within two hours of the incident. The licensed professional maintained the youth on close supervision for several hours after the completion of the Crisis Assessment. The licensed professional then conducted a mental status examination with the youth and placed them on standard supervision. A review of the Department's Juvenile Justice Information System alert database indicated a mental health alert was entered as required. Documentation on the Crisis Assessment indicated the youth's parent/guardian and juvenile probation officer was notified of the youth's crisis and placement on elevated supervision.

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

The program did not utilize a Baker Act or Marchman Act procedure during the review period; therefore, the indicator rates as non-applicable.

Standard 4: Health Services

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

The medical provider began services on March 17, 2020. Due to the recent change in medical providers, the new provider has not had the opportunity to demonstrate practice for the past six months. Medical services provided through the contracted provider, Camelot Community Care, Inc. will be reviewed at a later time.

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

The medical provider began services on March 17, 2020. Due to the recent change in medical providers, the new provider has not had the opportunity to demonstrate practice for the past six months. Medical services provided through the contracted provider, Camelot Community Care, Inc. will be reviewed at a later time.

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 has facility operating procedures to ensure parents/guardians are afforded the right to give or withhold consent regarding healthcare provided to their children. Five youth Individual Healthcare Records (IHCR) were reviewed for documentation of a completed Authority for Evaluation and Treatment (AET) form. All reviewed records contained a properly executed AET prior to the youth receiving medical services. Two of the five IHCRs included a valid original AET, one IHCR included a valid AET copy with a legible stamp with the word ‘Copy’, while two AETs did not have ‘Copy’ stamped on the forms. During the debriefing process, the medical staff acknowledged the two AETs did not have the word ‘Copy’ stamped on the forms and made the required corrections.

4.04 Parental Notification/Consent [Contract Provider]	Non-applicable
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 medical provider began services on March 17, 2020. Due to the recent change in medical providers, the new provider has not had the opportunity to demonstrate practice for the past six months. Medical services provided through the contracted provider, Camelot Community Care, Inc. will be reviewed at a later time.

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

The medical provider began services on March 17, 2020. Due to the recent change in medical providers, the new provider has not had the opportunity to demonstrate practice for the past six months. Medical services provided through the contracted provider, Camelot Community Care, Inc. will be reviewed at a later time.

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

The medical provider began services on March 17, 2020. Due to the recent change in medical providers, the new provider has not had the opportunity to demonstrate practice for the past six months. Medical services provided through the contracted provider, Camelot Community Care, Inc. will be reviewed at a later time.

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

The medical provider began services on March 17, 2020. Due to the recent change in medical providers, the new provider has not had the opportunity to demonstrate practice for the past six months. Medical services provided through the contracted provider, Camelot Community Care, Inc. will be reviewed at a later time.

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

The medical provider began services on March 17, 2020. Due to the recent change in medical providers, the new provider has not had the opportunity to demonstrate practice for the past six months. Medical services provided through the contracted provider, Camelot Community Care, Inc. will be reviewed at a later time.

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

The medical provider began services on March 17, 2020. Due to the recent change in medical providers, the new provider has not had the opportunity to demonstrate practice for the past six months. Medical services provided through the contracted provider, Camelot Community Care, Inc. will be reviewed at a later time.

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

The medical provider began services on March 17, 2020. Due to the recent change in medical providers, the new provider has not had the opportunity to demonstrate practice for the past six months. Medical services provided through the contracted provider, Camelot Community Care, Inc. will be reviewed at a later time.

4.11 Sick Call Process [Detention Staff/Contract Provider]	Non-applicable
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 medical provider began services on March 17, 2020. Due to the recent change in medical providers, the new provider has not had the opportunity to demonstrate practice for the past six months. Medical services provided through the contracted provider, Camelot Community Care, Inc. will be reviewed at a later time.

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 has facility operating procedures (FOP) to address the provision of episodic and emergency medical care. The FOP requires the center to provide emergency, first aid, and episodic care services to youth twenty-four hours a day. The center maintains a list of emergency numbers in the medical clinic and master control, including the poison control number, and both lists are inaccessible to youth. Five youth Individual Healthcare Records (IHCRs) were reviewed and one was applicable for an instance of episodic care. The center provided two additional youth records, of which both were applicable for instances of episodic care. Each was conducted by a licensed healthcare staff, included all required information and documented in each youth's IHCR. Each episodic care event was found on the center's episodic care log. The center's FOP and non-healthcare staff treatment protocols which were approved by the center's designated health authority (DHA), outlines the process in the event non-healthcare staff would need to conduct episodic care. A review of the episodic care log found there were no instances of non-healthcare staff conducting episodic care during the annual compliance review period. A review of five pre-service staff training records found all staff were certified in first aid, cardiopulmonary resuscitation (CPR), and automated external defibrillator (AED) training. A review of five in-service staff training records found each completed the annual training in first aid, CPR, AED, Epinephrine Auto-Injector, and medical emergency care. In addition, training documentation for three supervisors confirmed they were trained in the use of Epinephrine Auto-Injector. Each licensed healthcare staff had documentation of certification in first aid, CPR and AED. The center maintains two AEDs and eighteen first aid kits on-site. The center utilizes an outside provider to monitor the AEDs located in master control and the medical clinic. The batteries and pads for both units were replaced by the outside provider in September 2019 and expire in March of 2021. The green light was observed flashing and

functional on the front of both AEDs. The center maintains one first aid kit in master control, two in the medical clinic, one in each of the two classrooms, dining hall, kitchen, maintenance, one in each of the three living modules, and one in each of the seven vehicles. The reviewer visually observed each first aid kit in the center and in each vehicle. All eighteen first aid kits were secured with a zip tie. A review of the first aid kit box monthly check forms documented each first aid kit was reviewed monthly by the medical staff during the annual compliance review period. Three randomly selected first aid kits were reviewed. Two of the three first aid kits were from within the center and one was from a transport van. All three reviewed first aid kits were secured with a zip tie. The two first aid kits from within the center included all designated health authority (DHA) approved items with no expired or missing items. The first aid kit from the transport van was missing the adhesive tape but the item was replaced while the annual compliance review team was on-site and none of the items were expired. The center's FOP requires medical drills to be conducted at least quarterly on each shift and include first aid and CPR at least once a quarter for each shift. All drills were found to be conducted as required; however, one medical drill conducted during the third quarter, on third shift, was missing the date administrative staff signed off on the drill.

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.	

Five youth Individual Healthcare Records (IHCRs) were reviewed and two were applicable for off-site care. The center provided one additional record which was applicable for off-site care. Each of the three applicable records included the Summary of Off-Site Care form, discharge instructions and all Off-Site Care forms were reviewed by the designated health authority (DHA). Documentation was found in all reviewed IHCRs confirming the DHA was notified at the time each youth was sent off-site. Two of the reviewed records reflected each youth required follow-up care and both received care as required. All three incidents of off-site care were found on the center's episodic/emergency care log.

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

The medical provider began services on March 17, 2020. Due to the recent change in medical providers, the new provider has not had the opportunity to demonstrate practice for the past six months. Medical services provided through the contracted provider, Camelot Community Care, Inc. will be reviewed at a later time.

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

The center has facility operating procedures addressing medication management. The center stores all medication in the locked medication cart which is secured in the medical clinic. All oral, topical, and liquid medications are stored separately. Controlled medications are stored in

a locked box inside the locked medication cart. All over-the-counter (OTC) medications are securely stored in locked cabinets in the medical clinic. The Department's Office of Health Services completed the start-up monitoring at the center on April 9, 2020, which encompassed all requirements in the indicator with the exception of non-healthcare staff whom administered medication to youth. Of the five youth Individual Healthcare Records (IHCRs) reviewed, none received medications administered by a non-healthcare staff. The center provided one additional IHCR for a youth distributed OTC medications by a non-licensed staff. The one applicable record reflected a non-healthcare staff provided the youth with one OTC medication on one occasion, and all required information was documented within the record. There were no other instances of non-healthcare staff providing medications to youth during the annual compliance review period. Training documentation for the non-healthcare staff who provided the youth with medication confirmed the staff was trained in assisting youth with self-administration of medication. The one applicable youth's Medication Administration Record (MAR) was documented on the pre-printed Department's form and included all required information. Initials were found for both the non-healthcare staff providing the medication and the youth for the medication administered. The youth's MAR was not applicable for medication start/stop dates or refusals because the medication administered was an OTC pro-re-nata (PRN) medication. Weekly side effect monitoring was documented for the youth on the MAR by healthcare staff. There were no lapses found in the medication administration. A medication pass was unable to be observed during the annual compliance review due to the COVID-19 pandemic and social distancing standards. The center's procedures indicate juvenile justice detention officer supervisors, superintendents, and assistant superintendents are required to be trained in medication administration. A review of five staff in-service training records revealed three of the staff were supervisors and applicable for medication administration training. A review of the three applicable staff training records revealed each of the supervisors received medication administration training. The center maintains a list of all non-healthcare staff trained to assist youth with the self-administration of medication. Five youth were interviewed, and one reported the nurse provides medication. The other four youth reported they do not take medications. Five staff were interviewed and all reported they do not give youth medication, and none indicated they had been trained to assist youth in the self-administration of medications.

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

The medical provider began services on March 17, 2020. Due to the recent change in medical providers, the new provider has not had the opportunity to demonstrate practice for the past six months. Medical services provided through the contracted provider, Camelot Community Care, Inc. will be reviewed at a later time.

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

The medical provider began services on March 17, 2020. Due to the recent change in medical providers, the new provider has not had the opportunity to demonstrate practice for the past six months. Medical services provided through the contracted provider, Camelot Community Care, Inc. will be reviewed at a later time.

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

The medical provider began services on March 17, 2020. Due to the recent change in medical providers, the new provider has not had the opportunity to demonstrate practice for the past six months. Medical services provided through the contracted provider, Camelot Community Care, Inc. will be reviewed at a later time.

Standard 5: Safety and Security

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

The center has facility operating procedures which regulate active supervision of youth. The annual compliance review team observed numerous activities during the three days on-site. Three days of observations were conducted of active supervision of youth during line movements, recreation, education, transports, and meals. During all observations, the youth were within sight and sound supervision of staff. The annual compliance review team observed headcounts conducted throughout the day which included counts conducted after movements and counts randomly conducted throughout the day. All counts were observed to be logged into the center's logbook. The annual compliance review team observed staff positioned appropriately during observed activities and the youth and staff interaction was observed to be positive in nature. The annual compliance review team observed twelve hours of video footage which confirmed the on-site observations of proper supervision. Five staff were interviewed and all indicated there are currently enough staff at the center to provide adequate safety and security for the youth and staff at the center. All five interviewed staff elaborated their answers to indicate the staffing ratios are currently good because the population is down but when the center's population goes back up to normal numbers, they feel there should be more staff coverage.

5.02 Ten-Minute Checks (Critical)	Satisfactory Compliance

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

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

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

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

The center has facility operating procedures (FOP) to ensure ten-minute checks are conducted when youth are in their rooms sleeping or for other reasons. A re-review of ten-minute checks was conducted for the center in December 2019; therefore, four months of documentation was applicable for review during the annual compliance review period. The center's camera system is comprised of sixty total cameras, four of which were inoperable at the time of the annual compliance review and the system maintains video recordings for thirty days. The four inoperable cameras cover the left side of the recreation field (which is not currently utilized by the center), part of boy's module three, part of portable three and a secondary camera view of the sally port area. The center is in the process of coordinating the camera repairs and the installation of the additional sixteen cameras. The center uses the guard wand system to record checks electronically during sleeping hours. The system ensures staff physically touch a button outside each youth room door with a wand to register the ten-minute check completion. The guard wand system serves as an electronic tracking system and produces reports which are used to gauge the frequency of checks. Additionally, the center uses Visual Observation Report (VOR) forms to manually document ten-minute checks for youth in confinement. During the annual compliance review, a random selection of ten-minute checks was selected and evaluated for the boys one (B1), boys three (B3) and girls one (G1) modules. The videos of ten-minute checks were comprised of two random days equating to six hours of video surveillance. In all cases, the video surveillance corresponded with the guard wand reports and module logbooks. In some instances, there was a two to three-minute variance in times notated in the module logbooks, electronic wand system and the timestamp of the video; however; video, logbooks and wand tracking reflected consistent ten-minute intervals were maintained for all checks. Video surveillance confirmed staff are pausing at each door to observe through the room windows prior to registering the check with the electronic wand. Observations of youth room windows determined staff have no obstructions and a direct line of sight to each youth. The FOP dictates if staff cannot attain line of sight of each youth during the check, they are to open the door with another staff member to ensure each youth is present and safe. Five staff were interviewed regarding when room checks are conducted, and all indicated they are conducted every ten minutes. Four of the interviewed staff elaborated on their answer and indicated the center tries to conduct them between seven and eight minutes or more frequently than the required ten minutes. An interview with the superintendent confirmed the center completes visual checks on each youth every ten minutes while they are secured in their room.

The superintendent further indicated officers are to make visual contact with each youth at the time of the check and the checks are done both electronically and written.

5.03 Census, Counts, and Tracking	Satisfactory Compliance

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

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

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

The center has facility operating procedures (FOP) to regulate how census counts and tracking are conducted. A re-review of census, counts and tracking was conducted in December 2019; therefore, four months of documentation was applicable for review during the annual compliance review period. The procedures indicate staff must always know the exact number of youth under their supervision and the location of each youth within the center. The procedures further indicate youth counts are called into master control at the beginning and end of each shift, routine group movement, following emergencies, when population changes, and once randomly during each shift. Youth who are out of the center are not counted in the center counts. A span of four months of logbook entries were reviewed which comprised nine full days of master control and module logbooks. The reviewed logbooks confirmed census counts are conducted as stated in the centers FOP. During the annual compliance review, the team observed census counts during shift change and the counts were recorded in the required logbooks. Five staff were interviewed regarding counts and all indicated counts are conducted at the beginning and end of each shift and random counts are conducted throughout each shift. Two of the five interviewed staff elaborated to reflect the center stops all movement if the count is incorrect and does a recount until the count is rectified. The same five interviewed staff all indicated emergency counts are conducted when a youth is considered missing, when visibility is hindered and after a major disturbance. Three of the same staff indicated emergency counts are conducted during drills and one staff also indicated counts are conducted when the center is affected by weather issues.

5.04 Logbook Maintenance	Satisfactory Compliance

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

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

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

The center has facility operating procedures which regulate how logbook maintenance is managed. A re-review of logbook maintenance was conducted for the center in December 2019; therefore, four months of documentation was applicable for review during the annual compliance review. The center maintains four living module logbooks and one master control logbook. Logbooks for master control and the modules were reviewed and all logbooks were bounded and had numbered pages. Logbook entries were consistently documented in black ink and entries included the date/time of entry, name, and initials of staff making the entries. Errors in logbooks were lined out and initialed by the staff making corrections, with two exceptions. Two lineouts in the March 2020 logbook did not contain the staff initials. During the debriefing process, the center acknowledged the two exceptions. Highlighted entries included medical, special needs, mental health alerts, or other issues impacting facility safety and security as required. Logbook entries consisted of emergency situations, drills, Protective Action Responses (PAR), population counts, youth counts following emergencies, group movements, admissions, releases, the presence of law enforcement, and youth placement in confinement or precautionary/secure observations. Entries for confinement and precautionary/secure observations included the start and end times of the observations.

5.05 Logbook Reviews	Satisfactory Compliance

The superintendent or designee reviews all logbooks on a weekly basis.

The supervisor(s) reviews the facility logbook maintained at master control when he/she accepts responsibility for the facility.

The juvenile justice detention officer (JJDO) supervisor(s) reviews logbooks maintained in each living area daily.

The JJDO(s) reviews the logbook maintained in his/her assigned living area when he/she accepts responsibility for the living area at shift change.

The center has facility operating procedures (FOP) to regulate how logbook reviews are to be completed. A re-review of logbook entries was conducted for the center in December 2019; therefore, four months of documentation was applicable for review during the annual compliance review. A total of eight logbooks were reviewed for compliance which included two

master control logbooks and six living unit module logbooks for the last four months. All logbooks included the superintendent or designee weekly reviews and were notated in blue ink. The center's FOP dictates the superintendent or designee reviews must be highlighted in yellow; however, the center was not following their FOP and were not highlighting the superintendent reviews. Each master control and module logbooks contained a juvenile justice detention officer supervisor (JJDOS) review when they assumed responsibility for the shift and living module. Module logbooks contained daily entries and reviews from juvenile justice detention officers (JJDO) assigned to each module. All reviewed logbooks contained a notation of the superintendent or designee's walk-through on each shift. An interview with the superintendent confirmed management's role regarding logbooks is to review and sign both the master control and module logbooks weekly to ensure the accuracy of the documentation, and to correct documentation entered.

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

The center has facility operating procedures which regulate key control measures. A re-review of key control was conducted for the center in December 2019; therefore, four months of documentation was applicable for review during the annual compliance review. The procedures address key control by outlining the issuance of keys to staff, inventory and tracking of keys, key restrictions, storage of keys, what to do in case of a missing key, and reporting/replacement of broken keys. The center utilizes a tamper-resistant key ring to hold assigned key groupings together. There is a master key inventory which inventories all key rings by number, the number of keys on each ring, and key rings which are assigned permanently to staff. Staff's personal keys are gathered in master control upon entry and are placed on a numbered key ring within master control. No personal keys are allowed past master control. The review of the key control logs for each shift validated the distribution and accountability of keys at both the beginning and end of each shift. The key control logs contained date and time of issuance of keys, name of person issued keys, name of staff issuing keys, key ring number which corelates to the master inventory, and time the keys are returned. During the week of the annual compliance review, staff were observed carrying keys on their person and youth did not have access to the center's keys. A random review of three sets of staff keys was conducted to determine if the keys matched the shift key inventory log and the master key inventory. The three reviewed key ring sets matched the color code, key number and number of keys reflected on the master key inventory and shift key inventory. Additionally, a review of the master key inventory revealed the inventory matched both the actual key rings in use, inactive key rings and all keys were appropriately secured in a locked key box. An interview with the center's superintendent

revealed there were no reported instances of lost keys. Additionally, the superintendent stated in the event of a staff member mistakenly taking a set of keys off-site, the staff must immediately contact the shift supervisor and return the keys to the center within a two-hour time frame. The superintendent also indicated in the interview, the center has staff who have permanently issued keys and those keys are inventoried. They also indicated each staff with permanently issued keys signs a document acknowledging receipt and responsibility of the keys. Emergency keys which provide egress through exterior doors are stored in master control and locked in a secure red “break away” box. In the event staff would require the use of the emergency keys, staff would break the plastic cover on the box to access the keys, staff are directed to never use the set of keys unless there is an emergency. An interview with the master control technician on duty confirmed the center’s emergency key practice. Five interviewed staff were able to articulate the center’s key control process and all staff indicated the following keys are restricted: kitchen, property room, medical, mental health, and case management keys.

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

The center has facility operating procedures (FOP) which outline regulations for transportation, vehicle use, and maintenance of vehicles. A re-review of vehicles and maintenance was conducted in December 2019. The center received a minor deficiency in which two verifications were conducted, one in January 2020 and again on February 4, 2020, at which time the deficiency was closed. As a result, two months of documentation was applicable for review during the annual compliance review. The center has a total of seven vehicles. Six vehicles are strictly used for transport operations at the center. One of the seven vehicles is used solely for maintenance purposes and does not conduct youth transports. All six youth transport vehicles contained the appropriate number of seat belts, a seat belt cutter, a window punch, a current fire extinguisher, and an approved first aid kit. Reviewed documentation revealed each of the seven vehicles had an annual vehicle inspection by a certified mechanic. Vehicle logbook entries validated staff conduct a vehicle check prior to each transport and the entries contained information about the destination, the number of youth, name of staff, and the beginning and end time for each transport. Documentation also validated the maintenance mechanic or intake supervisor completed both the weekly and monthly checklist as required by the FOP. Each vehicle contains a binder with relevant vehicle logs, gas credit card, insurance, and vehicle registration. During the annual compliance review, a vehicle transport was observed and validated the center’s practice. Observations confirmed the vehicle was searched for contraband prior to the youth entering the vehicle, checks of safety equipment were conducted and each youth was searched for contraband prior to and after the transport. The reviewer observed all staff and youth were wearing seatbelts during the transport.

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

The center has facility operating procedures for tool inventory and management measures. A re-review of tool inventory and management was conducted for the center in December 2019; therefore, four months of documentation was applicable for review during the annual compliance review. All maintenance tools were stored in a secured maintenance workshop. Tools in the workshop and in the kitchen are displayed on shadow boards and each tool is numbered to indicate Department property and tool number. The center maintains a perpetual inventory of maintenance tools and kitchen knives which correlates with the dedicated Department property number for each individual tool. All tools are signed-out prior to use and are signed-in after they are returned. Review of available inventories revealed the months of February and March 2020 were available for review. Upon request, the center provided a timeline and memo to capture the reason the center had only two months of tool inventories for review. The memo indicated in December 2019 the maintenance mechanic abruptly vacated the position which led to a two-month vacancy. At the time of the abrupt departure, the superintendent gathered all workshop keys, secured the maintenance area and did not allow anyone access to the tools or workshop area until a new maintenance mechanic was hired on February 7, 2020. During the time the center was without a maintenance mechanic no one had access to any tools, which included the months of December 2019 and January 2020. The center did not inventory any of the tools during the two months because they were not utilized. When a contracted worker came to the center to complete any work, they provided their own tools, which were inventoried in accordance with the contract provider requirements. The predecessor's last inventory correlates with the new maintenance mechanic's first inventory validating tool accountability. The two months of inventories conducted by the new maintenance mechanic were completed correctly, which demonstrates compliance with the requirements. Kitchen knives are stored in a lockbox within the kitchen area and inventories were applicable since the re-review occurred in December 2019. A review of the four months of inventories indicated all knives/sharps were accounted for daily. Both the kitchen staff and maintenance mechanic conducts tool counts at the beginning of each shift and the end of each shift to ensure tool accountability. There were no tools missing from the center's inventory nor was there any reports of lost or missing tools. Both the maintenance mechanic and kitchen staff were interviewed, and each could articulate the centers practice for when tools are missing or damaged. Five staff were interviewed, and all staff indicated if a tool is broken, it is collected and removed from the youth area, they notify the supervisor, and the tool is replaced with a working tool.

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

The center has facility operating procedures to regulate youth access to and use of tools and cleaning items. A re-review of youth access and use of tools/cleaning items was conducted for the center in December 2019; therefore, four months of documentation was applicable for review during the annual compliance review. The youth only have access to mops, brooms, buckets, and cleaning rags and brushes when cleaning the center and are continuously under

the direct supervision of the center's staff. Observations during the annual compliance review, confirmed the center's procedures are followed and youth were seen cleaning under direct supervision and the youth only used the approved cleaning tools. Five youth and five staff were interviewed and all indicated youth can only use mops and brooms.

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

The center has facility operating procedures related to inventories of flammable, toxic, caustic, and poisonous items. A re-review of inventory of flammable, toxic caustic and poisonous items was conducted for the center in December 2019; therefore, four months of documentation was applicable for review during the annual compliance review. The center's materials are stored in a locked hazardous materials cabinet to limit access and prevent unauthorized use. The hazardous materials are stored neatly and are fully accounted for on the corresponding inventory sheets. Safety Data Sheets (SDS) are maintained in a binder and stored in the locked cabinet with the chemicals. A review of the SDS binder revealed there was an SDS sheet for each chemical found in the cabinet. All chemicals are required to be signed-out prior to use and are signed-in after they are returned and indicate quantity used. Review of available inventories revealed for only the months of February and March 2020 were available for review. Upon request, the center provided a timeline and memo to capture the reason the center had only two months of chemical inventories for review. The memo stated in December 2019 the maintenance mechanic abruptly vacated the position which led to a two-month vacancy. At the time of the abrupt departure, the superintendent gathered all workshop keys, including the keys to the hazardous chemical cabinet and did not allow anyone access to the chemicals until a new maintenance mechanic was hired on February 7, 2019. During the time the center was without a maintenance mechanic no one had access to any chemicals, which included the months of December 2019 and January 2020. The center did not inventory any of the chemicals during the two months because they were not utilized. The predecessor's last inventory correlates to the new maintenance mechanic's first inventory which validated chemicals were not used during the maintenance mechanics absence. The two months of inventories conducted by the new maintenance mechanic were completed accurately and demonstrates compliance with the required administrative rule and the center's procedures.

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

The center has facility operating procedures which regulate access to flammable, toxic, caustic, and poisonous items. The policy strictly prohibits youth access to these materials as they are hazardous materials. A re-review of access to flammable, toxic caustic, and poisonous items was conducted for the center in December 2019; therefore, four months of documentation was applicable for review during the annual compliance review. During the annual compliance review, no observations of youth using hazardous materials were found. An interview with the superintendent confirmed hazardous materials are only handled by approved staff which include appointed supervisors, administrators and maintenance staff. Five youth were interviewed, and four indicated they do cleaning with chemicals, but the staff always handle and spray the chemicals. The fourth youth indicated they have not had the opportunity to clean yet. Five staff were interviewed, and all indicated the youth clean with the use of chemicals; however, they spray or pour the chemicals and the youth never handle the chemicals.

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

The center has facility operating procedures (FOP) to regulate proper usage, storage and disposal of flammable, toxic, caustic or poisonous items. The FOP outlines the steps to follow in the event of a chemical leak or spill. A re-review of disposal of flammable, toxic caustic and poisonous items was conducted for the center in December 2019; therefore, four months of documentation was applicable for review during the annual compliance review. An interview with the maintenance mechanic verified materials are disposed of by evaporation, compaction or with a contracted disposal service. The kitchen does not use fryers and does not require grease disposal services. In the past four months, the center has not disposed of any chemicals; however, the process of disposal is widely understood. The superintendent and maintenance mechanic were interviewed, and both confirmed the center has experienced no chemical leaks or spills during the annual compliance review period. Additionally, each staff could articulate the proper disposal measures for hazardous materials.

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

The center follows the statewide detention facility operating procedures regarding confinement of youth. A minor deficiency was assigned to the center during a supplemental visit which was conducted on March 27, 2020. The center had twenty-three confinements since the minor deficiency was assigned, and five were selected to review for compliance. The center has designated confinement cells; however, several of these are not in use due to plumbing concerns. On most occasions, youth are typically confined in the room they have been assigned. All five confinements reflected the confinement room was searched prior to placing each youth in the room. A review of these confinements also confirmed staff are completing an incident report in the Facility Management System (FMS) within the required one-hour time frame after an incident. All five reviewed reports also reflected the required five-minute visual checks for the first hour of confinement and then ten-minute checks thereafter, without exceptions. All five of these confinement reports reflected a juvenile justice detention officer supervisor (JJDOS) completed a review for fairness and appropriateness within the two-hour requirement. Each of the five reviewed reports reflected three-hour checks were completed by a JJDOS without exception. Each supervisory review was documented in the FMS database and had information indicating the need for continued confinement, with two exceptions. On two supervisory reviews, one supervisor failed to document a reason for the continued confinement of the youth, and the center acknowledged the exceptions during the daily debriefing. Four of the five confinement reports had the superintendent/designee review completed within the twenty-four hour requirement. The fifth report was reviewed one day late. Five interviewed staff indicated they would complete ten-minute checks and would search the room prior to placing each youth in confinement. All five staff also indicated they complete a confinement report. Three of the five staff indicated in the interview they would complete checks at five-minute intervals during the first hour of confinement. A review of Visual Observation Reports for confined youth confirmed the centers visual observation practice.

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

The center follows the statewide detention facility operating procedures regarding confinement of youth. A review of confinements since the annual compliance re-review, which was conducted in December 2019, found the center had no confinements which exceeded twenty-four hours.

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

The center has facility operating procedures (FOP) addressing the Continuity of Operations Plan (COOP) and when the center is to conduct COOP drills. A re-review of the COOP was conducted in December 2019; therefore, four months of documentation was applicable for review during the annual compliance review. COOP drills are to be conducted at a minimum of two times a year with one drill completed prior to the first day of June. The COOP plan includes annexes to ensure proper command and control capabilities in the event of emergencies and disaster responses. The center executed a COOP drill during the annual compliance review period on April 10, 2020, which is prior to the June deadline. Drill documentation included a drill scenario form, critique forms, e-mails, list of participated staff, and logbook entries for the drill confirming all documentation was completed accurately. An interview with the superintendent confirmed the center has comprehensive safety procedures and they review the emergency plan annually and updates are made when necessary. The superintendent also indicated the center conducts drills related to fire prevention/evacuation, severe weather, major disturbances, bomb threats, hostage situations, chemical spills, flooding, and terrorism threats. Five staff were interviewed, two of the five staff indicated they had participated in a weather-related drill and three indicated they participated in a major disturbance drill.

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

The center has facility operating procedures to regulate the delivery of escape prevention measures and escape drills. A re-review of the center's escape drills was conducted in December 2019; therefore, four months of documentation was applicable for review during the annual compliance review. The center's procedures indicated they are to conduct quarterly escape drills. Reviewed documentation of escape drills and the corresponding logbook entries validated one escape drill was held during each of the center's three shifts in January 2020, which meets the quarterly requirement for the annual compliance review period. Drill documentation included a drill scenario, list of participated staff and a critique of the drill. Master control logbook entries were found for each drill. A review of five staff in-service training records revealed each staff received annual training in the center's escape procedures. Five staff were interviewed, and all indicated they have participated in mock escape drills.

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

The center has facility operating procedures which dictate the delivery of fire prevention measures and the frequency at which fire drills are to occur. A re-review of the center's fire drills was conducted in December 2019; therefore, four months of documentation was applicable for review during the annual compliance review. The procedures stipulate one fire drill shall be conducted on each shift monthly and proper documentation requirement for each drill shall be kept by the center. A review of twelve fire drills, one fire drill for each of the three shifts was applicable for review. Drill forms for each drill were marked as fire related drills and properly documented except for five of the twelve drills, which lacked the accompanying master control logbook entries. Each of the drill documentation packets contained a fire related scenario, list of youth/staff participants, post-drill recommendations, and critiques of the drills. The center's fire drill procedures were approved by the Hillsborough County Fire Department. The center's fire extinguishers were inspected by the local fire department annually. Five staff were interviewed, and all indicated they have participated in fire drills and the drills take place monthly. Five youth were interviewed, and four indicated they had participated in fire drills, while one indicated they had not. A review of five in-service staff training records revealed each staff member participated in fire prevention planning and disaster procedures.