STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Miami-Dade Detention Center

Department of Juvenile Justice
(State-Operated)
3300 NW 27th Avenue
Miami, Florida 33142

Review Date(s): December 1-4, 2020

Promoting Continuous Improvement and Accountability
in Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Rosa Flores, Office of Accountability and Program Support, Lead Reviewer (Standard 1)
Teves Bush, Office of Accountability and Program Support, Regional Monitor (Standard 4)
Peter Keelan, Office of Education, Education Coordinator (Standard 2)
Gabriel Medina, Office of Accountability and Program Support, Regional Monitor (Standard 2)
Patrick Morse, Office of Accountability and Program Support, South Region Supervisor (Standard 3)
Mamine Saintil, Detention Services, North Region Operations and Program Manager (Standard 5)

Program Name: Miami-Dade Detention Center
Provider Name: Department of Juvenile Justice
Location: Miami-Dade County County / Circuit 11
Review Date(s): December 1-4, 2020

MQI Program Code: 490
Contract Number: N/A
Number of Beds: 100
Lead Reviewer Code: 182

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

Overall Rating Summary

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

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

Standard 2: Youth Management
Detention Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Detention Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Detention Rating Profile

Indicator Ratings

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

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Program Overview

The Miami-Dade Regional Juvenile Detention Center is a state-owned detention facility, operated by the Department, located in Miami, Florida. The center serves youth in Miami-Dade, Broward, and Monroe Counties in Circuit 11. The male and female youth who are detained pending adjudication, disposition, or placement in a residential commitment program are housed in the 100-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 management team includes the superintendent, three assistant superintendents, two administrative assistants, thirteen juvenile justice detention officer supervisors (JJDOS), and seventy-five juvenile justice detention officers (JJDO). The center's educational services are provided by the Miami-Dade County School Board. Mental health and healthcare services are provided through the contracted provider, Camelot Community Care, Inc. Mental health services are provided by a licensed mental health counselor (LMHC) who serves as the center's designated mental health clinician authority (DMHCA). The DMHCA supervises four non-licensed master's-level mental health and substance abuse clinical staff. Clinical services provided by the center includes 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. Medical services are provided by one designated health authority (DHA), one advanced practice registered nurse (APRN), two registered nurses (RNs), and four licensed practical nurses (LPNs). The medical clinic maintains nursing coverage seven-days a week from 6:30 a.m. to 10:30 p.m., Mondays through Fridays, and from 7:00 a.m. to 7:00 p.m. on weekends.

The center has five living modules which consist of four male modules and one female module. A complete tour of the center reflected the center was clean and the grounds around the facility were observed to be manicured and maintained. At the time of the annual compliance review, the center had ten staff vacancies, which included six JJDO I positions, three JJDOII positions, and one JJDOS position. The center has a total of 183 surveillance cameras, of which thirty-three were not operational and were pending repair at the time of the annual compliance review.

Strengths and Innovative Approaches

- Kula Karma provides yoga exercise to the youth through video conferencing on Mondays and Fridays at 4:00 p.m. Once the COVID-19 pandemic restrictions are lifted, Kula Karma will conduct yoga classes in person with the youth at the center.

Standard 1: Management Accountability

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

The center maintains a written policy and procedures for completing a background screening prior to hiring a staff or utilizing the services of a volunteer, mentor, intern, or contracted provider with access to youth and confidential youth records. During the annual compliance review period, the center hired a total of forty-five new staff inclusive of twenty-five direct-care staff, nine healthcare staff, five contracted provider staff, two schoolteachers, and four volunteers/interns. The five contracted provider staff included a therapist from Camelot Community Care, Inc.

Reviewed documentation reflected each initial background screening was completed by the Department's Background Screening Unit (BSU) and Clearinghouse, prior to each hire date. Each direct-care staff is required to complete a pre-employment assessment and receive a passing score. The center had twenty-five direct-care staff who required a pre-employment assessment. Reviewed documentation confirmed a pre-employment assessment was completed by each newly hired direct-care staff and a copy of the passing score was maintained in each staff's personnel record. Two of the newly hired direct-care staff required an exemption from the Department prior to hire due to not earning a passing score on the pre-assessment tool, and both records contained the reason for the exemption. Supporting documentation was provided from the site administrator of the Miami-Dade County Juvenile Justice Center School confirming newly hired teachers were authorized by the Miami-Dade County Public Schools for employment. The Annual Affidavit of Compliance with Level Two Screening Standards was completed and submitted to the Department's BSU on January 30, 2020, meeting the annual requirement.

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

The center has a written policy and procedures requiring the completion of a background rescreening every five years for applicable staff. A background rescreening is completed on all Department staff, contractors, and volunteers every five years based upon the original date of

hire. Rescreening documentation must be submitted to the Department's Background Screening Unit (BSU) and Clearinghouse at least ten days prior to the staff's five-year anniversary date.

A review of the staff roster found three Department staff were applicable for a five-year background rescreening since the last annual compliance review. Reviewed documentation reflected each staff received a five-year background rescreening within the required time frame, as required. Each of the background rescreening/resubmissions were submitted to the BSU and Clearinghouse at least ten business days prior to the five-year anniversary date. The center had no volunteers/interns or provider staff applicable for a five-year rescreening.

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

The center maintains a written policy and procedures ensuring all staff adhere to a code of conduct. The center utilizes the Department's employee handbook, which contains a code of conduct. Staff are required to adhere to a code of conduct which prohibits any form of abuse, profanity, threats, harassment, intimidations, or personal relationships with youth. Seven applicable staff personnel records were reviewed, and each contained the acknowledgement, receipt, and review of the Department's code of conduct. Five of the seven applicable staff records contained documentation of disciplinary action. Reviewed documentation of each applicable record reflected management took immediate and appropriate corrective action to address the staff's code of conduct when staff violated the policies and procedures. These corrective actions included written memorandums, written reprimands, additional training, and/or suspension.

A review of the center's internal incidents, the Department's Central Communications Center (CCC) reports, and the Protective Action Response reports determined there were no incidents which should have been documented as a violation of a code of conduct and were not. Seven staff were interviewed regarding the working conditions of the center. Six of the seven staff reported they have never observed a co-worker use profanity when speaking to a youth. One of the seven staff reported they once overheard a co-worker use profanity while on the floor and the supervisor addressed the issue with the staff immediately and, therefore, has been the only occurrence. Each of the seven interviewed staff reported the working conditions at the center in

the past year have been good. All staff explained the process for allowing staff and youth to call the Florida Abuse Hotline or the Department's CCC to report suspected abuse.

Seven youth were interviewed, and each reported staff are respectful when talking with them and other youth. One youth reported once having overheard or witness a staff use profanity; however, the youth indicated it was not towards a youth. Additionally, each interviewed youth confirmed they have never been threatened by a staff or seen a staff member threaten another youth. The superintendent confirmed the center adheres to the code of conduct and indicated all internal investigation incidents are reported to the Florida Abuse Hotline/CCC. Furthermore, the superintendent indicated staff are held accountable and are subject to disciplinary action inclusive of oral/written reprimands, suspensions, and up to termination.

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 a written policy and procedures in place regarding incident reporting. A tour of the center was conducted, and observations reflected there were signs posted throughout the center of the Florida Abuse Hotline and the Central Communications Center (CCC) telephone numbers. The center had forty-six incidents reported to the CCC during the last six months, of which five were reviewed. The center maintains a current CCC logbook which documented all reviewed incidents. A review of five incidents reflected all incidents were reported to the CCC within the mandatory two-hour time frame and in accordance with the CCC reporting procedures. The center maintains a master control logbook for documenting reports to the CCC. Reviewed documentation reflected the center documented each incident in the center's CCC logbook. A review of internal incidents and grievances for the past six months determined there were no incidents which should have been reported to the CCC but were not. The center documents incidents not accepted by the CCC. An interview was conducted with the center's superintendent confirmed all staff must contact the Department's CCC for all reportable incidents. Direct-care staff notify the shift supervisor and administrative staff are authorized to make calls to the CCC.

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

The center has a policy and procedures pertaining to the use of Protective Action Response (PAR). The center had 276 PAR incident reports within the past six months, of which twenty-eight were reviewed. Each of the twenty-eight PAR reports contained a review by a PAR certified instructor and documented a post-PAR interview was conducted with the youth within thirty minutes after the incident. Twenty-eight of the reviewed PAR reports contained statements from all staff involved by the end of the staff's workday. None of the reviewed reports required a PAR medical review as a result of serious injury to the youth or staff. Each of the reviewed PAR reports contained a review of the PAR incident report by the superintendent or a designee within seventy-two hours of the incident to determine if use of force was consistent with policy. Each

report was maintained electronically in the Facility Management System (FMS) within the Department's Juvenile Justice Information System. None of the reviewed reports required a report to the Department's Central Communications Center (CCC) and there was no documentation to support any involved youth made or required a report to the Florida Abuse Hotline. Logbooks, internal incident reports, and grievances were reviewed, and documentation did not reveal any additional PAR incidents occurred.

The center's PAR rate during the annual compliance review period was 16.60, which is above the statewide Detention PAR rate of 16.56. An informal interview with the assistant superintendent was completed, regarding the increase in the number of PARs since the last annual compliance review. The assistant superintendent advised the reason was multi-fold, as the center has had youth at the center for a duration of at least a year or more and reports there are new youth who are admitted to the center with their co-defendants and they tend to accuse each other. The assistant superintendent reported another reason for the increase in PARs is due to the center having numerous youth with gang affiliations and neighborhood associates who create disturbances, which creates a need for staff to physically intervene. Furthermore, the assistant superintendent informed the center has many new officers and they are receiving all the training and additional training throughout the year and time must be provided to allow the officers to settle into their positions.

An interview with the superintendent confirmed the process for monitoring PAR incidents, the use of force, and the utilization of physical and mechanical restraints in accordance with Florida Administrative Code. The superintendent informed the use of mechanical restraints must be approved by the regional director and if utilized, the officer must then complete a mechanical restraint log and ensure circulation checks are completed within every ten minutes. The superintendent informed a review of all PAR reports are completed by a PAR certified instructor/supervisory staff and all post-PAR interviews are conducted with the youth by the superintendents or designee thirty-minutes after the incident and the superintendent or designee will review the incident within seventy-two hours. Seven staff were interviewed, and each indicated staff utilize verbal interventions before use of physical restraints or PAR techniques on youth.

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

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

phase two of the pre-service training requirements. All training was conducted by qualified trainers and documented in the Department's Learning Management System (SkillPro) within thirty days of training completion.

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 maintains a written policy and procedures which requires staff to complete at least twenty-four hours of annual in-service training beginning each calendar year after completion of certification with supervisors requiring an additional eight hours of supervisory training annually. The center provides in-service training for staff through a combination of instructor-led courses and web-based courses in the Department's Learning Management System (SkillPro). Seven applicable staff training records, which included two juvenile justice detention officer supervisors (JJDOS) training records, were reviewed for in-service training. Each staff training record documented the staff exceeded the twenty-four hours of in-service training requirements. Reviewed documentation reflected each staff received refresher trainings in Protective Action Response (PAR), cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), and first aid. Reviewed training records reflected each staff completed six hours of suicide prevention training, of which four hours were instructor-led training and two hours were training in SkillPro, as well as an active shooter training and training on professionalism and ethics.

Two JJDOS training records were reviewed for the completion of the eight hours of management and supervisory training inclusive of management, leadership, personal accountability, employee relations, and communications skills. Each of the reviewed supervisory staff completed epinephrine auto-injector and medication administration trainings. An interview with the center's superintendent confirmed staff are required to complete suicide prevention, PAR, CPR, and first aid training annually and for management staff to complete all leadership trainings. Each of the reviewed training records confirmed in-service training was documented in SkillPro within thirty days of training completion with the exception of one JJDO's training record where one training item was not added to SkillPro, after completion.

1.08 Grievances	Satisfactory Compliance
The grievance procedures establish each youth's right to grieve and ensure all youth are treated fairly, respectfully, without discrimination, and their rights are protected. The process includes: 1. *Informal phase, wherein the JJDO attempts to resolve the complaint or condition with the youth using effective communication skills;* 2. *Formal phase, wherein the youth submits a written grievance resulting in a response from a JJDO Supervisor by the end of the shift (if possible), or otherwise within twenty-four hours; and* 3. *Appeal phase, wherein the youth may appeal the outcome of the formal phase to the superintendent or designee.*	

The center maintains a written policy and procedures ensuring all youth are treated fairly, respectfully, and without discrimination. The center ensures all youth have the right to file a

grievance. The grievance process is posted in each module and throughout the center, and it is explained to each youth during the admission and orientation process. The grievance process consists of three phases. The first step in the process is the informal phase which is completed by detention staff whereby the youth and staff attempt to resolve the youth's issue. A written grievance will be submitted to the juvenile justice detention officer supervisor (JJDOS) if the staff is unable to resolve the issue which begins the formal grievance process. The appeal phase requires a response from the superintendent or designee. Grievance forms are electronically kept in the Facility Management System (FMS) for at least one year. Each grievance is forwarded to the on-duty JJDOS within the required time frame, through the FMS, and the youth is informed of the findings by the end of the shift. Reviewed documentation reflected the center had two grievances submitted within the past six months and nine grievances had been filed within the last twelve months. Five reviewed grievances confirmed four grievances were resolved at the formal phase and one was resolved in the appeal phase. Each grievance was forwarded to the on-duty JJDOS within the required time frame, through the FMS, and the youth was informed of the findings by the end of the shift.

An interview with the superintendent indicated the grievance process has three phases; an informal phase where the juvenile justice detention officers (JJDO) attempts to resolve the complaint, the formal phase where the youth submits a written grievance resulting in a response from a shift supervisor within twenty-four hours. The superintendent indicated the last phase is the appeal phase, where the youth has the right to appeal to the superintendent or designee. Seven youth were interviewed regarding the grievance process. Six of the seven interviewed youth recalled being explained the grievance process, and one youth did not recall the grievance process. Five of the seven interviewed youth stated they have never submitted a grievance and two indicated they would rate the grievance process as good. Seven interviewed staff confirmed to each have knowledge of the grievance procedure and were able to explain the center's grievance process.

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

Superintendents shall ensure critical and special alerts are reviewed and responded to appropriately.

Upon completion of the Admission Wizard, the officer shall ensure all critical and special alerts are listed in JJIS.

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

If the electronic system is inoperable, for any reason, the juvenile justice detention officer supervisor (JJDOS) shall ensure the last hard copy of the alerts shall have a written notification or update of the recent admissions or changes to existing alerts on the alert sheet and distribute to all staff within the center immediately.

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

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

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

The center maintains a written policy and procedures ensuring alerts are entered into the Department's Juvenile Justice Information System (JJIS) and the use of an internal alert system. Critical and special alerts are reviewed, updated, and responded to appropriately. The JJIS alert report is printed and reviewed daily by supervisors and administrators. JJIS alert reports and internal alerts are distributed to and are reviewed daily by the juvenile justice detention officer supervisors and administration. The center's practice is to have all direct-care staff maintain a copy of the detailed alert list on their person during their shift. A current alert list is maintained in the medical clinic and kitchen. A review of seven youth records found twenty-three alerts entered into the center's internal alert system and the JJIS alert system. Logbooks and shift reports were reviewed and reflected alert documentation.

Seven staff were interviewed, and each confirmed they are informed of all alerts through either JJIS, alert forms and printed for staff and staff are notified of the youth's alerts through memos, during daily shift debriefings. All seven staff reported all information from management is distributed through at the all-staff meetings. A shift briefing was observed during the annual compliance review week and alerts were observed to be reviewed with staff, as required. An interview with the center's superintendent was conducted and confirmed the medical alerts process, indicating all alerts are entered at the time of admission when parents/guardians or the juvenile probation officer (JPO) provides any medication or medical information to the center. Additionally, this information is confirmed and verified between the medical staff and the parent(s) or guardian(s).

Standard 2: Assessment and Performance Plan

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

The center maintains a written policy and procedures ensuring proper screening, evaluation, and documentation is provided for each youth admitted into secure detention. A review of seven active youth case management records found each record had a Secure Detention Admission Wizard completed in the Department's Juvenile Justice Information System (JJIS) which contained all the required admission elements. Each reviewed youth record contained the arrest affidavit or order to take into custody, a completed Detention Risk Assessment Instrument (DRAI), and a Suicide Risk Screening Instrument (SRSI). Reviewed documentation confirmed all seven youth were frisk searched, electronically searched, and full body visual searched by an officer of the same gender as the youth. Each of the records documented the youth made a telephone call to the parent/ guardian, at the center's expense, and received a meal or snack within the required time frame. Each reviewed record validated the youth received medical, mental health, and substance abuse admission screenings. When the youth admission process was completed, the youth received a sheet, a blanket, a toothbrush, and a comb. Then youth were taken to the assigned module, met the officers, and received a complete explanation of the daily schedule. During the annual compliance review, an admission was not able to be observed.

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

The center maintains a written policy and procedures ensuring youth are advised of the center's rules, regulations, expectations for behavior and related consequences for failing to meet those expectations, and youth rights through the orientation to the center within twenty-four hours of the youth admission into the center. A review of seven active youth case management records revealed each record included an orientation brochure signed by the youth and the juvenile justice detention officer (JJDO). The brochure covered information related to sick call, visitation schedule, and a copy of the center's handbook which contained staff information, medical care, mental health care, dress code, personal hygiene, searches, behavior management system, grievances, meals, fire evacuation plan, visitation, telephone and letter writing, admission, education, religious programs, and the Florida Abuse Hotline and the Department's Central Communications Center (CCC) telephone numbers. Each reviewed youth record documented the orientation was explained to the youth verbally and in writing by a JJDO. Each youth signed the orientation documentation acknowledging they received the complete orientation information and documentation. All seven interviewed youth confirmed when they came to the center, they received information regarding the center's rules, regulations, daily schedule, education services, visitation, abuse reporting, and behavior management system. An interview with an assistant superintendent (AS) indicated the center utilizes an orientation videotape for Prison Rape Elimination Act (PREA).

2.03 Classification	Satisfactory Compliance

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

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

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

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

The center maintains a written policy and procedures ensuring all youth admitted to the center are classified by the admitting officer to provide the highest level of safety and security. The center's policy listed all the elements required, including human trafficking information. The policy indicates youth must be assigned to a room based upon the youth's classification and are reclassified if changes in behavior or status are observed. Living areas and room assignments must be documented in the Department's Juvenile Justice Information System (JJIS) and in all applicable admissions paperwork and logbooks. JJIS must be utilized to document a single room only (SRO) youth classification. Youth with a history of committing sexual offenses, a victim of a sexual offense and/or abuse, or youth determined to be physically or sexually aggressive are not to be placed in a room with any other youth. In addition, the policy requires a review of the vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) results documented by the staff making a youth's room assignment.

The center's policy requires the center identify the juvenile probation officer (JPO) designated as the circuit's gang representative to communicate suspected gang activity. A review of seven youth case management records for classification found each record contained a copy of the Department's Admission Wizard, a booking classification form signed and dated by the juvenile justice detention officer supervisor (JJDOS), a copy of the completed VSAB, and the Suicide Risk Screening Instrument (SRSI). One of the seven youth records contained a classification form which not identify the module or room the youth was placed. An informal interview was completed with assistant superintendent and validated youth are classified utilizing several factors. Any youth with mental health issues may be placed on precautionary observation (PO), and youth with physical or cognitive performance issues will be placed on special needs status.

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

The center maintains a written policy and procedures ensuring gang information is shared with the identified juvenile probation officer (JPO) assigned as the circuit's gang representative. The center has designated one juvenile justice detention officer II (JJDOII) to serve as the gang representative for the center, who communicates with the JPO gang liaison and shares all information regarding suspected gang activity. The center's gang representative notifies the JPO gang representative and the Miami-Dade Police Department's intelligence analyst of any gang activity by electronic mail (e-mail). Staff are notified daily during shift briefings of all updates regarding youth with gang affiliations and applicable gang alerts. An informal interview completed with the assistant superintendent confirmed the practice. Seven youth case management records were reviewed, of which three were applicable for gang involvement. Each applicable reviewed record contained a corresponding e-mail to the Miami-Dade Police Department and the JPO. The center has a gang members notification binder. The binder contained a picture of each youth with suspected of gang affiliation, as well as a copy of the youth's face sheet and special alerts. Documentation reviewed found the police department's intelligence analyst consistently sent arrest reports and information for each of the applicable youth. In addition, the center received gang member notifications from the intake officer.

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

The center has a written policy and procedures related to ensuring the safe handling and security of each youth's personal property including valuables, which are collected and secured at the time of a youth's admission. The policy indicates the superintendent is responsible to ensure the youth's personal property and valuables are maintained in accordance with the center's policy and all staff are authorized to complete intake and release procedures. Intake staff are responsible for ensuring all youth property is inventoried on the Department's Juvenile Justice Information System (JJIS) property sheet. The policy indicates if the youth is wearing a medical identification bracelet or necklace, it is not to be removed. The center's procedures mandates youth property can be released to the youth's parent/guardian at any time during the youth's stay in the center, and if the youth or parent/guardian cannot be located, a money order shall be sent to the regional fiscal manager and a record must exist for any property disposed of or cash forwarded to headquarters. Any personal valuable items such as money, cellular telephones, and jewelry are placed in a clear, tamper-proof bag. The tamper-proof bag includes the date, name of the youth, Department's identification number (DJJID), a list of the items, and the name of the juvenile justice detention officer (JJDO) who secured the property. The property must be placed in the center's valuable drop safe and documented in the logbook. The youth's

clothing and shoes are placed in a garment bag and identified with the youth's name, DJJID, and complete list of the including items. The garment bag is placed in the center's secure property room under camera surveillance with limited staff access. Seven reviewed youth case management records each contained an itemized personal property receipt signed by youth and staff. All personal property was documented in the logbook. None of the youth refused to sign the property receipt form. Seven interviewed youth confirmed when they arrived at the center, staff checked their personal property and then had them sign a form stating the personal property is correct.

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.	

All youth personal and valuable property are inventoried in the Department's Juvenile Justice Information System (JJIS), maintained securely, and returned to the youth or the parent/guardian in a timely manner upon the youth's release. Observations of the storage area for youth personal property found youth clothing and shoes were placed in a garment bag with a property inventory attached and secured in a locked property room. The property room contains a safe where all the youth's personal valuable property is maintained. The property room is equipped and monitored by surveillance cameras. All property received by the center was documented in a bound safe logbook. The property room is accessible by the superintendent, assistant superintendents, and the juvenile justice detention officer supervisors. The center's procedures included a clear process related to the disposal of unclaimed property. The property is maintained in storage until the youth is released, or the youth's parent/guardian reports to the center to remove the property. After thirty days of a youth's release, a Notice of Impending Disposal of Property is mailed to the youth's last known address. A review of the Department's Central Communications Center (CCC) logbook and CCC incident reports from the previous six months found there were no incidents of lost or stolen property during the annual compliance review period. An interview with the assistant superintendent indicated there were no CCC reports or incidents related to youth property since the last annual compliance review.

2.07 Release	Satisfactory Compliance

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

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

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

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

The releasing officer shall verify the identification of the youth.

The center maintains a written policy and procedures addressing youth releases from the center. The juvenile justice detention officer (JJDO) and the assigned juvenile justice detention officer supervisor (JJDOS) completing the release shall verify the court authorization prior to releasing the youth. The JJDOS is responsible for verifying there are no holds, court orders, or any other legal reasons not to release the youth from the center. Each parent/guardian is notified and confirms the release, and a copy of the parent/guardian photo-identification card is placed in the youth's case management record prior to release. A review of three applicable closed youth case management records revealed each record contained an eight-step youth release checklist utilized for each youth release. Each checklist reviewed was initialed and dated by the applicable shift commander. Each record contained the appropriate documentation including the Department's Detention Release Wizard signed by the youth's parent/guardian or person taking custody of the youth, the court's authorization to release, a copy of the photo-identification card of the person taking custody of the youth, youth check list, and notifications. Each reviewed close record contained documentation confirming the youth's admission and termination dates, which correlated with the information in the Department's Juvenile Justice Information System (JJIS). Each youth was processed for release and verified receipt of all documented property according to the property receipt form, and youth and parent/guardian reviewed and signed the form. A review of the Department's Central Communications Center's (CCC) reports from the past six months and an interview with the assistant superintendent found there were no documented unauthorized releases at the center.

2.08 Release of Youth Personal Property	Satisfactory Compliance

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

The center has a written policy and procedures to ensure all youth personal property is released to the youth or the youth's parent/guardian. The parent/guardian, youth, and staff must sign a receipt acknowledging all property was returned upon release. Upon admission, youth sign a Property Letter of Acknowledgement, acknowledging the unclaimed juvenile property process. A review of three applicable closed youth case management records found each youth's

parent/guardian reviewed, dated, and signed the Department's Detention Release Wizard. All three youth case management records documented signatures of the youth, parent/guardian, and the staff on the Personal Property Receipt form. Reviewed youth property documentation revealed the center utilizes the Department's Thirty Day Notice of Impending Disposal of Property form sent to the youth's parent/guardian. When the youth's parent/guardian fails to pick-up or arrange for the return of the property, the property is considered abandoned and is disposed of according to center's policy and Florida Statue. There were no applicable reports made to the Department's Central Communications Center (CCC) for the past six months regarding lost or missing property.

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

The center maintains a written policy and procedures ensuring prescription drugs are given to the person to whom the youth is released to and documented on the release forms, as well as the Medication Release form which is completed and given to the medical office. A review of three closed youth case management records found the Department's Juvenile Justice Information System (JJIS) Detention Release Wizard confirmed none of the youth had medication upon release. The center reported there were no applicable youth for release with medication during the annual compliance review period. Each of the three reviewed records revealed medical, mental health, and/or substance abuse needs, as well as any pending appointments and instructions were provided to the youth and the youth's parent/guardian, when applicable, upon the youth's release. Documentation reviewed found all required parties signed and dated all applicable release forms.

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

The center maintains a written policy and procedures ensuring the center conducts detention reviews on a weekly basis to ensure youth are held in secure detention for the shortest time possible. The center has a juvenile justice detention officer II (JJDO) appointed as a detention review specialist to coordinate the weekly detention reviews. The purpose of the detention review meetings is to determine proper placement of the youth currently detained in the center or who have been placed on home detention. Documentation reviewed and an interview with the detention review specialist revealed the center conducts detention reviews on a weekly basis and the detention reviews have been held by telephone, since March 15, 2020, due to the COVID-19 pandemic. The detention review specialist indicated effective January 1st, 2021, the detention review meetings will be conducted virtually utilizing the Microsoft Teams application. Reviewed documentation from the past six months of detention reviews found consistent participation by all parties who have responsibility for the youth in each review. The center utilizes a follow-up form to ensure all issues or updates from previous meetings have been corrected or addressed. Placement status and updates regarding youth awaiting placement in a commitment program were discussed. Observations of the detention review process and an interview with the assistant superintendent confirmed the center's detention review practice.

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

The center maintains a written policy and procedures ensuring youth participate in constructive activities by maintaining a daily schedule which is posted in all living areas, and includes weekdays, weekends and holidays, and incorporate both structured and free time. Center staff must adhere to the daily schedule including gender-specific programming. Observations confirmed the center provides and maintains a weekday, weekend, and holiday schedule posted in all living areas. The schedule indicated the time frames of each daily activity provided to the youth on a regular basis including wake-up, personal hygiene, education, mealtimes, visitation, volunteer programing, large muscle exercise, shift change, bedtimes, groups, and open program times. The center offers youth the opportunity to participate in activities including decorating the modules for the holidays, and mural painting along with the designated muralist who designs and creates the artwork within the courtyard of the center. The center is equipped with a large gymnasium where most of the large muscle exercises are conducted. Interviews conducted with seven youth confirmed the center has a daily activity schedule which is followed each day. Interviews completed with seven staff revealed the center has a daily activity schedule which offers gender-specific programming as part of the daily schedule. Each interviewed staff indicated parent/guardian visitation stopped approximately in March 2020, due to the COVID-19 pandemic; however, visitation resumed at the beginning of September 2020.

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

The center maintains a written policy and procedures ensuring staff adhere to the daily activity schedule, including all the required elements of gender-specific programming. Any significant changes to the schedule must be approved by the shift supervisor and the reason for the changes must be documented on the shift report. Observations and reviewed logbooks found staff adhered to the daily activity schedule. Any significant changes to the schedule was approved by the applicable on-duty shift supervisor, and the reasons for the change was documented in the shift reports. A review of the shift reports for the previous six months verified there were no significant changes in the activity schedule besides the interruptions caused by the COVID-19 pandemic. Educational services were available to every youth and the youth attended school according to the guidelines established by the Miami-Dade County Public Schools Board and the Centers of Disease Control and Prevention (CDC) guidelines. Seven interviewed youth indicated the center’s daily schedule is followed. Seven interviewed staff indicated they are informed of any schedule changes, through the staff debriefings and meetings.

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 maintains a written policy and procedures ensuring integration of the educational instruction into the daily schedule in such a way which ensures the integrity of required instructional time. The center's education program is directly managed by the Miami-Dade County School District. It operates on a year-round basis providing 250 days of instruction distributed over twelve months, with a minimum of twenty-five hours weekly, including ten days of teacher professional development. A review of the weekly and annual academic calendars, as well as input from the interviews with the lead teacher and superintendent, confirmed this practice. According to the center's logbook entries, there were minimal interruptions during educational classes. Youth completed all assigned class work, as well as earned academic credits for participating in classes.

Reviewed documentation revealed the center has twenty-eight staff assigned to the Juvenile Justice Center School (JJCS). Observations of the center's educational practice found teachers were on-site; however, due to the COVID-19 pandemic, all youth have been receiving virtual school classes utilizing video conferencing. The youth receive remote instruction from teachers utilizing Zoom from within the center. Classes are conducted Monday through Friday, as well as every other Saturday, from 7:50 a.m. to 2:40 p.m., with one lunch break. Interviews completed with the lead Exceptional Student Education (ESE) teacher and other educational staff indicated the virtual classes began in March 2020, up to now, based on the Centers for Disease Control and Prevention (CDC) and the Miami-Dade County Public Schools Board guidelines in order to minimize the COVID-19 risk to the health and safety of both the youth and center's school staff. An interview with the school principal confirmed the center's practices. Interviews completed with seven youth indicated the center is preparing them for General Equivalency Diplomas (GED), high school, vocational school, employment, and/or college very well. All the seven interviewed youth confirmed they attend school Monday through Friday while in the center. The youth indicated they received mathematics, science, history, reading, social studies, and business, geometry, English II, computer, and language arts classes at the center.

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

The center maintains a written policy and procedures ensuring on-going collaboration of the center with the Miami-Dade School District to ensure implementation of a career educational competency development program. The center provides appropriate career education to the youth based upon, the youth's age, as well as the assessed cognitive and educational abilities. The career education component offered is categorized as a Type 1 Career Vocational curriculum. This classification, which stresses soft skills, includes activities centered on, but not limited to, communication, decision making, and interpersonal skills. Furthermore, this component provides the youth through various exercises, employment investigation, as well as life skills guidance to deal directly with exploring career choices.

2.15 Trauma-Informed Care	Satisfactory Compliance

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

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

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

The center maintains a written policy and procedures ensuring the incorporation of the trauma-informed practices into the current operations of the center, to deliver services, and to provide care to the youth in secure detention, acknowledging the role to which violence and victimization play in the lives of most of the youth entering the center. Observations during the annual compliance review and reviewed documentation confirmed the center has incorporated trauma-informed care practices into the current operations of the center. A review of the Department's Juvenile Justice Information System (JJIS) daily alert log identified youth with traumatic history and this information is placed in the center's internal alert system. Reviewed training documentation revealed for fourteen staff (seven pre-service and seven in-service) completed training in trauma-informed care as part of the pre-service and in-service training requirements. In addition, the center is diverse and has several staff with different cultural backgrounds and who speak different languages which helps the youth to understand the rules and procedures of the center. Observations of the center during the annual compliance week confirmed the center utilizes one room in module girls one (G1) as a soft room. The soft room was observed and was decorated with soothing colors and art murals. In addition, the center has a youth living environment, where a majority of the areas observed, were painted in soothing colors, and multiple inspirational wall paintings and murals were painted outside of the modules and throughout the courtyard area. The center has a dog therapy program, and Justice, the center's certified therapy dog continues to provide comfort and recreation for the youth, as needed.

Standard 3: Mental Health and Substance Abuse Services

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

The center maintains a policy and procedures ensuring there is a single licensed mental health professional appointed as the designated mental health clinician authority (DMHCA) who is responsible for the coordination and implementation of mental health and substance abuse services. The policy was approved by the superintendent and the designated mental health clinician authority (DMHCA) on September 2, 2020. The Department maintains a contract with Camelot Community Care, Inc. to provide mental health and substance abuse services to all applicable youth in the center. Camelot Community Care, Inc. provides a licensed mental health counselor to serve as the center's DMHCA and holds a clear and active license in the State of Florida, under Chapter 491, with an expiration date of March 31, 2021.

The DMHCA is full-time and scheduled to be on-site forty hours each week, Monday through Friday, from 11:00 a.m. to 7:00 p.m. A review of the Medical and Mental Health Logbook sign-in sheets confirmed the DMHCA was on-site, as required. The DMHCA is available seven days a week, twenty-four hours a day, by way of telephone for consultation. A review of the Camelot Community Care, Inc. job description found the DMHCA is responsible for oversight of all clinical and administrative operations ensuring clinical quality and integrity of the therapeutic program. An interview with the DMHCA indicated they are responsible for the overall direction, coordination, and evaluation of the mental health department and the four non-licensed master's-level therapists. The DMHCA assures the clinical quality and integrity of the therapeutic program as required by all applicable standards, regulations, and policies. The DMHCA identifies and analyzes problem areas in order to improve quality of care and oversees and monitors the implementation of therapeutic interventions utilized in the center. The DMHCA works directly with the psychiatrist and provides face-to-face updates once a week on applicable youth receiving services to discuss behaviors, progress, and applicable medications. Reviewed documentation supported the DMHCA, non-licensed therapist, psychiatrist, registered nurse, and program administration meet weekly for mini-treatment team meetings. The program has a back-up DMHCA in the event of scheduled leave and/or absences. The back-up DMHCA is a licensed clinical social worker, licensed under Chapter 491 in the State of Florida, with an expiration date of March 31, 2021.

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

The center maintains a written policy and procedures ensuring services are provided by individuals with appropriate qualifications. The designated mental health clinician authority (DMHCA) ensures the center's non-licensed master's-level therapists are working under direct

supervision and providing services they are qualified based on education, training, and experience. The policy was approved by the superintendent and the designated mental health clinician authority (DMHCA) on September 2, 2020.

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

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

The center maintains a written policy and procedures ensuring metal health and substance abuse services are provided by individuals with appropriate qualifications. The clinical supervisor ensures the clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience. The policy was approved by the superintendent and the designated mental health clinician authority (DMHCA) on September 3, 2020. The center is licensed through the Department of Children and Families under Chapter 397 to provide outpatient substance abuse treatment services through April 1, 2021.

The center has four non-licensed master's-level mental health and substance abuse clinical staff who work under the direct supervision of the licensed mental health counselor (LMHC). The LMHC serves as the center's designated mental health clinician authority (DMHCA). The non-licensed master's-level clinicians hold degrees in counseling, social work, counseling psychology, and forensic psychology, respectively. One clinician is a registered mental health counselor intern in the State of Florida with an expiration date of March 31, 2022. Two clinicians are scheduled to work Monday through Friday, 9:00 a.m. to 5:00 p.m., one clinician is scheduled to work Monday through Friday, 10:00 a.m. to 6:00 p.m., and one clinician is scheduled to work part-time on Tuesday and Thursday, 10:00 a.m. to 6:00 p.m. Two clinicians rotate every other weekend to provide on-site services for approximately sixteen to twenty hours.

A review of training records supported each non-licensed therapist completed the twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. The training included five Assessments of Suicide Risk

(ASR) or crisis assessments conducted on-site in the presence of the DMHCA. A review of direct supervision logs verified the DMHCA provided at least one-hour of weekly face-to-face supervision documented on the Department's Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log form. The reviewed forms reflected a review of the clinician's case load, clinical services provided, documentation, miscellaneous directions, instructions, and recommendations. Reviewed documentation supported each ASR completed by the non-licensed clinicians were reviewed by the DMHCA within twenty-four hours of the referral for assessment.

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

The center maintains a written policy and procedures ensuring the mental health and substance abuse needs of youth are identified through a comprehensive screening process in which referrals are made when youth are identified with mental health and/or substance abuse needs or are identified as a possible suicide risk. The superintendent has established procedures addressing a thorough review of each youth's preliminary screening conducted by the juvenile probation officers and existing documentation of mental health or substance abuse problem needs or risk factors, administration of the Suicide Risk Screening Instrument (SRSI) upon the youth's admission, and referral to the center's mental health and substance abuse clinical staff. The policy was approved by the superintendent and the designated mental health clinician authority (DMHCA) on September 3, 2020.

A review of seven youth mental health and substance abuse records indicated while the youth were in the juvenile assessment center (JAC), the juvenile probation officers (JPO) completed the mental health, substance abuse, and suicide risk screenings utilizing the SRSI and the Massachusetts Youth Screening Instrument - Second Version (MAYSI-2) assessments. Reviewed documentation supported the center's staff reviewed all prior documentation completed by the JPOs when the youth were admitted to the center. The SRSIs and MAYSI-2 assessments were completed for each youth upon intake electronically in the Department's Juvenile Justice Information System (JJIS).

Each of the seven SRSIs were reviewed by a mental health clinical staff and documented their recommendation. Each of the SRSIs had completed entries which included a summary and recommendations in the screening results section. None of the reviewed records documented a history of suicide risk and/or an override due to the youth providing all negative responses. However, the center's practice is to place a referral for an Assessment of Suicide Risk (ASR) for each youth. Reviewed documentation supported each youth was placed on precautionary observation (PO) and remained on PO until the ASR was completed by the center's clinical staff. Center practice is to complete the Department's Mental Health and Substance Abuse Referral Summary form. The results of the ASRs indicated six of seven youth were placed on standard supervision and one youth remained on constant supervision. The center's staff completed the Department's Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) assessment for each youth upon admission. An interview with the

superintendent confirmed the intake officer is responsible for completing the detention officer portion of the SRSI for each youth.

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

The center maintains a written policy and procedures establishing an intake and admission screening process ensuring youth identified through preliminary screenings in the juvenile assessment center (JAC) or upon admission to the center with mental health and substance abuse issues or needs are referred for further in-depth mental health and/or substance abuse assessment. All youth identified by screening or by staff observations or behavior after admission are referred for further in-depth mental health and substance abuse evaluation. The center utilizes the Department's Mental Health and Substance Abuse Referral Summary form. Youth identified in the JAC as in need of further assessment are referred to a community provider for a comprehensive assessment. The policy was approved by the superintendent and the designated mental health clinician authority (DMHCA) on September 2, 2020.

The center maintains a contract with Camelot Community Care, Inc. to ensure youth identified during the preliminary screening process receive an in-depth mental health and/or substance abuse assessment shortly after intake. A review of seven youth mental health and substance abuse records reflected four were applicable for referral for mental health and substance abuse services. A review of the four applicable youth mental health and substance records supported each youth was screened, and a referral was made to Camelot Community Care, Inc. for a comprehensive mental health and substance abuse evaluation based on the Massachusetts Youth Screening Instrument - Second Version (MAYSI-2) assessment and/or Suicide Risk Screening Instrument (SRSI). Two youth received a new evaluation documented on the Substance Abuse and Mental Health Assessment (SAMH) form and two received an updated evaluation documented on the Revised Comprehensive Assessment Addendum and attached to the original comprehensive evaluation. Each evaluation was completed in full and contained all required information including the diagnostic impression, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, summary of findings, and recommendations. Reviewed documentation supported each was completed within thirty days of the youth's admission into the center.

The assigned juvenile probation officer is responsible for ensuring pre-disposition comprehensive evaluations for detained youth are forwarded to the center in a timely manner. Reviewed practice validated the clinical staff contacted the assigned juvenile probation officer by e-mail, requesting a status update on the comprehensive assessment completed by the community provider. The request is discussed during the weekly detention review meetings.

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

The center has a written policy and procedures ensuring all youth who receive mental health and/or substance abuse treatment while in the center shall have a discharge summary completed documenting the focus and course of the youth's treatment recommendations for mental health and/or substance services upon the youth's release. The policy was approved by the superintendent and the designated mental health clinician authority (DMHCA) on September 2, 2020. A review of the contract indicated mental health clinical staff are required to be on-site seven days a week. Reviewed schedules support clinical staff are on-site as required.

Seven youth mental health and substance abuse records were reviewed for mental health and substance abuse treatment services. One reviewed youth record was applicable for requiring a treatment plan. A review of two additional applicable youth records validated all three youth were assigned to a mini-treatment team and were referred for services utilizing the Department's Mental Health and Substance Abuse Referral Summary form. Each reviewed youth record was applicable for treatment with psychotropic medication management, individual therapy, supportive counseling, and family therapy sessions.

Reviewed documentation and observations confirmed each applicable youth requiring treatment was assigned to a mini-treatment team consisting of mental health, medical, education, nursing staff, direct-care staff, and administrative staff. The DMHCA maintained documentation of weekly treatment team meetings. Mini-treatment team was conducted in a multi-purpose room and was conducted weekly for youth receiving services. All three applicable youth records supported each youth had an initial treatment plan completed within seven days of initiation of treatment developed on the Department's Initial Mental Health/Substance Abuse Treatment Plan form. Each reviewed initial treatment plan was completed in full and addressed each youth's prescribed psychotropic medications.

Further review indicated there were four applicable youth requiring an individual treatment plan. Reviewed youth records documented the individualized treatment plan was developed within the required time frame and in full. The practice is to utilize the Department's Individualized Mental Health/Substance Abuse Treatment Plan form. Reviewed documentation supported two of the four youth required individual treatment plan reviews. One youth required one and the other youth required four and each was conducted as required. Reviewed treatment team review attendance logs validated reviews are conducted weekly. The other two were not in the center long enough to require a review. An interview with the DMHCA indicated there were no applicable youth who was an alleged victim of a Prison Rape Elimination Act (PREA) event.

A review of three applicable closed youth records supported a Mental Health/Substance Abuse Treatment Discharge Summary was completed for each youth. Reviewed documentation

supported a copy was provided to the youth, parent/guardian, and assigned juvenile probation officer.

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

The center maintains a written policy and procedures ensuring mental health and substance treatment planning focuses on providing mental health treatment and/or substance abuse treatment which will reduce or alleviate the youth's symptoms of mental disorder or substance abuse impairment and enable youth to function adequately in the juvenile justice setting. Each youth determined to need mental health treatment, including treatment with psychotropic medication or substance abuse treatment, must be assigned to a mini-treatment team. Youth may request to receive mental health and/or substance abuse treatment services. The policy was approved by the superintendent and the designated mental health clinician authority (DMHCA) on September 2, 2020.

Seven youth mental health and substance abuse records were reviewed for mental health and substance abuse treatment services and four were applicable for receiving treatment services. A review of the four youth records validated each applicable youth was assigned to a mini-treatment team and was referred for services utilizing the Department's Mental Health/Substance Abuse Referral Summary form. Each reviewed youth record was applicable for treatment with psychotropic medication management, individual therapy, supportive counseling, group therapy, and when applicable, family therapy sessions. Reviewed documentation confirmed each applicable youth requiring treatment was assigned to a mini-treatment team consisting of mental health, medical, education, direct-care staff, nursing, and administrative staff. Reviewed group therapy attendance logs for the last six months validated the clinicians conducted one to two groups each week.

The contracted psychiatrist provides tele-psychiatry services on Tuesdays from 2:30 p.m. to 4:30 p.m. and discusses each youth receiving services with the clinical team. The DMHCA brings the discussed information to mini-treatment team for further discussion. The DMHCA maintained documentation of weekly treatment team meetings. Each applicable youth receiving services had a valid Authority for Evaluation and Treatment (AET) form and proper consent for treatment and each signed the Department's Consent for Substance Abuse Treatment and Youth Consent for Release of Substance Abuse Treatment Records. Treatment notes were documented on the Department's Counseling/Therapy Progress Note form and in the Mental Health Chronological Notes. Seven youth were interviewed and six rated the mental health and substance abuse services provided as good and one youth indicated they were not receiving mental health and/or substance abuse services while in the center.

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

The center maintains a policy and procedures ensuring psychiatric services are provided to youth in need as indicated by symptoms of mental disorder or substance-related disorder, or youth who are being treated with psychotropic medication prior to or subsequent to admission. The policy was approved by the superintendent and the designated mental health clinician authority (DMHCA) on September 2, 2020, and the psychiatrist on September 3, 2020. The center maintains a contract with Camelot Community Care, Inc. for the provisions of a licensed psychiatrist to provide psychiatric services for applicable youth in the center. Camelot Community Care, Inc. provides a part-time psychiatrist. A review of the independent contract for psychiatric services signed on May 1, 2020 outlined for the provision of services for two hours each week. The psychiatrist is medical doctor with a clear and active license in the State of Florida under Chapter 458 which expires on January 31, 2022. Camelot Community Care, Inc. contracts with an osteopathic physician to serve as the back-up psychiatrist in the event the psychiatrist is on scheduled leave or out sick. The back-up psychiatrist has a clear and active license in the State of Florida under Chapter 459 with an expiration date of March 31, 2022. The center does not utilize a psychiatric advanced practice registered nurse (APRN).

Reviewed documentation and the Tele-Psychiatry Log validated the psychiatrist provided weekly services, as required, through tele-psychiatry. Due to the COVID-19 pandemic, the center began utilizing tele-psychiatry on April 7, 2020 and continues as of the annual compliance review. The center utilizes the Department's Mental Health/Substance Abuse Referral Summary form to request a psychiatric evaluation. The psychiatrist signs and dates the referral form. Psychiatric services include an initial diagnostic psychiatric interview, psychiatric evaluations, psychiatric follow-up assessments and consultations, coordination of services, crisis interventions, treatment planning, communication, and emergency procedures.

A review of seven mental health and substance abuse records indicated five youth were applicable for receiving psychiatric services. Each applicable record contained a current Authority for Evaluation and Treatment (AET) form. All five youth were admitted with prescribed psychotropic medications and each youth received an in-depth psychiatric evaluation which included all required elements. Each evaluation was documented on the Department's Clinical Psychotropic Progress Note (CPPN) and completed within one week of the youth's admission. All reviewed mental health and substance abuse documentation was completed utilizing the Department's required forms. Four of the five youth required Tardive Dyskinesia monitoring; however, only one youth had been in the center for thirty days or longer to require the monthly monitoring. Reviewed documentation supported monitoring was completed, as required.

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

The center maintains a written policy and procedures ensuring youth with elevated risk of suicide are safely screening, referred, monitored, and protected in the least restrictive means

possible. The policy was approved by the superintendent and the designated mental health clinician authority (DMHCA) on September 2, 2020. The plan outlines the center's procedures addressing the use of suicide precautions, suicide prevention training, and the process by which any youth identified as having suicide risk factors at any time must be placed on suicide precautions and receive an Assessment of Suicide Risk (ASR). The plan includes the identification and assessment of youth at risk of suicide utilizing the Department's ASR and Follow-Up ASR. The plan identifies the levels of supervision, referral process, communication, notification, and documentation requirements. In the event of a life-threatening suicide attempt, staff are to call 9-1-1 immediately. Decisions to use extra precautions are determined on a case-by-case basis based upon the individualized risk factors and needs of each youth. Clinical staff assist in training detention officers throughout the fiscal year on suicide prevention, including verbal and behavioral cues indicating a suicide risk. The plan outlined emergency contact telephone numbers to include the superintendent, on-call administrator, DMHCA, Miami-Dade Police Sheriff's Office, designated health authority, licensed mental health professional, psychiatrist, emergency room, crisis stabilization unit, and Poison Control. The plan is located in the superintendent's office, medical clinic, DMHCA's office, and is accessible to all staff on the center's network drive and SharePoint.

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

The center maintains a written policy and procedures addressing the use of suicide precautions, suicide prevention training, and the process by which any youth identified as having suicide risk factors at any time must be placed on suicide precautions and receive an Assessment of Suicide Risk (ASR). Youth placed on suicide precautions are maintained on one-to-one or constant supervision. The superintendent established a review process for every serious suicide attempt or serious self-inflicted injury requiring hospitalization or medical attention, and a mortality review for a completed suicide. The multidisciplinary review includes the circumstances surrounding the event, procedures relevant to the incident, training, pertinent medical and mental health services involving the victim, possible precipitating factors, and recommendations for changes in policy, training, physical plan, medical or mental health services, and/or operational procedures. The policy was approved by the superintendent and the designated mental health clinician authority (DMHCA) on September 10, 2020.

The center maintains seventeen suicide response kits. Observations found the kits located in each of the five sub-controls, medical clinic, intake office, master control, supervisor's office, and one in each of the eight vans.

A review of seven youth mental health and substance abuse records validated each youth was screened upon admission for suicide risk factors. Each youth was screened utilizing the

Department's Suicide Risk Screening Instrument (SRSI) and Massachusetts Youth Screening Instrument – Second Version (MAYSI-2). When further assessment is indicated by the SRSI or MAYSI-2 suicide ideation subscale, as well as any information obtained during the admission process which may suggest the youth is a possible suicide risk, the youth is placed on suicide precautions and constant supervision until the ASR is completed by the licensed mental health clinician or trained master's-level clinician. Reviewed documentation found each youth was identified with an elevated risk of suicide identified during the admission screening process.

Each of the seven applicable youth was placed on precautionary observation (PO) until the ASR was completed. Six of the ASRs were completed within twenty-four hours by a trained master's-level non-licensed clinician and one was completed by the DMHCA. Each ASR completed by a non-licensed clinician was reviewed by the DMHCA, as required. A review of the completed ASRs found six of the seven youth placed on PO were stepped down to standard supervision and one remained on constant supervision. A review of two additional applicable records of youth placed on PO due to staff observations found an alert was placed in the Department's Juvenile Justice Information System (JJIS) and a referral was made to the clinical staff utilizing the Department's Mental Health/Substance Referral Summary form. The mental health staff conducted a Follow-Up ASR prior to the removal of PO and down to Close Supervision. The conference with the superintendent and the DMHCA was documented and the discontinuation of close supervision was documented in accordance with the center's approved Suicide Prevention Plan.

A review of the center's logbook entries supported administrative and supervisory staff provided instructions related to the applicable youth's elevated suicide risk levels and precautions. The center utilizes secure observation for potentially suicidal youth. An interview with the superintendent indicated when a youth is on precautionary observation and actively trying to harm themselves, the youth will be placed on secure observation. All items are removed from the youth and an officer is assigned to the youth to maintain constant visual observation while the youth is in a secure room. The supervisor then completes the necessary documentation in JJIS, such as the health checklist, producing a secure observation log, and a JJIS incident report. The center's administration is notified of the incident.

An interview with the DMHCA indicated the center had only one applicable youth placed on secure observation in the last twelve months. Reviewed record supported the placement was authorized by the superintendent and the DMHCA. The secure room was designated, in writing, and the Department's Health Status Checklist was completed as required. The center staff completed the Suicide Precaution Observation Logs in their entirety and in real time. The youth was removed from secure observation within twenty-four hours of placement. A review of JJIS indicated the appropriate alert was entered and removed, as required. A review of the center logbooks validated the youth placed on precautions had documentation regarding the beginning and ending times of their precaution periods.

Seven interviewed staff indicated in the event a youth expressed suicidal thoughts, staff indicated they would notify the mental health authority and document the supervision. Six of seven staff responses included searching the youth and their room for sharp objects and placing the youth on constant sight and sound supervision. Five of the seven staff indicated additional responses to include entering alerts, complete room checks, notify the supervisor, and document the incident in the center's logbook. Seven interviewed staff indicated the suicide response kits are located in each sub-control. Six of seven interviewed staff indicated additional suicide response kits are located medical, in the school office, and inside each van.

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

The center maintains a written policy and procedures outlining staff supervision of youth placed on suicide precautions, one-to-one supervision, or when constant supervision must be maintained, including documenting the youth's behavior on the Department's Suicide Precautions Observation Log. The policy was approved by the superintendent and the designated mental health clinician authority (DMHCA) on September 2, 2020.

Seven reviewed youth mental health records found each youth was placed on precautionary observation (PO); however, the mental health clinical staff conducted the Assessment of Suicide Risk (ASR) immediately and subsequently placed six of the seven youth on standard supervision. Therefore, no Suicide Precaution Observation Logs were required for the youth placed on standard supervision. A review of two additional applicable youth records found a Suicide Precautions Observation Log was maintained for the duration each youth was on PO and each was reviewed and signed daily by the shift supervisor, as well as the mental health clinician. Reviewed documentation reflected staff observations did not exceed the required intervals and were documented in real time. There was one day, on Bravo-shift, where there were three documented thirty-minute checks were conducted late, varying from three to seven minutes beyond the required thirty-minute time frame. Safe housing areas were clearly documented on each log. The licensed mental health clinical staff conferred with the superintendent prior to revising the supervision level, which was recorded on the ASR in the date/time sections. The program had one youth detained who had been placed on PO at the time of the annual compliance review. The interviewed youth indicated when they were on suicide precautions, staff watched them the entire time. Seven interviewed staff indicated they received training in suicide prevention. A review of the three incidents of youth placed in secure observation validated the Secure Observation Logs were completed as required. A review of three applicable youth records of youth returning to the center from a Baker Act proceeding determined the Suicide Precaution Observation Logs were completed as required.

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

The center maintains a written suicide prevention plan outlining the training requirements for all staff who work with youth. The plan was approved by the superintendent and the designated mental health clinician authority (DMHCA) on September 2, 2020. Camelot Community Care, Inc.'s designated mental health clinician authority (DMHCA) assists in training juvenile justice detention officers throughout the fiscal year on suicide prevention, including verbal and behavioral cues indicating a suicide risk. The plan outlines all staff who work with youth must receive six hours of annual training on suicide prevention and implementation of suicide precautions. Suicide prevention trainings are completed and documented in the Department's Learning Management System (SkillPro). The plan reflects all staff with direct contact with youth, on a day-to-day basis, must participate in at least one quarterly suicide drill semi-annually. The drills are designed to practice responses to a suicide attempt or incident of serious self-injury.

A review of seven staff training records validated each staff completed at least two hours of suicide prevention training in SkillPro and four hours of instructor-led suicide prevention training. Reviewed documentation of suicide drills completed since the last annual compliance review reflected the center completed drills on Alpha, Bravo, and Charlie shifts at least quarterly with some shifts conducting drills more often. Reviewed documentation supported the center had seventy-two applicable staff requiring participation in a suicide drill semi-annually; however, reviewed documentation supported there was one staff who participated in one and not the second semi-annual drill, as required. Most staff participated in multiple drills. Staff who are not present during a drill have the opportunity to review each drill scenario, procedures, and critique in an effort to understand the process and receive the necessary training to respond to an incident of a suicide attempt or incident of serious self-inflicted injury. The provision of life saving measures such as cardiopulmonary resuscitation (CPR) was demonstrated at least one time on each shift and the use of a suicide response kit was documented for almost all reviewed suicide drills.

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

The center maintains a written mental health Crisis Intervention Plan ensuring the center will respond to youth in crisis in the least restrictive means possible to protect the safety of the youth and others while maintaining control and safety of the center. The plan was approved by the superintendent and the designated mental health clinician authority (DMHCA) on September 2, 2020. The plan details crisis intervention procedures including a notification and alert system, means of referral including youth self-referral, communication, supervision, documentation, and review. The center's procedures outline conducting a crisis assessment to evaluate a youth presenting with acute emotional or psychological distress which is extreme and does not respond to ordinary interventions conducted by a mental health clinician to determine the severity of the youth's distressing symptoms, level of risk to self or others, and recommendations for treatment and follow-up care. The Crisis Intervention Plan is placed in the superintendent's office, medical clinic, DMHCA's office, and is accessible to all staff on the center's network drive and SharePoint.

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

The center maintains a written Emergency Care Plan outlining mental health and substance abuse emergency procedures and ensuring youth who are believed to be an imminent danger to themselves or others because of mental illness or substance abuse impairment receive emergency mental health or substance abuse services. The plan was approved by the

superintendent and the designated mental health clinician authority (DMHCA) on September 2, 2020. The center's plan reflects the superintendent, assistant superintendent, and DMHCA are to review all critical incidents and discuss the circumstances surrounding the incident, center procedures relevant to the incident, and recommendations. The center's plan includes procedures for immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services (Baker Act or Marchman Act), documentation, and training. The center utilizes Citrus Health Network in Hialeah, Florida for Baker Act crisis stabilization and Marchman Act emergency substance abuse assessment and treatment. A review of seven staff training records supported each was trained on the center's emergency care plan. A copy of the approved plan is maintained in the superintendent's office, medical clinic, DMHCA's office, and is accessible to all staff network drive and on SharePoint.

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

The center maintains a written policy and procedures ensuring the center responds to youth in the least restrictive means possible to protect the safety of the youth and others while maintaining control and safety of the center. The plan was approved by the superintendent and the designated mental health clinician authority (DMHCA) on September 2, 2020. An interview was conducted with the DMHCA and the superintendent confirmed the center had one applicable youth requiring a Crisis Assessment in the last twelve months. Reviewed documentation reflected all phases of the center's Facility Operating Procedures (FOP) within the Emergency Care Plan were followed. The completed Crisis Assessment documented the reason, the youth's mental status, risk to self and/or others, initial clinical impression, supervision recommendations, treatment recommendations, and a follow-up evaluation. Notification of the youth's parent/guardian was documented, and an alert was entered into the Department's Juvenile Justice Information System (JJIS). The youth was placed on Standard Supervision. The Crisis Assessment was completed by the licensed mental health counselor (LMHC) and was reviewed by the center's superintendent the same day.

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

The center maintains a written policy and procedures ensuring there is a written plan which outlines mental health and substance abuse emergency procedures and ensure youth who are believed to be an imminent danger to themselves or others because of mental illness or substance abuse impairment receive emergency mental health or substance abuse services.

A review of seven youth mental health and substance abuse records found one youth who required crisis stabilization and was transported by law enforcement for Baker Act proceedings to Citrus Health Network in Hialeah, Florida. A review of two additional records of youth who received Baker Act proceedings in the last twelve months were reviewed. All three reviewed applicable records documented each youth was placed on suicide precautions prior to transportation to Citrus Health Network and upon return to the center. Each youth received a Mental Status Examination completed by the licensed mental health counselor. Each youth was placed on constant supervision until the completion of the Assessment of Suicide Risk (ASR) and subsequent Follow-Up ASR were completed and determined the youth was eligible to transition to a lower level of supervision. A review of the Department's Juvenile Justice Information System (JJIS) determined an alert was placed for each youth and two of the three youth had the alert closed prior to their discharge from the center. One youth was released while on constant supervision. Reviewed documentation supported the center notified the Department of Children and Families' caseworker of the youth's supervision level status.

Standard 4: Health Services

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

The center has a written policy and procedures to ensure clinical services are provided to youth who are in the center. The center has a contract agreement with Camelot Community Care, Inc. A licensed physician who served as the designated health authority (DHA) holds an unrestricted clear and active license which meets all requirements for independent and unsupervised practice in the State of Florida which expires on January 31, 2021. The DHA is a medical doctor who has specialized training in pediatrics. The center has an advanced practice registered nurse (APRN) who holds an unrestricted clear and active license to practice in the State of Florida and specializes in family health, one registered nurse (RN), and three licensed practical nurses (LPN) whom hold a valid unrestricted license to practice in Florida. The APRN is on-site fifteen hours a week and has collaborative practice protocols in place which are filed with the Department of Health and approved by the DHA. The DHA is on-site each Tuesday form the hours of 1:00 p.m. to 6:00 p.m. and at no time did more than nine days pass between on-site visits.

A review of the medical sign in and out logs for the past six months verified this practice. The DHA is available twenty-four hours a day, seven days a week to communicate with center's staff regarding youth medical needs, acute medical concerns, emergency care, and to coordination of off-site care. When the DHA is on vacation or on a scheduled absence, a substitute licensed physician is designated by the DHA to provide clinical services. A review verified the substitute physician is a medical doctor who holds an unrestricted clear and active license in the State of Florida which expires on January 31, 2021. An interview with the DHA indicated they are on-site once a week to perform Comprehensive Physical Assessments (CPA), periotic evaluations, sick calls, and procedure development. The DHA coordinates with the clinical manager regarding youth medical needs to ensure youth who receive off-site care are placed on the list for follow-up visit with the DHA.

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

The center has a written policy and procedures for all health-related procedures and protocols utilized at the center. The designated health authority (DHA) sign and date all respective written treatment policies and protocols. This process is followed each time a new policy, procedure, or protocol is developed and/or an existing one is changed. Nursing staff review, sign, and date a cover page on which all facility operating procedures (FOP), treatment protocols, and other procedures are listed. New policies or changes in policies made during the year are reviewed, signed, and dated by each nurse on each individual policy. An annual review of all FOPs and protocols is conducted which is demonstrated by the signature and date of the DHA. A review of the FOPs indicated the DHA reviewed the policy and procedures by signing and dating the FOPs on July 21, 2020. Further review of the protocols indicated the center's superintendent signed and dated the protocols and FOPs on July 21, 2020. All newly employed health care personnel receive a comprehensive clinical orientation to Department's Health Care policies and

procedures, given by the registered nurse. A review of the personnel records indicated a clinical orientation was provide to the nursing staff and each signed the FOP signature page indicating the training was received.

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 a written policy and procedures to ensures 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 original AETs are filed in the youth's individual healthcare record (IHCR) and are signed by the parent/guardian and witnessed by a Department representative. A review of seven youth IHCRs verified five records contained a valid copy of the AET signed by the parent/guardian and witnessed by a Department representative. Two youth were in the custody of the Department of Children and Families which required the youth to have a limited consent for treatment. A review of the two IHCRs indicated each contained a Limited Consent for Evaluation and Treatment. An interview with the nursing staff indicated medical staff reach out to the youth's juvenile probation officer (JPO) to obtain a copy of the AET. If an AET is not obtained, a call by nurse to the parent/guardian is conducted to obtain verbal consent in accordance with the emergency policy guidelines. The youth's parent/guardian is advised to come to the center at their earliest convenience to sign a hard copy of the AET. If the parent/guardian is not available, a court order is then obtained.

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

The center has a written policy and procedures to inform the parent/guardian of significant changes if the youth's condition and obtain consent when new medications and treatments are prescribed. Seven reviewed youth individual healthcare records (IHCR) found three were applicable. None of the reviewed IHCRs were applicable for over-the-counter (OTC) medication or vaccinations not covered by the Authorization of Evaluation and Treatment (AET) or had any changes to existing medication or psychotropic medication. Two records were applicable for new medication and two of the three records were applicable for emergency off-site care. In each instance, the correct health services form was utilized, the parent/guardian was notified by telephone, and a certified letter was forwarded explaining the changes of each youth's health status.

For the two-applicable youth with new medications, each of the parents/guardians were contacted by telephone and provided verbal consent for the youth to be administered the medication. A follow-up letter was sent to the parents/guardians to obtain written consent. None of the reviewed IHCRs required the parent/guardian to be notified of discontinued medication or youth being hospitalized. An interview with the nursing staff indicated parental notifications are obtained for dental and surgical procedures, vaccinations or any over the counter medications not covered by an AET, emergency care or any appointments. Parental consent is to be obtained prior to starting any new medication or changes in any medications.

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

The center has a written policy and procedures to ensure a Healthcare Admission Screening and Rescreening form is completed on each youth in the center. Seven youth individual healthcare records (IHCR) were reviewed and each IHCR contained a Medical and Mental Health Admission Screening Form completed by a juvenile justice detention officer (JJDO) on the date of admission. Each of the screenings were reviewed by the licensed practical nurse (LPN) within twenty-four hours of the screening. None of the reviewed youth had a change in physical custody since their arrival. Three applicable female youth who were sexually active received a qualitative urine pregnancy screening test, with their approval, upon approval. An interview with the superintendent indicated the doctor, nurse, and staff complete the healthcare admission screening form.

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

The center has a written policy and procedures to ensure each youth in the center receives an orientation to healthcare services and health education. A review of seven individual healthcare records (IHCR) indicated six IHCRs contained a general healthcare orientation completed on the Department Health Education form within twenty-four-hours of the youth admission. One youth's orientation was completed eighty-two days late. Each youth received the required orientation topics to include access to medical care, sick call process, emergency situations, medication process, right to refuse care, what to do in case of sexual assault or attempt sexual assault, non-disciplinary role of healthcare staff, and a review of a list of healthcare contacts.

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

The center has a written policy and procedures to ensure the designated health authority (DHA) is notified when a youth admitted requires emergency care or routine notification. A review of seven individual healthcare records (IHCR) indicated none required emergency care upon admission. An interview with nursing staff indicated if a youth requires emergency care upon arrival to the center, the supervisor and nursing staff contact the parent/guardian immediately. If the parent/guardian is unable to be contacted, the juvenile probation officer (JPO) is contacted. All contact and attempts are documented. Five of the seven IHCRs were applicable for youth identified with a chronic medical condition. In each instance, the DHA was notified within twelve hours of the youth's admission and notification was documented in the IHCR. Each of the five youth were referred to the advanced practice registered nurse (APRN) or the DHA. Three of the five applicable youth were on psychotropic medication at the time of admission. Each of the three applicable IHCRs indicated the psychiatrist was notified.

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

The center has a written policy and procedures to ensure each youth in the center has a standard Department Health-Related History (HRH) form completed. A review of seven individual healthcare records (IHCR) validated five contained a new HRH form and two contained an updated HRH form. Each form was completed on the most recent HRH form by a licensed nurse within seven days of the youth's admission and reviewed by the advanced practice registered nurse (APRN). Each reviewed HRH form was completed before the Comprehensive Physical Assessment (CPA).

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

The center has a written policy and procedures to ensure each youth in the center has a completed Comprehensive Physical Assessment (CPA). A review of seven youth individual healthcare records (IHCR) verified each contained a CPA completed within seven days of admission, were reviewed, and initialed by the advanced practice registered nurse (APRN). Each of the reviewed records documented a medical grade of two to five and were placed on the center's alert system. None of the seven reviewed records documented the youth refused any part of the exam and the Department's Problem List was updated. Each of the seven IHCRs documented tuberculosis skin test was completed. None of the reviewed youth required further evaluation prior to them entering general population.

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

The center has a written policy and procedures to ensure each youth in the center is evaluated and treated for sexually transmitted infections (STI). The center provides human immunodeficiency virus (HIV) counseling by the center's registered nurse (RN) who is certified counselor from the University of Miami Medical Center, for youth who consent to HIV testing. Seven individual healthcare records (IHCR) were reviewed, of which five were applicable. Each of the five IHCRs documented the youth admitted to being sexually active or were out of the custody of the Department thirty days or longer and were screened for an STI. Two of the five youth Comprehensive Physical Assessments (CPA) indicated the youth refused a gynecological examination; however, there was no signed documentation by the youth refusing the examination. Each of the five applicable youth required screening results to be documented on the youth's Infectious and Communicable Disease form located in the IHCR. Reviewed documentation confirmed each of the seven youth was offered counseling, testing, and treatment for HIV. Four youth consented to HIV testing and three youth refused, in writing, to have HIV testing. A review of the four applicable IHCRs verified written consent was obtained by the center, documented pre-test and post-counseling, and conducted by a certified HIV counselor. A review of the counselor credentials verified they were trained to provide the service. A review of the four applicable records validated the HIV results were placed in a

sealed envelope stamped, “Confidential” and filed in the youth’s IHCR. Seven youth were interviewed, and each stated they can ask for an HIV test.

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

The center has a written policy and procedures regarding sick call requests. The center conducts sick call seven days a week to respond to a youth’s medical illness or injury of a non-emergency nature by a healthcare professional. The shift supervisors are trained in the sick call procedures and will review the sick call request within four hours in the absence of the healthcare professionals. The center’s sick call hours are Monday through Friday from 9:00 a.m. to 12:00 p.m. and 5:00 p.m. to 9:30 p.m. Saturday and Sunday from 8:00 a.m. to 12:00 p.m. and 2:00 p.m. to 6:00 p.m. Youth who require a sick call will inform staff of their complaint and staff will generate a sick call request in the Department’s Juvenile Justice Information System (JJIS). A review of seven youth individual healthcare records (IHCR) found four were applicable for a sick call. Documentation in each of the four IHCRs indicated the sick call was conducted by the licensed practical nurse (LPN) and reviewed by the registered nurse (RN) within twenty-four hours, as well as documented on the Sick Call Referral Log. None of the reviewed youth presented a similar sick call complaint three or more times within a two-week period or complained of any severe pain which staff were unfamiliar.

A sick call was observed during the annual compliance review week. Prior to the observation, consent was obtained from the youth. The youth was escorted by direct-care staff to the clinic. The nurse identified their self and asked why the youth was there. The youth signed the sick call request log prior to the examination. The youth was examined in a private area where direct-care staff was able to maintain supervision. Seven staff were interviewed, and each stated the doctor and nurse conduct sick calls. One of the seven stated supervisors can review sick calls if medical staff is not on-site. Seven youth were interviewed on how quickly they can see the nurse. Five stated within one day and two have never requested a sick call. Seven youth were interviewed and stated the doctor and nurse conduct sick call. Seven youth were interviewed and three stated the medical services at the center is “very good,” two stated “good,” and two stated “fair.”

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 a written policy and procedures for the provisions of episodic care and first aid. The center utilizes an episodic care log to document episodic care and first aid treatment. The log documents the date and time of the treatment, nature of the complaint, person rendering aid, treatment, and if an off-sit care is needed. Seven youth individual healthcare records (IHCR) were reviewed, of which five were applicable for episodic care or first aid. Each reviewed applicable record contained a progress note identifying first aid or emergency care, the date and time of care, nature of the complaint, findings regarding care, and treatment rendered. Each of the five applicable IHCRs contained an off-site care referral and follow-up plans for future care, the youth was placed on the center’s alert list, and documented parental notification. None of

the reviewed youth received episodic care from a non-healthcare professional; therefore, a follow-up evaluation was not required by the licensed healthcare professional.

The center has seventeen first aid kits strategically located in areas frequented by youth. Eight of these kits are designated for the center's vehicles used to transport youth. Observations of four first aid kits from the living modules and vehicles verified each kit was stocked with approved supplies with no expired contents. Reviewed documentation confirmed the kits were monitored monthly by the nursing staff, and were replenished as needed.

The center has three automated external defibrillators (AED) located in the clinic, Dade I room, and Dade II room. Each AED is equipped with automated instructions. The nurse checks the AED monthly to ensure the devices are operable. A review of the AED check log for the past six months verified this practice. The AEDs are maintained by a contracted provided who checks the devices on an annual basis to ensure they are operable, and the battery and pads have not expired. According to the nurse, the provider was scheduled to check the devices on November 25, 2020. A follow-up call to the provider indicated, due to the COVID-19 pandemic, the company was short-staffed. The provider assured the center someone would be on-site on December 4, 2020 to service the devices. During the annual compliance review week, observations were conducted while the nurse completed a self-test on each of the devices. The battery and pads in Dade I room expire August 20, 2023 and March 28, 2021, respectively. The battery and pads in Dade II building expire August 2022 and April 28, 2021 respectively. The battery and pads in the clinic expire August 2022, and March 28, 2021, respectively.

The center conducts emergency medical drills at least quarterly on each shift and emergency drills including cardiopulmonary resuscitation (CPR)/AED are conducted once a year on each shift. Emergency and cellular telephone numbers are located in master control, on each module, and are accessible to all staff. A review of quarterly emergency drills from October 2019 to December 2020 verified the center conducted drills, as required. Seven staff training records verified staff received CPR/AED/first aid training. A review of the licensed healthcare staff records verified each healthcare staff maintains a current certification in CPR/AED. Seven staff were interviewed, and each stated they can call 9-1-1 if they feel it is necessary.

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

The center has a written policy and procedures to provide timely referrals for off-site healthcare. A review of seven individual healthcare records (IHCR) found three were applicable for off-site care. A Summary of Off-Site Care form was completed and discharge documentation was filed in the IHCR. In each instance of off-site care, the designated health authority (DHA) was notified to include the date and time of notification, signed each the off-site care findings, and each instance of off-site emergency care was documented on the episodic care log. One of the three applicable youth required follow-up care. Documentation verified a referral was entered on the Sick Call log and was tracked to ensure the youth received the appropriate follow-up care.

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

The center has a written policy and procedures to ensure youth with chronic conditions receive regularly scheduled evaluations and follow-up care. A review of seven youth individual healthcare records (IHCR) indicated each of the youth had a medical grade between two and five and were identified with a chronic condition. None of the youth were diagnosed with a communicable disease or were taking medication for tuberculosis (TB); however, one youth was considered morbidly obese. In four applicable records, periodic evaluations were conducted prior to renewing prescription medication. The center had one youth who was pregnant since the last annual compliance review. A review of the applicable IHCR indicated periodic evaluations were conducted every two weeks and weekly thereafter. Four applicable youth received on-site care which was documented in the IHCR chronological progress notes with clearly written treatment orders. Two applicable youth had an off-site evaluation which was documented on the Summary of Off-Site Care form and filed in the youth's IHCR. A review of the Chronic Physical Health Conditions Roster indicated periodic evaluations were tracked with no indications of missed or lapsed periodic evaluations. Two youth medical grades increased on October 7, 2020 and November 23, 2020; however, the youth were not added to the center's chronic conditions list until December 2, 2020. Each of the seven records documented Department's Problem List was updated, as required.

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

The center has a written policy and procedures for medication management. Verification of medication is conducted by the center's nurse, whenever a youth is admitted with medication. Youth who are taking medication while in the care of the center will have medication administered by the healthcare professionals. Supervisors are trained in medication administration and administer medication in the absence of the healthcare professionals. A review of supervisor training records verified each supervisor was trained in medication administration. Seven individual healthcare records (IHCR) were reviewed, of which four were applicable for taking medication. Each applicable IHCR contained documentation indicating the medication was verified by a licensed pharmacist or the youth's primary physician. All medication was stored in a container intact with the original label and approved medication. In each instance, the physician or psychiatrist was contacted to obtain an order to resume the medication and consent was documented in the youth's IHCR. There were no youth in restricted housing requiring medication or youth taking over-the -counter medication not listed in the Authorization for Evaluation and Treatment (AET) during the annual compliance review period. Four applicable reviewed youth records and internal incidents indicated there were no lapses or errors in administered medication. An interview with the center's nurse verified there were no standing orders of psychotropic medication, no emergency treatment order for psychotropic medication, and no pro re nata (PRN) orders for psychotropic medication.

A review of four applicable youth records for youth who were admitted with medication verified the medication administration was documented on the standard Department Medication Administration Record (MAR). Each of the MARs documented the youth's name, Department

identification number (DJJID), date of birth, allergies, precautions, medical grade, medical alerts, youth current picture, start and stop dates, and monitored side effects. Further review of the MARs indicated the youth received the medication as ordered, and staff and youth initialed the MAR after the administration of the medication. None of the four youth refused medication; however; an informal interview with the nurse revealed if a youth refuses medication, an "R" is documented on the MAR were the youth would have initial if the medication was administered and a refusal form is signed by the youth. A review of three additional youth records whereby youth have refused medication verified this practice. None of the three reviewed closed youth records required parenteral medication or were prescribed psychotropic medication while in the center; however, two of the three youth were on psychotropic medication prior to admission. In each instance, the designated health authority (DHA), the psychiatrist, and the designated mental health clinician authority (DMHCA) were notified upon admission, and the medication was continued until a diagnostic psychiatric interview was conducted. There were no applicable youth who remained in the center over thirty days who were on medication.

An observation of medication administration was conducted and indicated the Six Rights of Medication Administration is verified for each youth. The nurse verified any allergies to the medication, observed the youth swallowed the medication, and the nurse and youth initialed the MAR. None of the medication was pre-poured from the original packaging or placed in another container.

Observations of medication storage indicated all medications were separated by type, stored in a locked area designated for storage, and inaccessible to youth. The center maintains a list of staff who are required to have access to the clinic and medications. Medication requiring refrigeration is stored in a secured refrigerator used for medication only. Medication which cannot be returned to the pharmacist for a credit or medication requiring disposal is documented on the Medication Disposal form and disposed of using RX Destroyer. The center maintains a contact with a provider who comes on-site to dispose of all biohazard material every fifteen days. Seven interviewed staff stated they do not administer medication to youth and only supervisors, nursing staff, and the doctor administer medications. Five of the seven interviewed youth stated the nurse administers medication, one of the five youth stated the doctor, and the remaining two youth reported not taking medication.

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

The center has a written policy and procedures to ensure medical equipment and medications are secured and inventoried. The center maintains a perpetual daily inventory of medications to include prescribed and over-the-counter (OTC) medications. Documentation of each individual dosage of medication administered to youth is maintained on the Medication Administration Record (MAR) to demonstrate the distribution of medications. Medical equipment to include sharps is secured and inventoried using a perpetual inventory count, subtracting from the count as a sharp is used. Observations of the clinic indicated it is secured with limited access to the healthcare professional, supervisors, superintendent, and assistant superintendents. The healthcare professionals maintain a locked medication cart which contains prescribed and OTC medications, as well as sharps. Controlled mediations are maintained within the locked medical cart within a separate locked storage box. A review of three prescribed medications, three

controlled medications, and three OTC medications verified the counts were accurate. A review of the daily inventory of prescribed and OTC medications matched the count. The center maintains an inventory of all sharps to include items such as scissors, needles, and syringes. A review of three sharps verified each matched the inventory list.

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

The center maintains a written policy ensuring proper procedures are followed to prevent the spread of infectious diseases or illnesses and provide staff with the knowledge of appropriate prevention, containment, treatment, and reporting requirements of infectious diseases. The center maintains a separate Exposure Control Plan/Infection Control Plan approved by the designated health authority (DHA) on July 21, 2020. A review of seven youth healthcare records supported each youth received infection control training within twenty-four hours of admission. The infection control training included hand-washing techniques, universal/standard precautions, prevention/transmission of communicable diseases, vaccinations, and the Centers for Disease Control and Prevention (CDC) guidelines for infection control. Reviewed documentation supported the Exposure Control Plan/Infection Control Plan was written in accordance with Occupational Safety and Health Administration (OSHA) guidelines to include risk assessment and methods of compliance. The plan addresses common childhood infectious diseases, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, tuberculosis, Hepatitis A, B, and C, human immunodeficiency virus (HIV), bloodborne pathogens, other outbreaks and epidemics, and outbreaks of pediculosis. In addition, the plan included methicillin resistant staphylococcus aureus (MRSA) and other antibiotic-resistant micro-organisms, food-borne illnesses, bioterrorism agents, chemical exposures in the workplace, and protocols for needlestick post-exposure intervention and treatment. The center ensures Hepatitis B immunization is made available for staff and staff have access to protective equipment. There were no reportable incidents for which the local county health department, CDC, and the Department's Central Communications Center (CCC) should have been notified of an infectious disease since the last annual compliance review. A review of seven staff pre-service training records and seven in-service training records supported each staff received pre-service and in-service training on the center's Exposure Control Plan/Infection Control Plan.

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

The center has a written policy and procedures for the care of pregnant youth to include procedures for medical issues, nutrition, education, and medication. An interview with the nursing staff indicated the center had one pregnant youth since the last annual compliance review who was documented on the Pregnant Log. A review of the youth's individual healthcare record (IHCR) supported the youth was admitted in the center with a positive confirmation of pregnancy and prenatal care protocols were implemented. Prenatal care was delivered at recommended intervals, including off-site medical prenatal, obstetrical, or gynecological

appointments. A review of documentation indicated the designated health authority (DHA) and/or advanced practice registered nurse (APRN) conducted a focused medical evaluation at least once every thirty days. Reviewed chronological notes supported there was daily monitoring of danger signs of pregnancy complications.

Reviewed healthcare education records verified the youth received prenatal education to include alcohol and drug use, smoking, nutrition, sexually transmitted infections, contraception, prenatal care, birthing process, postpartum care, basic baby care, child/infant development, and parenting skills. While at the center, nursing staff monitored the youth for weight and nutritional status. A pregnancy alert was entered into the Department's Juvenile Justice Information System (JJIS). A review of seven staff training records verified six staff received Girls Health training specific to working with pregnant youth. One staff did not receive the training. Staff training was provided by the registered nurse (RN) at the time of hire and annually, thereafter. One female youth was interviewed and stated prenatal, obstetrical, or gynecological services were not needed.

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 program has a policy and procedures in place to ensure staff to youth ratio. Youth are supervised by both certified and non-certified staff, who are certified in Protective Action Response (PAR) and cardiopulmonary resuscitation (CPR), while accompanied by a certified detention staff while on the modules, in the classroom, on video conference court hearings, and during recreational activities. Observations during the annual compliance review were conducted daily, and on each day, the center had an adequate number of staff to meet the required ratio. The center utilizes a bound logbook in each living unit and one in master control. The logbook is used to document all movements, head counts, and any major incidents occurring on the living unit and within the center. All movements were controlled by master control in which staff cannot move without clearance. The center's census is updated, as needed, when youth are admitted and/or released or off site from the center. The center created a daily activity schedule which is utilized to dominate all free time of the youth.

A review of the daily youth census log during the annual compliance review verified each youth in the center was accounted for. During the annual compliance review, all staff were aware of the location of the youth in their care. During the annual compliance review week, staff were observed supervising youth during school hours, lunch time, line movement, and shift change. Seven staff were interviewed regarding whether they thought there was enough staff to provide for the safety and security of the youth at the center. Six staff responded yes, there is adequate staffing pattern and one staff stated it could be better with more staff on duty.

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

The center has a written policy and procedures to ensure the center provides a system of rewards, privileges, and consequences to encourage the youth to fulfill the center's expectations. The system includes rewards for positive behavior and consequences for inappropriate behavior. The behavioral management system (BMS) expectations are posted throughout the living area and the center. During admission, each youth is informed of the BMS, along with the rules and regulations of the center. Each youth enters the center on level two. At this level, the youth is provided all the basic rights at the center. After the third day of positive behavior, the youth can move up to the next level which is level three. This level provides youth with all basic rights and will receive more privileges than a level two youth. Level one is the most restrictive level and is usually utilized due to negative behavior. Youth may move up and down the level system based on their behavior and their ability to respond to staff intervention. Once a level drop is warranted, staff will request and obtain permission from the shift supervisor and followed by an incident report. The registered behavioral technician when on duty, reviews all incidents and intervenes when appropriate and guides both staff and youth. The registered behavioral technician works with both the staff and youth to come to a solution. All youth levels are updated daily on the level card which is issued during intake and updated on each shift prior to departure. These cards are update nightly on the Charlie-shift and provided for the morning shift who debriefs with the youth during morning sessions.

Observations during the annual compliance review confirmed the youth received counseling and redirection based on behavior. Seven youth were interviewed regarding the BMS. One youth indicated it was poor, one stated it was an okay system and four stated the behavioral management system was fair. All seven interviewed youth indicated the BMS restricts certain types of punishment including corporal, group, and youth-on-youth punishment. Seven staff were interviewed and indicated the center's BMS is effective. All seven interviewed staff revealed staff speak with youth to discuss the consequences being imposed, and all seven staff members indicated they provide youth with the opportunity to explain their behavior and give youth alternative acceptable behaviors. All seven interviewed staff indicated they can only take away youth's levels as discipline.

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

The center has a policy and procedures in place prohibiting group and/or corporal punishment of youth. The youth are not allowed to discipline other youth in the center. Seven interviewed youth each validated this. The superintendent was interviewed and indicated the youth are rewarded when they exhibit good behaviors. Three interviewed youth stated they have never received consequences, and three received consequences whereby their levels were dropped, or the youth were placed in confinement. Seven interviewed staff indicated they have not witnessed unauthorized use of punishment or observed staff encouraging youth to participate in physical altercations. Additionally, staff reported they have never taken away meals, snacks, clothes, education, or medical care for inappropriate behavior.

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

The center maintains a written policy and procedures to ensure ten-minute checks are conducted when youth are in their rooms for sleeping purposes or other reasons. The center has a total of 183 surveillance cameras, of which thirty-three were not operational and were pending repair at the time of the annual compliance review. The surveillance camera system has a recording capacity of thirty-days. Staff utilize an electronic wand to conduct ten-minute checks by tapping the wand on the check point sensors located on the outside of each youth's assigned room. The data from the wand is downloaded daily to ensure no data is lost. When

conducting checks, the juvenile justice detention officer (JJDO) must observe the youth behind the closed door before the check point sensor is activated and staff pause at each room door and look into the room to ensure there are no issues with the youth. Observations of the ten-minute room checks of surveillance was conducted on four different modules, two reviews on Alpha-shift, two on Bravo-shift, and two on Charlie-shift were conducted. These observations were conducted on four different days and times. These reviews were completed within the allotted time frame except for three checks on Bravo-shift. Two of the three checks were conducted two minutes late and one was conducted five minutes late. Staff were observed pausing at each room to observe each youth.

Seven staff were interviewed and indicated all room checks are conducted every ten minutes. Whenever a youth is placed in a secure room, officers are required to conduct ten-minute checks. Youth are supervised based upon their level of supervision.

5.05 Census, Counts, and Tracking	Satisfactory Compliance

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

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

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

The center has a written policy and procedures addressing census, counts, and tracking. Staff must always know the exact number and location of all youth under their supervision. Head counts are conducted throughout the day and called into master control and documented in the center's master control and living module logbooks. There are no youth movements until master control confirms the counts, reconciles the count, and authorizes center activities to resume. A review of the master control logbooks and living unit logbooks for the past six months verified headcounts were documented at the beginning and end of each shift, following any emergency situations, whenever a population change occurs, and randomly on each shift. Seven interviewed staff indicated emergency counts are conducted when a youth is believed to be missing or when visibility is hindered, such as an electrical outage and after a major disturbance.

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

The center maintains a written policy and procedure to ensure the maintenance of all the logbooks. The center has separate logbooks for master control and for each of the four living modules, and staff books. A review of each logbook found the logbooks were bound with numbered pages. A review of logbooks for the past six months for each living module and master control verified all entries were legible and written in ink. All entries included the date and time of the event, name of the staff and youth involved, a brief description of the event, initials of the staff making the entry, and the date and time of the entry. Logbooks documented medical, special needs, and/or mental health alerts impacting the safety and security of the center and were all highlighted. The master control logbook included all emergency situations, incidents, fire drills, medical and mental health drills, Continuity of Operations Plan (COOP) drills, escape drills, population counts at the beginning and ending of each shift, group movements, admissions and releases, and presence of law enforcement.

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

The center maintains a written policy and procedures regarding logbook reviews. The superintendent or designee reviews the logbooks on a weekly basis. The supervisor, master control operator, and juvenile justice detention officers (JJDO) review the logbooks when the shift is accepted, to document awareness of current relevant situations in the center. Master control and living unit logbooks for the past six months were reviewed and verified supervisors from each shift documented a review of the master control logbook prior to accepting the shift. A review of the living module logbooks verified the JJDO coming on-duty documented a review of

the logbook. An interview with the superintendent reported shift supervisors are required to review the logbooks each shift. A review of the center's logbooks verified this practice.

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

The center maintains a written policy and procedures ensuring the proper usage, storage, and general security of the center's keys. Center keys are maintained on a tamper-resistant ring with a brass tag identifying the ring number and the number of keys on the ring. The center's keys are locked and secured placed in master control office, the key box is only accessible by the shift supervisor, captains and superintendent. All restricted keys are secured in the supervisor and a restricted key box. Emergency keys providing access through exterior doors are stored in master control, and in emergency key boxes near the exit doors on each unit. A key inventory is maintained in the supervisor office and superintendent's office for each key. The inventory identifies the ring number, number of keys assigned to the ring, the location assigned to the keys and the staff department assigned to the keys. When staff enter the center, personal keys are placed in lockers on the nonsecure side of the center and staff proceed to master control where each staff is issued keys by a shift supervisor. Staff sign the key logbook and document the keys assigned to them. Once the shift is over, the staff returns work keys to the on-duty supervisor, once the keys are returned, the time and date is entered by the staff next to their name. A review of the key log indicated keys were distributed, as required, by the shift supervisor.

A review of seven pre-service and seven in-service staff training records verified each staff received key control training. Interviews with several staff during the annual compliance review, verified the staff had no personal keys, and youth were not permitted to handle center keys. Each staff was in possession of their assigned keys. Staff were questioned regarding the procedures for missing, damaged, and lost keys; all staff indicated if any keys are missing or lost, they must be reported to the shift supervisor. All staff reported the medical records keys, youth property keys, mental health record keys, case management record keys, and kitchen keys were restricted to all floor staff. The center reports there has been no incidents of lost, damage keys or staff leaving with center keys at the end of their shift in the last six months.

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

The center maintains a written policy and procedures for transportation, operation and maintenance of each vehicle, which are used to transport youth. The maintenance mechanic is responsible for weekly and monthly vehicle inspections. The transportation supervisor has been designated to complete the vehicle checks daily to ensure all vehicles are equipped and readily available to drive. The center has eight vehicles used to transport youth. Each vehicle had an annual safety inspection conducted by a certified automobile mechanic. Observations of all vehicles verified each was locked when not in use. All eight vehicles have the appropriate number of seat belts, a seat belt cutter, a window punch, up-to-date fire extinguishers, and a first aid kit with approved items by the center's doctor. A binder is maintained for each vehicle which contains the vehicle mileage log, mechanical restraint key, gas card, vehicle registration, and vehicle policy. All vehicle inspections conducted by staff when a vehicle is used and logged in the vehicle logbook. The logbook was reviewed and showed where the vehicle was searched, inspected prior to and upon return. There were no transports during the annual compliance review; therefore, observations were not conducted.

5.10 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 a written policy and procedures in place to ensure all tools and equipment are properly maintained, stored, and inventoried. The center's maintenance mechanic, with the assistance of the regional maintenance mechanic, oversees on all tools as needed. A perpetual tool inventory list is maintained by the center and inventoried monthly. All tools are stored in a locked area when not in use. Tools are maintained on a shadow board and marked with an identification number. A review of the tool inventory verified there were no missing tools or damaged tools. When all tools are in use, a tool tracking form is used indicating the date the tool was used and has the signature of the person using the tool. Tools which need to be disposed or replaced is requested by completing a tool disposal/replacement form which the maintenance mechanic signs and requests the approval of the assistant superintendent or superintendent.

An interview with the maintenance mechanic indicated when items are lost, or it is assumed to be left in an area where youth are located, staff notify the shift supervisor and administration is made aware and a searched is initiated. An interview with the maintenance mechanic and assistant superintendent indicated there were no instances of missing tools within the past six months. All vendors are identified prior to entering the center and are accompanied by a designated staff when in the secure area. Youth are removed from the area being serviced and not allowed to re-enter the area until it has been searched and cleared by staff. The vendor checks for all tools to ensure they leave with what they entered with.

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

The center maintains a written policy and procedures which does not allow youth to have access to any tools, including kitchen and/or medical equipment. Youth can use cleaning items such as mops, brooms, buckets, and dustpans during general cleaning. Youth are under staff supervision when these items are in use. Seven interviewed youth reported they only use brooms and mops in the center. Seven interviewed staff reported youth are permitted to use brooms and mops at the center under staff supervision.

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

The center maintains a written policy and procedures to ensure the proper inventory of flammable, toxic, caustic, and poisonous items. All items are inventoried weekly and securely stored when not in use. All chemical items observed during the annual compliance review had a Safety Data Sheet (SDS) on record for each chemical. Observations of the storage area indicated all items matched the inventory list and are stored in a locked shed located outside the secure area of the center.

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

The center maintains a written policy and procedures in place to ensure limited access to flammable, toxic, caustic, and poisonous items. These Items can be used by authorized staff.

The center maintains a list of authorized staff who have approved access to the chemical storage. Chemical storage is located outside the secure area of the center. Youth are not permitted to use or handle hazardous chemicals. Seven youth were interviewed; all youth stated they clean with cleaning agents sprayed down by staff. Seven staff were interviewed and stated youth do not clean with any type of cleaning agent such as bleach, laundry soap, window or toilet cleaner.

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

The center maintains a written policy and procedures to ensure flammable, toxic, caustic, and poisonous items are disposed of according to the Safety Data Sheet (SDS). The center's food director reported the center does not utilize oil for cooking. All kitchen liquid waste is disposed in the kitchen drain. An interview with the center's maintenance mechanic indicated there has been no chemical spills within the last six months. If a chemical spill occurs, the center's policy dictates the staff will notify master control of the location, the shift supervisor or master control will contact the maintenance mechanic for directions.

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

The center maintains a written policy and procedures which addresses confinements under twenty-four hours. The center uses utilizes the youth's assigned sleeping room for confinement. Observations of the designated youth rooms indicated rooms were free from obstruction and with no non-fixed items. Youth who are in confinement have no contact with the general population. The center documents confinements under twenty-four hours in the Facility Management System (FMS). A review of thirty-six confinement reports indicated youth placed in confinement were afforded the same services as youth in the general population, including medical, mental health, education, exercise, showers, meals, clothing, bedding, and hygiene items. Confinement reports indicated all rooms were searched prior to the youth's placement in the room and the youth was informed of the right to file a grievance. Each report reflected visual observations were conducted in accordance with policy. Each reviewed confinement report indicated all reports were completed within the two-hour time frame and were reviewed by the shift supervisor.

Each of the thirty-six confinement reports indicated the superintendent and/or designee reviewed the confinement report within forty-eight hours, as required. Supervisors must review and approve the confinement report. Once the initial review is completed, the supervisor conducts a review every three hours. If a youth confinement was not appropriate, the youth will be immediately released. The superintendent or designee must review the report within forty-eight hours of release, and all confinement events are monitored by regional and headquarter staff. Seven staff were interviewed and stated when a youth is placed in confinement, staff must complete a confinement report, conduct and document five-minute checks for an hour then ten-minute room checks, and each room is searched.

5.16 Confinement Over Twenty-Four Hours	Satisfactory Compliance
Staff shall use behavioral confinement as an immediate, short term response strategy during volatile situations in which a youth's sudden or unforeseen onset of behavior imminently and substantially threatens the physical safety of others or self. *Confinements should not exceed twenty-four hours; however, if a youth continues to exhibit behavior which poses a risk to him or herself, staff, or others, a Confinement Review must be conducted.*	

The center maintains a written policy and procedure to address youth placed in confinement over twenty-four hours. All confinements over twenty-four hours require approval by the center's superintendent or designee. The center had no confinements over twenty-four-hours during the annual compliance review period.

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

The center maintains a written policy and procedure to ensure a plan is in place to manage various emergencies and disaster events. The center's Continuity of Operations Plan (COOP) was approved by the reginal director. The center's documentation showed there were two COOP drills conducted, as required. The hurricane drill was conducted on May 20, 2020 and a tornado drill on November 20, 2020. In each instance, there were written scenarios and drill forms, critique forms and electronic mail (e-mail) used to document the drills. Drills are reviewed during monthly management meetings and during shift briefings. An interview with the center's superintendent reflected the center conducts various safety, emergency and medical drills on a monthly basis. All drills were conducted on each shift, and sign-in rosters were used to capture signatures of all staff who participated in the drills. The evacuation plan is included in the COOP. The center has a COVID-19 pandemic plan in place. Seven staff were interviewed regarding participation in drills. Staff reported participating in weather, major disturbance, bomb threat, hostage situation, chemical spill, flooding, terrorism, escape, fire, medical, and mental health drills in the past six months.

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

The center maintains a written policy and procedures addressing youth escapes. The center has an escape prevention plan which requires all staff to remain alert while on the modules and look out for the youth attitude and demeanor. The plan addresses procedures regarding escape attempt during youth transportation. A review of the prevention plan indicated all required elements are included. Escape drills are required to be conducted once each quarter. A review of the center's escape drill documentation for the past year, along with corresponding logbook entries, verified the center met the requirements for the year. A review of seven pre-service and seven in-service staff training records verified annual escape training was completed by each

reviewed staff. An interview with staff regarding drill participation reflected they have attended in the drills and training.

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

The center has a disaster plan, fire prevention plan, and evacuation plan which addresses fire prevention and safety of the center. The center has evacuation escape plans posted throughout the center. Each escape plan defined a primary and secondary exit route, and the locations of emergency equipment, such as fire extinguishers and first aid kits. The center's disaster plan and fire prevention and evacuation plan were reviewed and approved by the local fire marshal. A review of the emergency drill documentation and logbook documentation for the past year verified the center conducted fire drills each month, on each shift, during different times. Master control calls for a headcount throughout the shift to ensure there is an accurate count for the building. During drills, master control ensures a clear count is confirmed prior to resuming any activities. Seven staff were interviewed and indicated fire drills take place on a monthly basis. Seven youth were interviewed and indicated they have been instructed on what to do in the case of a fire