STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

# BUREAU OF MONITORING AND QUALITY IMPROVEMENT

## Annual Compliance Report

## Monroe Regional Juvenile Detention Center

***Department of Juvenile Justice***

**(State-Operated)**
**5503 College Road**
**Key West, Florida 33040**

***Review Date(s): June 2-5, 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:

Christine Calvert-Joyner, Office of Program Accountability, Lead Reviewer (Standard One and Four)
Rosa Flores, Office of Program Accountability, Regional Monitor (Standard Two)
Rondarrell George, Office of Program Accountability, Regional Monitor (Standard Five)
Tonya Gittens, Office of Program Accountability, Regional Monitor (Standard Three and Interviews)
Shakela Minns, Office of Program Accountability, Regional Monitor (Standard Two)
Maryann Sanders, Office of Program Accountability, Deputy Regional Supervisor (Standard Three)

Program Name: Monroe Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: Monroe County / Circuit 16
Review Date(s): June 2-5, 2020

MQI Program Code: 1076
Contract Number: N/A
Number of Beds: 10
Lead Reviewer Code: 163

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

## Overall Rating Summary

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

| Limited Ratings | Failed Ratings |
|---|---|
| 1.05 Protective Action Response (PAR) | |

# 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) | Limited |
| 1.06 | Pre-Service/Certification Requirements * | Satisfactory |
| 1.07 | In-Service Training | Satisfactory |
| 1.08 | Entering Alerts(JJIS) and Sharing of Alert Information * | Satisfactory |

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

# Standard 2: Youth Management
# Detention Rating Profile

**Indicator Ratings**

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

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

## Indicator Ratings

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

* 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 4: Health Services
# Detention Rating Profile

## Indicator Ratings

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

* 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 5: Safety and Security
# Detention Rating Profile

## Indicator Ratings

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

* 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).

## Program Overview

The Monroe Regional Juvenile Detention Center is a state-owned detention center, operated by the Department, located in Key West, Florida. The center serves youth in Monroe County in Circuit 16. Male and female youth who are detained pending adjudication, disposition, or placement in a residential commitment program are housed in the ten-bed center. Youth are provided services which include youth orientation, behavior management, safety and emergency procedures, transportation, mental health, and healthcare services. The center's educational services are provided by the Monroe County School District. The center's management team includes one superintendent, the south regional detention chief, one shift commander, four juvenile justice detention officer supervisors, and one administrative assistant. At the time of the annual compliance review, the center had three juvenile justice detention officer II (JJDOII) positions vacant, and seven filled. Due to the center's geographic location and high cost of living, all direct care staff hold a position of JJDOII or higher, and the center maintains three vacant positions at all times to off-set the salary increase for the JJDOII positions. Mental health services are provided by the contracted provider, Camelot Community Care, Inc., who sub-contracts with Guidance Care Center, Inc., which is a local agency located in Key West, Florida. There is one licensed designated mental health clinician authority (DMHCA), one licensed mental health clinician, who serves as the backup to the DMHCA, and two non-licensed mental health staff. Clinical services provided by the center include mental health and substance abuse evaluations, mental health treatment planning, individual, group, and family therapy, mental health crisis intervention services, tele-psychiatry services, and availability for substance abuse services for youth with co-occurring disorders. Food services are provided by the Monroe County Sheriff's Office which is located on the same property. Meals are prepared by the food service workers in the county jail and delivered to the detention center. Staff are responsible for the custody and control of youth in their care, providing youth supervision twenty-four hours a day, seven days a week. The center has two living modules. Due to the low population rate, the center houses male and female youth within the same living unit whenever possible. There are fourteen security cameras at the center, and all were reported operational at the time of the annual compliance review. One youth was securely detained in the center during the annual compliance review week. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site. On-site observations will be conducted on a later date. Additionally, the medical provider began services on March 17, 2020. Due to the recent change in medical providers, the new provider has not had the opportunity to demonstrate practice for the past six months. A review of medical services provided through the contracted provider will be conducted at a later time.

# Standard 1: Management Accountability

| 1.01 Initial Background Screening (Critical) | Satisfactory Compliance |
| --- | --- |

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

The center maintains a written policy and procedures to ensure all staff, contracted providers, volunteers, mentors, and interns with access to youth undergo a criminal history background check prior to hiring or providing services. Since the last annual compliance review, the center hired three new Department staff and two contracted staff. A review of all five background screenings reflected each staff received clearance from the Department's Background Screening Unit (BSU)/Clearinghouse prior to hire. Additionally, the mental health contracted provider rescreened the four mental health staff prior to a contract update executed March 17, 2020. None of the reviewed background screenings were applicable for an exemption prior to working with youth. Three of the hired staff were direct care staff and were applicable for a pre-employment assessment tool to be administered. All three received a passing score and a copy of the pre-employment assessment was maintained within the staff record. The center's Annual Affidavit of Compliance with Level 2 Screening Standards for center staff and school board teachers was submitted on January 31, 2020, meeting the annual requirement.

| 1.02 Five-Year Rescreening | Satisfactory Compliance |
| --- | --- |

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

The center maintains a written policy and procedures to ensure all staff, contracted providers, volunteers, mentors, and interns with access to youth undergo a criminal history background check every five years. None of the center or contracted provider staff were applicable for the completion of a five-year background rescreening since the last annual compliance review.

| 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 to ensure staff communicate and interact with youth in a manner which provides a role model of socially acceptable behaviors. Staff behaviors shall be respectful of others and reflect desired behaviors of youth. Three staff records were reviewed. Each record contained a copy of the center's code of conduct signed by the staff. None of the staff records were applicable for disciplinary action due to a code of conduct violation. An interview with the center's superintendent determined there were no disciplinary actions and/or violations since the last annual compliance review. One of the three reviewed records was applicable for commendations. The center provided two additional records for review. Each of the three applicable staff was recognized as the employee of the month. Additionally, the center's shift commander was recognized as the Detention Services south region employee of the month. One youth was interviewed regarding the ability to report abuse at the center, and the youth reported never being stopped from calling the Florida Abuse Hotline. The youth also reported staff are respectful when talking to youth and never hearing staff use curse words when speaking with youth and/or threatening youth. The youth reported feeling safe at the center. Three staff were interviewed regarding witnessing staff use profanity towards youth and/or witnessing staff using threats or intimidation towards youth. Each of the three staff reported they never heard staff use profanity when interacting with youth, and they never witnessed staff members threaten or intimidate youth. All three interviewed staff rated working conditions at the center as very good. An interview with the center's superintendent revealed staff are prohibited from any abuse, profanity, threats, harassment, intimidation, horseplay, or personal relationships with youth. The superintendent reported actions taken for code of conduct violations include internal investigations, reports to the Florida Abuse Hotline and the Department's Central Communications Center (CCC), no youth contact, oral or written reprimand, suspension, and 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 maintains a written policy and procedures to ensure consistency and expediency in reporting of all incidents. The center's procedures outline the process for notifying the Department's Central Communication Center (CCC) within two hours when a reportable incident may disrupt, or has the potential to disrupt, center operations. The center had four incidents reported to the CCC since the last annual compliance review. There was an increase of CCC reports at the center compared to the previous year. The center's shift commander attributed the increase to the COVID-19 pandemic. A review of all four CCC reports was conducted. Each incident was reported within the required two-hour time frame and was documented within the center's master control logbook. There were no additional observed internal incident reports and/or grievances which should have been reported to the CCC. Three staff were interviewed regarding the process for allowing youth to call the Florida Abuse Hotline or the CCC. All three staff reported the assigned staff member would allow the youth to make the call and the numbers were posted within the center. One youth was interviewed regarding access to reporting abuse. The youth reported never being stopped from reporting abuse since admission to the center. An interview with the center's superintendent revealed whenever a reportable incident occurs, the center will call the CCC within two hours of the incident. The superintendent also reported whenever there is an allegation of abuse, the center's staff will call the Florida Abuse Hotline.

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

The center maintains a written policy and procedures to ensure all detention staff use physical intervention techniques in accordance with Florida Administrative Code. The center's Protective Action Response (PAR) training plan was reviewed and signed on August 15, 2019 by the Assistant Secretary of Detention Services and the Department's Office of Staff Development and Training. The center had one PAR incident since the last annual compliance review. The reviewed PAR report documented one staff was involved and included no narrative of the event within the report. There was an incident report coinciding with the PAR report reviewed. The incident report for the event which occurred on October 18, 2019 was completed by a staff not included on the PAR report, and indicated two staff members were involved; however, only one staff incident summary was available for review. The incident narrative for the staff listed on the PAR report was not available for review. The center reported the staff member listed on the PAR report was not yet trained in the Department's Juvenile Justice Information System (JJIS) at the time of the incident; therefore, did not have access to complete the report. The shift commander reported the staff completed a typed report; however, the staff's statement could not be located at the time of the annual compliance review. The PAR incident did not result in the use of mechanical restraints, and there was no indication of serious injury to the youth or staff requiring contact to the Department's Central Communications Center (CCC). The incident did not require contact to the Florida Abuse Hotline due to a youth alleging abuse. The reviewed

PAR incident documented a PAR certified supervisory review, and the completion of a Post-PAR Interview with the youth completed twenty minutes beyond the thirty-minute requirement. The reviewed incident did not indicate a PAR Medical Review was necessary due to youth distress or injuries. The reviewed report documented was reviewed by the superintendent, as required; however, it was completed three hours and sixteen minutes beyond the seventy-two-hour requirement. Three staff were interviewed regarding the use of PAR, and all three staff reported the staff try to talk to youth prior to using any physical interventions. An interview with the center's superintendent determined all PAR reports are reviewed by a PAR certified instructor or supervisory staff, a post-PAR interview is conducted with the youth by the superintendent or designee within thirty minutes, and the superintendent or designee has seventy-two hours to review the incident. The center's PAR rate during the annual compliance review period was 0.00, which is below the statewide Detention PAR rate of 14.09. The center's PAR rate has remained the same since the last annual compliance review. Based on the small sample size used to determine this rating, the Office of Detention Services is not in agreement with the rating. Additionally, this rating is not a reflection of the center as a whole.

| 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 maintains a written policy and procedures to ensure proper training equips staff with the skills necessary to conduct themselves in a manner consistent with the ethical standards established by the Department. The center abides by the detention center statewide annual training plan. The annual training plan serves as a written list of training curricula for all state-operated secure detention centers in Florida. The center had three newly hired staff applicable for pre-service training since the last annual compliance review. One reviewed staff member obtained a juvenile justice detention officer (JJDO) certification within 180 days of hire, and the two remaining staff had not yet reached 180 days since hire. The two staff not yet certified, were on track for certification within the 180-day requirement. Each of the three reviewed staff records documented the completion of training in Protective Action Response (PAR), cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), first aid, mental health services, substance abuse services, suicide recognition, suicide prevention, suicide intervention, safety, security, youth supervision, the center's emergency plans, Prison Rape Elimination Act (PREA), human trafficking, and center operations prior to youth contact. Each of the three reviewed records documented the completion of phase one training to include essential skills, orientation, information security awareness, legal, Department organizational training, gang awareness, communication skills, youth management, and active shooter training. One of the three reviewed records also documented completion of the phase two 120-hour training academy. All reviewed staff trainings were documented in the Department's Learning Management System (SkillPro).

| 1.07 In-Service Training | Satisfactory Compliance |
| --- | --- |
| *All center staff, including food service and maintenance staff, are required to complete twenty-four hours of in-service training, including mandatory topics specified in Florida Administrative Code, each calendar year, effective the year after pre-service/certification training.*<br><br>*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 to ensure proper training equips staff with the necessary skills to conduct themselves in a manner consistent with the ethical standards established by the Department. The procedures outline the provision of continued education and in-service training requirements. Three staff training records were reviewed for completion of in-service training. Each reviewed record reflected staff exceeded the required twenty-four hours of in-service training. Each of the three records documented the completion of a Protective Action Response (PAR) update, cardiopulmonary resuscitation (CPR) update, automated external defibrillator (AED) update, first aid update, two hours of web-based suicide prevention training, four hours of instructor-led suicide training, professionalism and ethics, and active shooter training. Two of the three reviewed records were applicable for a minimum of eight hours of supervisory training. Both records documented the staff exceeded the required hours. Both applicable training records documented training in management, leadership, personal accountability, employee relations, communication skills, and fiscal. All reviewed staff trainings were documented in the Department's Learning Management System (SkillPro). The center maintains an annual training calendar, which is updated as needed. The center's superintendent personally reported receiving training in leadership, communication skills, and certified public manager (CPM) training. The superintendent also reported all center staff are required to complete CPR, first aid, suicide prevention, professionalism, and PAR training.

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

The center maintains a written policy and procedures to ensure the safety and well-being of youth through the proper documentation, review, and response to youth critical and special alerts. Three youth records were applicable for five separate documented alerts. Reviewed documentation reflected alerts were entered, reviewed, and updated, as required, by an appropriate staff member. Logbooks were reviewed and reflected alert documentation to include gang affiliation, medical status, mental health alerts, and suicide precautions. The Department's Juvenile Justice Information System (JJIS) alert report is printed, reviewed, and distributed to direct care staff daily by juvenile justice detention officer supervisors (JJDOS). The center reviews all alerts with oncoming staff during daily shift briefings and requires all direct care staff to always maintain a copy of the detailed alert list on their person during their shift. The center's practice is to maintain a current alert list in the medical clinic. Three staff were interviewed regarding the center's notification process for youth alerts. All three staff reported they were informed of youth alerts during shift briefings and one staff reported they are also informed through JJIS alert report print outs. The three interviewed staff reported the center's management informs staff about issues at the center through shift briefings. One staff also reported issues are discussed during meetings. Each of the staff rated communication at the center as very good.

## Standard 2: Assessment and Performance Plan

| 2.01 Admission | Satisfactory Compliance |
|---|---|

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

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

The center maintains a written policy and procedures to ensure proper screening, evaluation, and documentation of each youth detained at the center. There was one youth detained in the center during the annual compliance review week; therefore, two additional records were reviewed. Each reviewed case management record included the youth's arrest affidavit, court orders for admission to the center, completed Detention Risk Assessment Instrument (DRAI), and documented electronic frisk and/or strip search by an officer of the same gender as the youth. Each reviewed record indicated the youth received a telephone call and meal or snack upon admission to the center. Each reviewed record also indicated the youth were evaluated for medical, mental health, and substance abuse needs. The three reviewed records indicated each youth was admitted to the center in accordance with the center's policy and procedures. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site; therefore, observation of a youth admission was not possible.

| 2.02 Orientation | Satisfactory Compliance |
|---|---|

*Program orientation process shall occur within twenty-four hours of a youth being admitted into the center and documented according to Facility Operating Procedures. During the orientation process, youth must be advised, both verbally and in writing, at a minimum, the following:*

1. *Center rules and regulations;*
2. *Grievance procedures;*
3. *Visitation;*
4. *Telephone calls;*
5. *Available medical, mental health and substance abuse services and how to access them;*
6. *How to access the Florida Abuse Hotline (or CCC for youth eighteen years old or older);*
7. *Expectations for behavior and related consequences;*
8. *Possible new law violations for destruction of property; and*
9. *Youth rights.*

The center maintains a written policy and procedures to ensure all youth admitted into the center are notified of the center rules and regulations, related consequences for failing to meet behavior expectations, expectations for behavior, and youth rights within twenty-four hours of

admission. There was one youth detained in the center during the annual compliance review week. Two additional records were reviewed. Each case management record reviewed showed the youth signed an orientation acknowledgement form. The reviewed forms included the center's rules and receipt of information regarding rules and regulations, youth rights, visitation, telephone calls, grievance procedures, access to medical, mental health, and substance abuse services, access to the Florida Abuse Hotline, access to the Department's Central Communications Center (CCC), behavior expectations, behavior-related consequences, and possible new law violations for destruction of property. The admission process is documented during intake/booking and is signed by both the admitting officer and the youth. Copies with signatures are placed and maintained in each youth's active case management record. Each of the records reviewed had signed copies of the orientation brochure. No youth were admitted to the center at the time of the annual compliance review. One youth was interviewed regarding orientation and confirmed receiving information about the center's rules and regulations, educational services, visitation, daily schedule, abuse reporting, and the behavior management system upon admission.

| 2.03 Classification | Satisfactory Compliance |
|---|---|

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

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

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

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

The center has a written policy and procedures regarding classification of youth admitted to the center. There was one youth detained in the center during the annual compliance review week; therefore, two additional records were reviewed. Each of the three case management records contained a Department Face Sheet which included the youth's address, gender, height, weight, age, and physical characteristics. The center uses the Secure Detention Admission Wizard form to determine a youth's aggressiveness, mental illness, suicide risk, intellectual and physical disabilities, history of violence, maturity, living arrangements, and gang affiliation. One of the three applicable records documented gang involvement and an alert was placed in the Department's Juvenile Justice Information System (JJIS). All three reviewed youth records

contained a Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) assessment, which was included in the classification process. The superintendent reported all staff are briefed on all alerts and pertinent classification information during daily shift briefings and as changes occur.

| 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.*<br><br>*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.*<br><br>*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 has a written policy and procedures in place to ensure youth are screened to determine if the youth are affiliated or identified as gang members and for the purposes of notification to the designated juvenile probation officer circuit gang representative. The center has designated the center's shift commander as the gang representative. The shift commander was interviewed and confirmed the center's gang representative communicates any suspected gang activity to local law enforcement and the juvenile probation officer supervisor (JPOS). The JPOS serves as the local gang representative for Circuit 16. The center's practice is to enter a gang alert into the Department's Juvenile Justice Information System (JJIS) for all applicable youth. The center had one youth identified with gang affiliation since the last annual compliance review. The youth's gang affiliation was noted during admission. The initial correspondence to the JPOS was not available; however, electronic mail correspondence was provided. The center's shift commander reported the notification was initially completed by telephone call. The reviewed documentation supported the center has a process in place to communicate gang involvement between the center and circuit gang representative. A review of three staff training records showed each staff received gang awareness training. Additionally, gang information is shared with all other pertinent parties during the weekly detention review meetings.

| 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 in place related to ensuring the proper safe handling and security of each youth's personal property including valuables, which are collected and secured at the time of a youth's admission. There was one youth detained in the center during the annual compliance review week. Two additional records were reviewed. Each case management record contained a property form which was signed by the youth and staff. Each of the youth case management records documented valuable property was securely stored. According to the center, the valuable youth property is stored in a clear tamper-proof bag, which is labeled with the youth's name, Department identification number, date, staff name, and signatures of the youth and staff. The property is then placed in a drop safe, which is under video surveillance twenty-four hours a day. The center maintains a drop safe logbook to document the time, youth's name, name of the officer securing the property, and the officer's

initials. Each of the three reviewed records contained documentation the youth signed an unclaimed property acknowledgement form and each reviewed Admission Wizard form documented whether the youth had personal property upon their admission. The center reported there was no missing personal property for the past six months and a review of the Department's Central Communication Center (CCC) validated this as well. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding COVID-19, this review was conducted off-site; therefore, observation of a youth admission was not possible. Photographs of all youth storage, youth records, and a review of the property logbook confirmed the center's practice. One youth was interviewed regarding personal property. The youth indicated upon admission to the center, staff checked their personal property and the youth signed and received a form stating the inventory and listing of their personal property was 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.* | |

The center has a written policy and procedures in place to ensure the youth's personal property is inventoried, maintained securely, and returned to the youth in a timely manner upon release from the center. Personal items of value are inventoried and placed in clear tamper-proof plastic bags. The center advised the superintendent or designee will place the youth's valuables within a drop safe, which is under video surveillance. A review of three youth case management records reflected safeguards were in place for each youth's personal property until it is returned to the youth and/or parent/guardian. Each reviewed youth case management record had acknowledgements of unclaimed property signed at the time of the youth's admission. The center's process for unclaimed property is to send a letter to the parent/guardian after thirty days, and all unclaimed property is disposed of in accordance with the center's policy. The center's shift commander reported there were no instances of unclaimed property since the last annual compliance review. A review of youth property logbooks, and property receipts confirmed the youth's property was inventoried by the intake/booking officer, in the presence of the youth, and signed by both parties. All three reviewed youth case management records indicated each youth's property was appropriately logged in the Department's Juvenile Justice Information System (JJIS) Admission Wizard. A review of the Department's Central Communications Center (CCC) logbook and CCC incident reports since the last annual compliance review, found there were no incidents of lost or stolen property during the annual compliance review period.

| 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.*<br><br>*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.*<br><br>*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.*<br><br>*Questions concerning release are presented and addressed by the superintendent, or designee, prior to release.*<br><br>*The releasing officer shall verify the identification of the youth.* | |

The center has a written policy and procedures in place to ensure all releases from the center occur promptly and accurately. The on-duty juvenile justice detention officer supervisor (JJDOS) verifies the release by reviewing the court order and signing the secure detention release form prior to the youth's release. Three closed youth case management records were reviewed for release documentation, procedures, and approval. A review of the three closed youth records revealed each had the appropriate documentation including the Release Wizard signed by the youth's parent/guardian or person taking custody of the youth, the court authorization to release, a copy of photo identification of the parent/guardian or person taking custody of the youth, youth check list, and notifications. The release date in the Department's Juvenile Justice Information System (JJIS) corresponded with the youth's correct release date in each reviewed record. Each of the closed records indicated the youth and the youth's parent/guardian were informed of future court dates and appointments. A review of the Department's Central Communications Center (CCC) reports since the last annual compliance review validated the center had no unauthorized releases. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site; therefore, observation of a youth release was not possible.

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

The center has a written policy and procedures ensuring youth property is maintained securely during admission and released to the youth or the youth's parent/guardian. Three closed youth case management records were reviewed. Each youth admission's record contained a signed acknowledgement from the youth regarding understanding of the unclaimed property process. Upon release from the center, the detention staff, youth, and parent/guardian review and sign the property receipt form prior to the return of any property. If property is not claimed during release, it is kept secured and an acknowledgment is sent to the parent/guardian notifying of the unclaimed property. A review of personal property reports on the Department of Juvenile Justice Information System (JJIS) Facility Management System (FMS) module did not indicate any

property was left at the center over thirty days since the last annual compliance review. There were no applicable reports made to the Department's Central Communications Center (CCC) regarding lost or missing property. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this review was conducted off-site; therefore, observation of a youth release was not possible.

| 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 has a written policy and procedures in place to ensure prescribed medication, along with medication instructions are provided to the parent/guardian or responsible adult at the time the youth is released. A review of three closed youth records indicated one youth applicable for the release of medications and medical instructions in the last six months. The center indicated there were no other additional applicable youth records since the last annual compliance review. A review of the applicable closed youth record found it contained a signed medication receipt with the name and signature of the youth's parent/guardian who took possession of the medication upon the youth's release from the center. The form also documented the type of medication, instructions, and any applicable pending appointments.

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

The center has a written policy and procedures to address detention reviews of youth held in secure detention or who are awaiting placement to a residential program. Detention reviews are conducted on a weekly basis to address the status of each youth. Updates are provided as to the next court date, behavior while in detention, residential placement status, and release status. A review of weekly sign-in sheets for the past six months confirmed the center conducted reviews in accordance to the Department's policy. All staff attending in person signed the sign-in sheets. Some attendees participate by way of telephone, which was reflected on the sign-in sheets. A detention review was not observed during the week of the annual compliance review. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site. However, the center provided documentation to confirm the center conducted a detention review the week of the annual compliance review. Reviewed documentation found notes were taken regarding what was discussed, tasks assigned for follow-up, and the identified staff members responsible for those actions. Each youth's status was reviewed individually and included a review of behavior, projected release date, medical status, and other pertinent information relevant to keep youth and staff safe. An interview with the superintendent confirmed the center's 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 has a written policy and procedures to address the daily activity schedule. Youth are provided the opportunity to participate in constructive activities benefiting the youth in the center. The center provided a copy of the daily schedule for review, which documented the days, times, and all elements outlined by the Department's policy. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site; therefore, observation of activities and programming was not possible. The center maintains a copy of the daily schedule throughout the center. The center had one youth during the week of the annual compliance review. An interview with the youth confirmed the center maintains a daily schedule. Three staff were interviewed, and all reported the daily schedule is followed.

| 2.12 Adherence to Daily Schedule | Satisfactory Compliance |
|---|---|
| *Center staff shall adhere to the daily activity schedules. Documentation of all activities shall be made in all applicable logs.*<br><br>*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.*<br><br>*Any cancellation of visitation shall be approved by the superintendent.* | |

The center has a written policy and procedures which outlines adherence to a daily schedule. A review of the center's daily activity schedule, in comparison with logbooks for various dates within the past six months, confirmed the center's adherence to the daily schedule. An interview with the center's superintendent regarding outdoor recreation revealed when the heat index exceeds ninety degrees, the center provides indoor recreational activities opposed to outdoor recreational activities. The logbooks did not indicate any significant changes in the schedule. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site; therefore, observation of daily activities was not possible. The center had one youth during the week of the annual compliance review. An interview with the youth confirmed the center's adherence to the daily schedule. Three staff were interviewed, and all reported the daily schedule is followed.

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

The center has a written policy and procedures ensuring educational access to youth in the center. The center offers an education component operating on a year-round basis. Education instruction is provided by the Monroe County School District. An interview with the lead educator and a review of the center's logbooks confirmed the center's educational program is scheduled on-site Monday through Friday. The center's educational schedule also designates nine days set aside for Saturday school. The lead teacher also reported providing the youth within the

center 240 days of instruction, which is distributed over twelve months, with a minimum of twenty-five hours of instruction weekly. Six days are provided for professional planning. A review of the center's logbooks found youth were involved in classroom activities as designated by the daily activity calendar with minimal interference. The lead teacher reported youth still attended school during the COVID-19 pandemic. Youth were provided with paper packets to complete as an alternative method. The center had one youth during the week of the annual compliance review. One interviewed youth was aware of the courses currently offered at the center. The youth also confirmed the center conducts school Monday through Friday. Three staff were interviewed regarding educational classes, and each reported there is minimal interference during educational instruction time. A review of the school calendar and school courses, in addition to an informal interview with the center's shift commander, confirmed the center's practice.

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

The center has a policy and procedures regarding career education. The center offers a career education competency development program provided by the Monroe County School District. The center offers Type One career education, which teaches personal accountability skills, behaviors appropriate for students in all age groups and ability levels, leading to work habits which help maintain employment and living standards. The center utilizes Life Centered Career Education for their career education curriculum. An informal interview with the lead teacher found the school district has partnered with Edmentum to provide an online experience filled with engaging courses and attainable credit recovery, assisting youth to get back on track towards graduation.

| **2.15 Behavior Management System** | **Satisfactory Compliance** |
|---|---|
| *The center provides a system of rewards, privileges, and consequences to encourage youth to fulfill the center's expectations.*<br><br>*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.*<br><br>*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 outlining behavioral management to ensure the safety and security of youth and staff. The center utilizes an approved statewide behavior management system (BMS) which has levels one, two, and three, and includes rewards for positive behavior, and consequences for negative behavior. The rewards and privileges increase as youth progress through the system. The center's three-level system provides youth with all basic rights and additional privileges such as a 9:30 p.m. bed time, extra snacks weekly, haircuts, additional ten-minute telephone calls each week, participation on honor module, and participation in work detail. Youth levels are updated daily on the level sheets. Youth can view their status and are able to ask questions, if needed. An informal interview with the center's shift commander confirmed this practice. All newly admitted youth receive an orientation on the BMS upon arrival to the center. The shift commander also confirmed once a youth reaches level

three, youth can receive items such as a soft pillow and blanket, pajamas, slippers, and a journal. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site; therefore, daily activities to determine implementation of the BMS was not possible. The center had one youth during the week of the annual compliance review. The interviewed youth rated the center's BMS as very good. The youth reported never receiving any consequences since admission to the center. Three staff were interviewed, and all staff thought the BMS was effective. Each staff reported they discussed consequences imposed, speak with the youth about alternative behaviors, and give the youth the opportunity to explain their behavior. Each staff stated youth will drop a level and/or lose points as a consequence to negative behaviors. Each staff stated they receive feedback from their supervisor regarding the implementation of the BMS, as needed.

| **2.16 Unauthorized Use of Punishment (Critical)** | **Satisfactory Compliance** |
|---|---|
| *The center's behavior management system (BMS) restricts certain types of penalties on youth who demonstrate negative behaviors.*<br><br>*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.*<br><br>*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.*<br><br>*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 written policy and procedures in place prohibiting group and/or corporal punishment of youth. The center utilizes a level system. Upon admission, all youth are placed on level two. During their stay, if the youth's behavior is good, the level will be raised until they have reached a level three status. The center reported there were no incidents indicating any unauthorized use of punishment since the last annual compliance review. The center had one youth during the week of the annual compliance review. One interviewed youth reported youth are not allowed to punish other youth. The youth reported never being sent to a room for punishment or witnessing mechanical restraints used on out of control youth to prevent them from hurting themselves or others. Three interviewed staff indicated they have not witnessed an unauthorized use of punishment nor observed staff encouraging youth to participate in physical altercations. All interviewed staff reported they have never taken away meals, snacks, clothes, education, or medical care for inappropriate behavior.

| 2.17 Grievances | Satisfactory Compliance |
|---|---|

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

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

The center has a written policy and procedures related to youth grievances to ensure each youth has the right to file a grievance and is treated fairly, respectfully, without discrimination, and the youth's rights are protected. The grievance process is posted throughout the center and explained to each youth during the admission and orientation process. The grievance forms are located on each living area and accessible to all youth at the center. The center had no grievances since the last annual compliance review. The superintendent indicated the grievance process has three phases. Phase one, the informal phase, wherein the juvenile justice detention officers (JJDO) attempt to resolve the complaint or condition with the youth and enter the grievance into the Facility Management System (FMS) on behalf of the youth. The second phase is the formal phase and occurs when the JJDO is unable to resolve the original complaint. The written grievance is submitted to the shift supervisor within two hours of completion for review and is then documented in the logbook and forwarded to the superintendent or designee. The third phase is the appeal phase which occurs if the youth was not satisfied with the outcome, the youth may appeal the outcome of the formal phase to the superintendent or designee. The center had one youth during the week of the annual compliance review. The interviewed youth reported never filing a grievance. Three staff were interviewed and were able to explain the center's grievance process.

| 2.18 Trauma-Informed Care | Satisfactory Compliance |
|---|---|

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

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

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

The center has a written policy and procedures for trauma-informed care. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site; therefore, on-site observations of the center's soft room was not possible. The shift commander provided pictures of the

center’s soft room which displayed soothing colors and child-friendly schemes. An interview with the shift commander also indicated the center has art supplies, pajamas, soft blankets, slippers, and pillows. A review of three in-service and three pre-service training records indicated all staff are trained on trauma-informed care. All training is completed and documented in the Department’s Learning Management System (SkillPro).

## Standard 3: Mental Health and Substance Abuse Services

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

The center has a policy and procedures in place to ensure there is a licensed mental health professional in place who will be identified as the designated mental health clinician authority (DMHCA). The DMHCA is responsible for coordination and implementation of mental health and substance abuse services provided at the center. The center's DMHCA is a licensed mental health counselor (LMHC). A review of the license showed it was clear and active in the State of Florida, with an expiration date of March 31, 2021. A review of the DMHCA's job description determined the DMHCA is responsible for overseeing all clinical and administrative operations of the assigned center to ensure clinical integrity, quality, contract compliance, utilization, budget/fiscal efficiency, and Council on Accreditation (COA) compliance. The DMHCA is on-site once a week only when youth are in the center. Reviewed sign-in sheets supported the DMHCA was on-site, as required. An interview with the DMHCA revealed there is communication with on-site mental health staff, when needed, to address any outstanding issues or processes with youth. The mental health staff ensure youth referred receive suicide risk assessment within twenty-four hours and are offered ongoing supportive mental health, and substance abuse services while at the center. Youth are invited to discuss what clinical interventions they would like to work on while detained. Youth who are in the center for thirty days or more receive an updated assessment and individualized treatment plan. The DMHCA will track youth by reviewing and signing all documentation, conducting record reviews, and making corrections to any documentation. Mental health and substance abuse services and youth needs are communicated with the treatment team each during the weekly detention review. During detention review, all youth who are receiving mental health services are discussed using a team approach with education, probation, the superintendent or designee, and medical staff. Daily coordination with mental health staff, supervisors, and briefing with the superintendent designee is conducted when youth are admitted. The DMHCA coordinates with the psychiatrist for those youth who need evaluation or medication management. Every Tuesday, the psychiatrist is updated on youth behaviors and medication is discussed. The DMHCA also reported the mental health staff also communicate with all departments, as needed.

| 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 to ensure mental health services and substance abuse services are provided by individuals with appropriate qualifications. The center has a backup designated mental health clinician authority (DMHCA) who ensures the non-licensed clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience. The backup DMHCA maintains a

license as a mental health counselor (LMHC). A review of the license showed it to be clear and active in the State of Florida, with an expiration date of March 31, 2021.

| **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 to ensure services are provided by individuals with appropriate qualifications. The center has a backup designated mental health clinician authority (DMHCA) who ensures the non-licensed clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience. The center has two non-licensed mental health counselors who both hold a master's-level degree. One holds a Master of Science in clinical mental health counseling and the second holds a Master of Arts in professional counseling. Documentation showed both non-licensed clinicians are qualified to provide services based on education, training, and experience. Both non-licensed clinicians received twenty hours of training, which was completed in the presence of the licensed mental health professional and included five Assessments of Suicide Risk (ASR). A review of supervision logs for the past six months showed each non-licensed clinician received weekly face-to-face direct supervision from the center's DMHCA and/or the backup DMHCA.

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

The center maintains a written policy and procedures ensuring mental health and substance abuse needs of youth are identified through a comprehensive screening process ensuring referrals are made when youth are identified with mental health and/or substance needs or are identified as a possible suicide risk. A review of mental health record documentation for three youth showed each youth received a completed Suicide Risk Screening Instrument (SRSI) and a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2), which was completed by detention staff, upon admission. Both documents were in the Department's Juvenile Justice Information System (JJIS). Medical and/or mental health staff completed the required sections of the SRSI in all three records. Each record included a summary and recommendations within the screening results sections. Two of the three youth were applicable for positive "yes" responses on the SRSI form and were placed on suicide precautions, and a mental health referral was completed. Two reviewed SRSIs and MAYSI-2 assessments indicated the need for further assessment, and the center notified mental health staff and the superintendent, as required. All reviewed screenings where completed by a trained staff.

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

The center maintains a written policy and procedures ensuring youth who are identified through preliminary screening or during intake and admission, with mental health and/or substance abuse issues or needs are referred for a further in-depth mental health and/or substance abuse evaluation. In an interview, the designated mental health clinician authority (DMHCA) stated youth are referred for a comprehensive evaluation based on the results of the Massachusetts Youth Screening Inventory - Second Version (MAYSI-2) and staff observations. The center utilizes the Global Appraisal of Individual Needs (GAIN-1), a comprehensive bio-psychosocial assessment designed to support clinical diagnosis, placement, treatment, planning, performance monitoring program planning, and economic analysis. Each GAIN-1 is completed by mental health staff. A review of three youth mental health and substance abuse records found two youth were applicable for a mental health and substance abuse evaluation; however, neither youth remained in the center long enough to be assessed within the required time frame. In addition, none of the three youth were applicable for a comprehensive assessment, as they were not detained longer than thirty-days.

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

The center maintains a written policy and procedures ensuring mental health and substance abuse 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 the youth to function adequately. Each youth determined to need mental health treatment, including treatment with psychotropic medications or substance abuse treatment while in the center, must be assigned to a mini-treatment team. The mini-treatment team meets bi-weekly to discuss each youth receiving services. An interview with the designated mental health clinician authority (DMHCA) confirmed the center's practice and treatment services provided. A review of three youth mental health and substance abuse records indicated none were applicable for treatment services. The DMHCA confirmed there were no youth in the center applicable for treatment services since the last annual compliance review. Any youth applicable to receive treatment services must have a properly executed Authorization for Evaluation and Treatment (AET) form and a signed youth consent for substance abuse treatment. The center maintains a Chapter 397 license by way of Guidance Care Center which expires on July 10, 2020. There were no youth securely detained at the time of the annual compliance review who were receiving mental health treatment services.

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

The center maintains a written policy and procedures ensuring mental health and substance abuse 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 the youth to function adequately. All youth receiving mental health and substance abuse treatment 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 the youth's release. A review of three youth mental health and substance abuse records found none were applicable for requiring an initial treatment plan completed within seven days of initiation of treatment. An interview with the designated mental health clinician authority (DMHCA) confirmed there were no applicable youth in the center since the last annual compliance review. The policy and procedures stated the initial treatment plan must be completed within the required seven-day time frame and included the reason for referral for treatment, the initial Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, initial treatment methods, and goals. In addition, each applicable plan must include the need for psychiatric services and/or psychotropic medication and frequency of monitoring. Each youth with a treatment plan must also have a mental health and substance abuse discharge summary completed on the Department's required form. Each completed discharge summary must be signed by the youth, clinical staff, licensed mental health clinician, and treatment team members. An interview with the DMHCA explained parents/guardians are provided a copy of the discharge summary by mail, and the assigned juvenile probation officer is provided a copy of the discharge summary by e-mail.

| 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 written policy and procedures ensuring psychiatric services are provided to youth in need, to include psychiatric evaluation, consultation, medication management, and medical supportive counseling. Psychiatric services are provided to youth in need of services, as indicated by symptoms of mental disorder or substance-related disorder, or to youth who are treated with psychotropic medication subsequent to their admission to the center. The center maintains a contract with Camelot Community Care, Inc. for the provisions of a licensed psychiatrist to provide psychiatric services for applicable youth in the center. Camelot Community Care, Inc. provides a psychiatrist who is contracted to provide services for one hour each week youth are on-site and in need of services. The psychiatrist is an osteopathic physician with a clear and active license in the State of Florida which expires on March 31,

2021. The center does not utilize a psychiatric advanced practice registered nurse (APRN). Scheduling of the psychiatrist will be coordinated by Camelot Community Care, Inc. and the center's superintendent for services to meet contractual and Florida Administrative Code requirements for psychiatric services. The center's approved facility operating procedures (FOP) includes tele-psychiatry. The FOP indicates the psychiatric care delivered through tele-psychiatry is intended to remain the same as rendered face-to-face care. Psychiatric services are conducted through tele-psychiatry one hour a week, as needed. A review of psychiatric documentation supported the psychiatrist was meeting contractual requirements. A review of three youth mental health and substance abuse records indicated one applicable youth was admitted to the center on prescribed psychotropic medications. The designated mental health clinician authority (DMHCA) reported there were no other applicable youth who were admitted to the center taking psychotropic medication or subsequently prescribed psychotropic medication since the last annual compliance review. The one applicable youth was referred for an initial psychiatric diagnostic interview. The initial psychiatric interview was conducted within fourteen days of the youth's admission and included all required elements inclusive of the reason for the referral, history, mental status examination, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, treatment recommendations, prescribed medication with the explanation for the need when applicable, and frequency of medication monitoring. The one youth admitted on psychotropic medication was not applicable for an in-depth psychiatric evaluation within thirty days of intake or the referral utilizing the Department's Clinical Psychotropic Progress Note (CPPN) due to not meeting the length of stay requirement of thirty-days. There were no applicable youth requiring Tardive Dyskinesia monthly monitoring. Reviewed documentation validated consent for psychotropic medication was not required because there were no new medications prescribed or any changes to existing medications. The applicable reviewed youth record contained a copy of the signed Authority for Evaluation and Treatment.

| 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 a suicide prevention plan is in place to safely screen, refer, assess, monitor, and protect youth with elevated risk of suicide in the least restrictive means possible. The plan was revised and approved by the superintendent on June 1, 2020 and the designated mental health clinician authority (DMHCA) on June 2, 2020. The plan included the identification and assessment of at-risk youth for suicide, suicide risk alert, levels of supervision, suicide precautions, referrals, documentation, notification and communication, immediate staff response, use of extra precautions, review process, and emergency contact telephone numbers. In an interview, the shift commander reported the plan is maintained in the center's master control and accessible to all staff.

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

The center maintains a written policy and procedures ensuring a suicide prevention plan is in place to safely screen, refer, assess, monitor, and protect youth with elevated risks of suicide in the least restrictive means possible. A review of three closed applicable youth mental health and substance abuse records indicated each youth was placed on Precautionary Observation (PO) resulting from an elevated risk of suicide at the time of admission due to prior suicide alerts. Reviewed documentation found all three applicable youth records documented a new suicide alert was placed in the Department's Juvenile Justice Information System (JJIS). Each of the three completed mental health/substance abuse referral summaries contained documentation requesting an Assessment of Suicide Risk (ASR) be completed and each of the three records documented completion of the ASR. Each ASR was completed within twenty-four hours or less for all applicable youth. Three ASRs were completed by a non-licensed mental health clinician and reviewed by the licensed mental health counselor (LMHC) within twenty-four hours. Reviewed training records for the non-licensed mental health therapist supported the staff received the required suicide prevention training to complete the ASR. Reviewed documentation supported the non-licensed therapist completed twenty hours of training and supervised experience including five ASRs, and/or crisis assessments, conducted on-site in the physical presence of the licensed mental health counselor (LMHC). A review of the center's logbook entries clearly documented the beginning and ending times youth were placed on PO. In an interview, the shift commander reported staff are provided instructions related to the suicide risk assessment findings and suicide precaution decisions during the shift briefings. Three interviewed staff were able to articulate the center's procedure when a youth is identified with an elevated suicide risk. Each staff stated they would notify the mental health authority, search the youth and the youth's room for sharp objects, document supervision, and place the youth on constant sight and sound supervision. There were no youth securely detained at the time of the annual compliance review who were placed on suicide precautions.

| **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 ensuring the staff assigned to monitor each youth on suicide precautions must maintain one-to-one supervision or constant supervision and document their observations of the youth's behavior on the Department's Suicide Precautions Observation Log. A review of three records for youth placed on Precautionary Observation (PO) documented Suicide Precautions Observation Logs were

maintained for each youth. Each completed log documented the safe housing areas, and each documented the observations in real time, at required intervals. Reviewed logs supported the mental health therapist and shift supervisor(s) reviewed and signed, as required for two of the three youth. One youth's PO log was missing the Charlie shift supervisor's review and signature. The center had no youth applicable for Secure Observation.

| 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 policy and procedures ensuring all staff will receive at least six hours of suicide prevention and implementation of suicide precautions training annually. The mental health clinical staff will assist in training staff on suicide prevention, including verbal and behavioral cues which indicate a suicide risk, throughout the year. All staff who work with youth must be trained in suicide precautions and emergency response procedures and participate in mock suicide drills quarterly, on each of the three shifts. Three reviewed staff training records found each received the required four hours of instructor-led and two hours of web-based training of suicide prevention and implementation of suicide precautions training, in the Department's Learning Management System (SkillPro). The center's designated mental health clinician authority (DMHCA) conducts mock suicide drills on each shift, at least quarterly. Reviewed suicide drills from August 2019 through June 2020, supported drills were conducted at least quarterly on all three shifts and each staff participated in at least one drill semi-annually. Each drill documented the demonstration of life-saving techniques including utilization of cardiopulmonary resuscitation (CPR), the automated external defibrillator (AED), and demonstration of first aid. Staff who are not present during a quarterly drill have the opportunity to review each drill scenario and procedures to understand the process and receive the necessary training to respond to an incident of suicide attempt or incident of self-inflicted injury in the center during monthly all-staff meetings. This practice was validated in an interview with the center's shift commander. Three interviewed staff reported the center maintains a suicide response kit in master control. Two of the three staff indicated there is also a suicide response kit in the medical clinic.

| 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 policy and procedures ensuring the center responds 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 center maintains a combined emergency services plan which addresses mental health crisis intervention procedures. The plan was revised and approved by the superintendent on June 1, 2020 and the designated mental health clinician authority (DMHCA) on June 2, 2020. The plan detailed crisis intervention procedures inclusive of verbal de-escalation and Protective Action Response, as set forth in Florida Administrative Code, notification and alert system, referrals including self-referral, crisis assessment and follow-up mental health status examination, communication, supervision,

mental health supportive services, and documentation and review. In an interview, the shift commander reported the plan is maintained in the center's master control and accessible to all staff.

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

The center maintains a written emergency care plan outlining mental health and substance abuse emergency procedures and ensure youth who are believed to be an imminent danger to themselves or others, due to mental illness or substance abuse impairment, receive emergency mental health or substance abuse services. The plan was revised and approved by the superintendent on June 1, 2020 and designated mental health clinician authority (DMHCA) on June 2, 2020. The plan detailed emergency procedures inclusive of immediate staff response, notification and communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment under Chapter 394 Florida Statute (Baker Act), transportation for emergency mental health evaluation and treatment under Chapter 397 Florida Statute (Marchman Act), return from emergency mental health or substance abuse services, documentation, training and mock drills, and review. The center utilizes Lower Keys Medical Center for crisis stabilization. In an interview, the shift commander reported the plan is maintained in the center's master control and accessible to all staff.

| 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 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 center's mental health crisis intervention plan includes a notification and alert system, means of referral inclusive of self-referral, communication, supervision, documentation and review. An interview was conducted with the regional mental health and substance abuse clinical director for the south region who confirmed the center had no applicable youth requiring a crisis assessment since the last annual compliance review.

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

The center did not have any Baker Act or Marchman Act proceedings since the last annual compliance review; therefore, this indicator rates as non-applicable

# Standard 4: Health Services

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

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

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

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

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

The center has a written policy and procedures to ensure the completion of the Authority for Evaluation and Treatment (AET) or Limited Consent for Evaluation and Treatment authorizing specific treatment for youth in the custody of the Department. A review of three youth healthcare records supported two contained a copy of a signed Authority for Evaluation and Treatment (AET) form which was clearly stamped as a “copy.” The third record contained the original AET form. The record containing the original AET form also contained a previously executed Limited Consent for Evaluation and Treatment allowing initial authorization for youth treatment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

| 4.11 Sick Call Process [Detention Staff/Contract Provider] | 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 and maintains designated health authority (DHA) approved non-licensed protocols appropriate to the level of the juvenile justice detention officer supervisor (JJDOS) reviewing submitted Sick Call Request forms. The center utilizes the Department's Facility Management System (FMS) to enter a sick call request made by a youth. Interviews with the center's shift commander and nursing staff indicated there was no documented practice of JJDOS staff reviewing Sick Call Request forms when licensed nursing staff were not on-site in the last twelve months. One youth was interviewed regarding sick call services at the center. The youth reported he was not receiving medical services and never submitting a sick call request. Three staff were interviewed regarding the center's sick call process. Each of the three staff reported the center's nurse conducts sick call. Three staff were interviewed regarding their ability to call 9-1-1 if they felt it was necessary. Each of the three staff reported staff are able to call 9-1-1 if needed.

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

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

| 4.13 Off-Site Care/Referrals [Contract Provider] | Non-Applicable |
|---|---|
| *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 medical provider began services on March 17, 2020. Due to the recent change in medical providers, the new provider has not had the opportunity to demonstrate practice for the past six months. Medical services provided through the contracted provider, Camelot Community Care, Inc. will be reviewed at a later time.

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

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

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

The center has a written policy and procedures ensuring all medication and pharmaceutical products are stored safely, accurately, and in accordance with state, federal, and industry standards. The center's practice is for the nursing staff to verify medication with the parent/guardian delivering medication to the center. Youth who are taking medication while in the care of the center are administered medications by the healthcare professionals. Six juvenile justice detention officer supervisors (JJDOS) are trained in medication administration and administer medication in the absence of the healthcare professionals. Reviewed documentation supported the training was provided by the registered nurse. An interview with the nurse and the shift commander noted there was only one instance of a JJDOS assisting in the delivery of medication to youth when licensed nursing staff were not on-site in the past twelve months. The non-licensed staff and youth initialed the delivery of medication on the Medication Administration Record (MAR) for two separate occasions. The medication was delivered, as ordered, and there were no documented refusals. Three staff were interviewed regarding whether or not they personally provided medication to youth. Two staff reported they did, and one staff reported they did not. The two staff who reported they did were supervisors and authorized to assist youth in the self-administration of medication.

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

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

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

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

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

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

# Standard 5: Safety and Security

| 5.01 Active Supervision of Youth (Critical) | Non-Applicable |
|---|---|

*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.*

In accordance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site; therefore, this indicator shall be reviewed at a later time.

| 5.02 Ten-Minute Checks (Critical) | Non-Applicable |
|---|---|

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

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

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

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

In accordance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site; therefore, this indicator shall be reviewed at a later time.

| 5.03 Census, Counts, and Tracking | Satisfactory Compliance |
| --- | --- |

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

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

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

The center maintains a written policy and procedures to ensure the census, counts, and tracking of all youth under the juvenile justice detention officer (JJDO) staff supervision shall always be maintained. The center requires all head counts to be taken and called into master control at the beginning and end of each shift, following any emergency, prior to and following routine group movement, when a population change occurs, and randomly on each shift. A review of master control logbooks for the past six months found the center documented the daily counts, youth movement, drills, and emergency counts in the master control logbook. Three interviewed staff reported counts are conducted at the beginning of shift and before and after meals. Staff also reported when counts are not correct, all movement is stopped, and a recount is conducted. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site; therefore, observations of the center's counts being conducted was not possible.

| 5.04 Logbook Maintenance | Satisfactory Compliance |
| --- | --- |

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

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

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

The center maintains a written policy and procedures outlining the chronological record of events, incidents, and activities in logbooks maintained at master control and in each living area in accordance with Florida Administrative Code. The center is required to maintain a logbook in master control and one for each living unit. A review of a random sampling of logbooks for the

past six months showed all logbooks were bound with numbered pages and with the date documented at the top of the page. Reviewed logbook entries were legible and written in ink. Reviewed documentation showed no errors struck through with a single line in the logbooks. The master control logbook entries included transportation, emergency situations, incidents such as contacts to the Florida Abuse Hotline, contact to the Department's Central Communications Center (CCC), drills, documentation of medical and mental health alerts, population counts, emergency situations, group movement, admissions, releases, and presence of law enforcement. The center does not utilize an electronic logbook.

| **5.05 Logbook Reviews** | **Satisfactory Compliance** |
| --- | --- |
| *The superintendent or designee reviews all logbooks on a weekly basis.*<br><br>*The supervisor(s) reviews the facility logbook maintained at master control when he/she accepts responsibility for the facility.*<br><br>*The juvenile justice detention officer (JJDO) supervisor(s) reviews logbooks maintained in each living area daily.*<br><br>*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 center's juvenile justice detention officer supervisor (JJDOS) documents a review of logbooks daily at the beginning of each shift. Each juvenile justice detention officer (JJDO) reviews the logbooks each shift to document awareness of current relevant situations in the center. A sample of master control and living unit logbooks for the past six months were reviewed and verified the JJDOS 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. The center practice is to have JJDOS and administrative staff conduct regular logbook reviews. JJDOS staff documented daily review and administrative staff documented weekly reviews. Reviewed documentation verified this practice.

| 5.06 Key Control | Satisfactory Compliance |
| --- | --- |

*Each center is responsible for maintaining inventory and control of all facility keys.*

*All keys shall be placed on a tamper-resistant key ring designed to inhibit the removal of keys.*

*Emergency key rings shall be maintained separately from other facility keys, in master control, in a secure location designated by the Superintendent. These keys shall be notched or otherwise identifiable by touch.*

*The key(s) on these rings shall provide egress through facility exterior doors providing access to evacuation areas.*

*A key inventory shall be maintained by the Superintendent or designee at all times.*
*(For the entire indicator statement, please reference the Monitoring and Quality Improvement FY 2019-2020 Detention indicators.)*

The center maintains a written policy and procedures ensuring the proper usage, storage, and general security of facility keys. A review of the key inventory was conducted and was verified to match the actual key rings in use. The center keys are maintained on a tamper-resistant ring with a brass tag identifying the ring number and the number of keys on the ring. All restricted keys for medical, mental health, and education staff are stored in master control in a locked key box distributed by the master control operator. Emergency keys are kept in the superintendent's office in a lock box. Key inventory and issuance of keys is documented during each shift to include the date, time, name of staff receiving the keys, time keys were returned, and name of supervisor issuing the keys. Policy states if a key becomes lost or missing, a supervisor is notified, if the keys are not located, the Department's Central Communications Center (CCC) is contacted. According to the center's shift commander, the center had no incidents of lost keys or broken keys since the last annual compliance review. Three staff were interviewed to verify which center keys are restricted. All three staff indicated the center maintains restricted keys for medical records and mental health records, and two indicated for the youth property area. Interviews with staff indicated youth do not have access to center keys. An interview with the center's shift commander reported the center does issue permanent keys to two staff members. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site; therefore, observation of the center's collection and distribution of keys was not possible. A Face-Time teleconference observation was attempted but the service was very poor. As an alternative to the Face-Time teleconference, the center provided three pictures of staff holding the key rings to match the inventory key log.

| 5.07 Vehicles and Maintenance | Satisfactory Compliance |
| --- | --- |

*The center ensures any vehicle used by the center to transport youth is properly maintained, as well as maintains documentation on the use and maintenance of each vehicle.*

*Youth and staff are not permitted to use tobacco products.*

*Center vehicles are locked when not in use.*

The center maintains a written policy and procedures for operating and maintaining vehicles used to transport youth. The center has two vehicles, one caged sedan and one fifteen

passenger caged van. The center does not have a maintenance mechanic and the weekly and monthly vehicle inspections are conducted by the supervisors or transportation officers. Each vehicle was equipped with the appropriate number of seat belts, seat belt cutter, window punch, fire extinguisher, and a first aid kit which was verified by pictures the center sent to the annual compliance review team due to the review being conducted off-site. The center utilizes a vehicle maintenance monthly inspection checklist, weekly vehicle checklist, daily vehicle checklist, and a pre-trip vehicle inspection sheet. Reviewed documentation reflected each of the two vehicles utilized to transport youth received an annual vehicle inspection. Documentation supported the center's supervisors or transportation officers conduct weekly visual checks of each transport vehicle including the water coolant, lights, oil, emergency equipment, brakes, horn, interior/exterior, and cleanliness. The center also conducts a monthly check of each vehicle including the tires, battery, windshield, wipers, windows, mirrors, and damage. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site; therefore, observations of a youth transport and the security of vehicles while not in use was not possible.

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

The center maintains a written policy and procedures to ensure all tools and equipment related to maintenance are properly maintained, stored, and inventoried. The policy forbids youth to use or access any tools. The center does not store tools. Youth may use cleaning items such as brooms, mops, buckets, and other common household items under direct supervision of staff. Three staff were interviewed, and two staff reported the center does not have tools. The third staff stated the youth are only permitted to use mops and brooms.

| 5.09 Youth Access & Use of Tools, Cleaning Items (Critical) | Satisfactory Compliance |
| --- | --- |
| *Youth are forbidden to use or access any tools, including kitchen or medical equipment.*<br><br>*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 for kitchen tools and medical equipment. The policy forbids youth to use or access any tools. Food service is provided by the Monroe County Sheriff's Office and meals are prepared in the kitchen at the county jail and delivered to the center. There are no kitchen tools stored at the center. Youth may use cleaning items such as mops, brooms, buckets, and other common household items under the direct supervision of the juvenile justice detention officer (JJDO) staff. One interviewed youth stated he has never used tools at the center. Three staff were interviewed, and two staff reported the center does not have tools. The third staff stated the youth are only permitted to use mops and brooms. In compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this annual compliance review was conducted off-site; therefore, observation of youth using cleaning tools was not possible.

| 5.10 Inventory of all Flammable, Toxic, Caustic, and Poisonous Items | Satisfactory Compliance |
|---|---|
| *The Superintendent is responsible for the implementation of a safety plan addressing proper use, storage, and disposal of chemicals, including flammable, toxic, caustic, and poisonous items.*<br><br>*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.*<br><br>*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.*<br><br>*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 storage and inventory of flammable, toxic, caustic, and poisonous items. The center maintains a master monthly inventory list of controlled materials, identifying the item, location, beginning inventory, new stock, used stock, and ending inventory. The center's flammable, toxic, caustic, and poisonous items are stored in a secure locked closet, inaccessible to the youth. A complete inventory of all such items was conducted. A Safety Data Sheet (SDS) binder is maintained with each material and a number corresponding to the SDS for each chemical. A review of inventories and SDS forms verified the practice.

| 5.11 Access to all Flammable, Toxic, Caustic, and Poisonous Items | Satisfactory Compliance |
|---|---|
| *Flammable, toxic, caustic, and poisonous fluids and other dangerous substances may only be drawn or acquired by authorized personnel.*<br><br>*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 to ensure flammable, toxic, caustic, and poisonous fluids, and other dangerous substances may only be accessed by authorized staff and youth are not permitted to use, handle, or clean-up dangerous or hazardous chemicals spills. All flammable, toxic, caustic and poisonous materials are stored in a secure locked closet, inaccessible to youth. Three interviewed staff reported youth are not allowed to clean with toxic, flammable, or poisonous substances. One youth was interviewed regarding the use of chemicals at the center. The youth reported not being permitted to use any chemicals and not having access to toxic items.

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

The center maintains a written policy and procedures ensuring the maintenance staff 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) standards. The center does not have kitchen services on-site; therefore, there is no grease trap or other liquids to be disposed of in the center. Liquid waste resulting from work details is disposed of in the center's utility sink. An interview with the center's shift commander indicated there were no chemical spills since the last annual compliance review. An interview with the center's shift commander reported the Monroe County Facilities Maintenance Department handles all disposal of flammable, toxic, caustic, and poisonous items.

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

The center maintains a written policy and procedures for confinements under twenty-four hours. Staff are required to use behavioral confinement as an immediate, short-term, crisis management strategy for use during volatile situations in which one or more youth's sudden or unforeseen onset of behavior imminently and substantially threatens the physical safety of others and compromises security. The center documents confinements under twenty-four hours in the Facility Management System (FMS). Three staff were interviewed regarding staff responsibilities when a youth was placed in confinement. All three staff reported ten-minute checks would be conducted and documented. One staff also reported the staff will talk to the youth to deescalate the situation. The center had no confinements under twenty-four-hours since the last annual compliance review.

| 5.14 Confinement Over Twenty-Four Hours | Satisfactory Compliance |
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*Confinement beyond twenty-four hours must be approved by the Superintendent or designee.*

*The Superintendent shall approve confinements extended beyond twenty-four hours and every twenty-four hours afterwards. Reasons for extended confinement must be clearly documented on the confinement report.*

*The JJDOS(s) shall continue to evaluate and document the youth's status every three hours. Current youth behavior and/or conversation with the youth shall be documented on the confinement report as evidence for the need to continue or terminate confinement.*

*If it is necessary to extend the confinement beyond twenty-four (24) hours, permission is needed from the regional director or designee. The regional director will notify the Assistant Secretary. This must be done every twenty-four (24) hours.*

*The length of confinement shall not exceed three days unless the release of the youth into the general population would jeopardize the safety and security of the facility as documented by the Superintendent. No youth shall be held in confinement beyond three days without a confinement hearing, conducted by an employee of the Department who holds a management or supervisory position.*

The center maintains a written policy and procedures for confinement over twenty-four hours which requires confinement reports to be submitted within one hour of the incident and reviewed within two hours by the superintendent or designee. The supervisor must conduct reviews within three hours, document the youth's behavior, and the reason for continued confinement. All confinements beyond the twenty-four-hour time span must also be approved by the regional director or designee. The center had no confinements beyond twenty-four hours since the last annual compliance review.

| 5.15 Continuity of Operations Planning (COOP) Drills | Satisfactory Compliance |
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*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 procedures ensuring a plan is in place to effectively manage emergencies and disaster events, including those requiring the detention center to relocate youth and staff while maintaining operations, safety, and security. The center has a Department approved Continuity of Operations Plan (COOP) which outlines a comprehensive approach to effectively manage emergencies and disaster events. The center is required to conduct two COOP drills annually. Hurricane COOP drills were conducted May 20, 2020 and August 29, 2019. A review of documentation found there were written scenarios, findings, and recommendations on the center's emergency drill reporting forms. Three staff were interviewed regarding their participation in drills. Staff reported participating in weather, bomb threat, escape, and fire drills in the past six months.

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

The center maintains a written policy and procedures to ensure staff are prepared to address youth escapes and prevention. Staff are trained on the requirement to remain alert and attentive to the moods, attitudes, and behaviors of the youth. The center is required to conduct simulated escape drills on a quarterly basis. Reviewed documentation of drills for the past twelve months supported escape drills were conducted quarterly on each shift. Reviewed logbooks contained documentation of when escape drills were conducted. A review of three staff in-service and three pre-service training records verified annual escape training was completed by all staff. Three interviewed staff indicated they have participated in an escape drill at the center in the past six months.

| 5.17 Fire Drills | Satisfactory Compliance |
| --- | --- |
| *Management has implemented a disaster preparedness plan and fire prevention plan.*<br><br>*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 preparedness plan which addresses its fire prevention plan. The center's annual fire extinguisher inspection is conducted by the local fire official in April of each year; however, due to the COVID-19 pandemic, this year's annual inspection was postponed. The center's last annual inspection was conducted on May 9, 2019. A review of the emergency drill forms and the logbook documentation for the past twelve months verified the center conducted fire drills every month on each shift. Each completed drill documented an evaluation and recommendations for improved emergency response. Three interviewed staff indicated fire drills take place at least once a month at the center.