STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Palm Beach Regional Juvenile Detention Center

Department of Juvenile Justice
(State-Operated)
1100 45th Street
West Palm Beach, Florida 33407

Review Date(s): April 14-17, 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 1)
Rondarrell George, Office of Program Accountability, Regional Monitor (Standard 5)
Tonya Gittens, Office of Program Accountability, Regional Monitor (Interviews)
Shakela Minns, Office of Program Accountability, Regional Monitor (Interviews)
Patrick Morse, Office of Program Accountability, Regional Monitor Supervisor (Standard 3 and 4)
Yvrose Sylvain, Office of Program Accountability, Regional Monitor (Standard 2)
Sharon Wong, Office of Program Accountability, Regional Monitor (Standard 2)

Program Name: Palm Beach Regional Juvenile Detention Center MQI Program Code: 207
Provider Name: Department of Juvenile Justice Contract Number: N/A
Location: Palm Beach County / Circuit 15 Number of Beds: 60
Review Date(s): April 14-17, 2020 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

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

Standard 1: Management Accountability
Detention Rating Profile

Indicator Ratings

Standard 1 - Management Accountability		
1.01	Initial Background Screening*	Satisfactory
1.02	Five-Year Rescreening	Satisfactory
1.03	Staff Code of Conduct	Satisfactory
1.04	Incident Reporting *	Satisfactory
1.05	Protective Action Response (PAR)	Satisfactory
1.06	Pre-Service/Certification Requirements *	Satisfactory
1.07	In-Service Training	Satisfactory
1.08	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 *	Non-Applicable
3.03	Non-Licensed MH/SA Clinical Staff	Satisfactory
3.04	MH/SA Admission Screening	Satisfactory
3.05	MH/SA Assessment/Evaluation	Satisfactory
3.06	MH/SA Treatment	Satisfactory
3.07	Treatment and Discharge Planning	Satisfactory
3.08	Psychiatric Services *	Satisfactory
3.09	Suicide Prevention Plan *	Satisfactory
3.10	Suicide Prevention Services *	Satisfactory
3.11	Suicide Precaution Observation Logs *	Satisfactory
3.12	Suicide Prevention Training *	Satisfactory
3.13	Mental Health Crisis Intervention Services *	Satisfactory
3.14	Emergency Care Plan *	Satisfactory
3.15	Crisis Assessments *	Satisfactory
3.16	Baker and Marchman Acts *	Non-Applicable

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Standard 4: Health Services
Detention Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Detention Rating Profile

Indicator Ratings

Standard 5 - Safety and Security		
5.01	Active Supervision of Youth *	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

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Program Overview

The Palm Beach Regional Juvenile Detention Center is a state-owned detention facility, operated by the Department, located in West Palm Beach, Florida. The center serves youth in Palm Beach County within Circuit 15. All youth are processed through the Juvenile Assessment Center (JAC), which is located at the detention center. Male and female youth who are detained pending adjudication, disposition, or placement in a residential commitment program are housed in the sixty-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 Palm Beach County School District. The center's management team includes the superintendent, two assistant superintendents, one administrative assistant, one staff assistant, eight juvenile justice detention officer supervisors (JJDOS), and forty-six juvenile justice detention officers (JJDOs). Mental health and healthcare services are provided through the contracted provider, Camelot Community Care, Incorporated. Mental health services are provided by a licensed mental health counselor who serves as the designated mental health clinician authority (DMHCA), as well as two non-licensed, master's-level mental health therapists. Clinical services provided by the center include mental health and substance abuse evaluations, mental health treatment planning, individual, group, and family therapy, mental health crisis intervention services, on-site psychiatric services, and availability for substance abuse services for youth with co-occurring disorders. Food services are provided by Department staff and include menus, meal planning, meal schedules, special diets, nutritional analysis, daily allowance, food preparation, health certifications, food product standards, sanitation, and cleaning. Staff are responsible for the custody and control of youth in their care, providing youth supervision twenty-four hours a day, seven days a week. The center has three living modules. Two modules are used to house males and one module houses female youth. There are eighty-one security cameras at the center, of which all were operational. At the time of the annual compliance review, the center had four vacancies, which included two JJDOs, one food service position, and one mechanic position. 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 specific indicators or elements were unable to be completed, during this fiscal year. Off-site supplemental reviews were conducted as desk audits throughout the remainder of this fiscal year. 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.

Strengths and Innovative Approaches

- The center created and maintains a butterfly garden. The garden was created in July 2019 and is maintained by the youth. The garden is a peaceful trauma-informed retreat for youth to enjoy.

- The center hosts a culinary program each Monday and Wednesday as part of the Behavior Management System (BMS). Level three youth learn how to budget and make family meals.

- Junior League volunteers began providing life skills training to the center's female youth. This volunteer component is gender-specific and was added since the last annual compliance review.

- The center holds weekly incentive celebrations for youth with positive behavior. Youth with a BMS level of three and a half or higher enjoy snacks and entertainment. Celebrations included "chicken and waffle day", watching movies, and participating in arts and crafts. The center also implemented ice cream socials each Sunday and an incentive canteen for all youth with positive behavior.

- The center hosted their first annual July celebration. Center staff, probation staff, representatives from the public defender's office, and staff from the juvenile assessment center (JAC) attended. The day was coordinated as a field day and included outdoor games, activities, obstacle courses, and lots of freshly made food.

- The center partnered with the Palm Beach County Library System and has its very own small library. The library is located in the center's lobby where youth, visitors, and families, can help themselves to a free book.

- The center hosted a Halloween celebration in October 2019. Youth worked diligently on creating their own haunted houses within each of the three living modules. Youth also participated in original performances such as skits and dances.

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 employees, 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 had twenty-two new Department staff, five new volunteers, and two new contracted staff providing services to youth. A review of all twenty-nine background screenings reflected each received clearance from the Department's Background Screening Unit (BSU)/ Clearinghouse prior to services being provided. None of the reviewed background screenings were applicable for an exemption being obtained prior to working with youth. Each of the twenty-two newly hired direct care staff were applicable for a pre-employment assessment tool to be administered. Each 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 was submitted and completed on January 24, 2020, meeting the annual requirement. The Annual Affidavit of Compliance with Level 2 Screening Standards for school board teachers was submitted to the BSU/Clearinghouse on January 31, 2020.

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

The center maintains a written policy and procedures to ensure all employees, contracted providers, volunteers, mentors, and interns with access to youth undergo a criminal history background check every five years. Four center staff were applicable for the completion of a five-year rescreening since the last annual compliance review. Each five-year rescreening was submitted to the Department's Background Screening Unit (BSU)/ Clearinghouse at least ten days prior to the five-year anniversary date, as required.

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. Five staff records were reviewed. Each record contained a copy of the center's code of conduct signed by the staff member. One staff record was applicable for disciplinary action due to a code of conduct violation. The center provided an additional four staff code of conduct violations which resulted in management response. Five management responses were reviewed and two resulted in dismissal, two resulted in a written reprimand, and one resulted in an oral reprimand. All management responses were maintained within the applicable staff record. None of the original reviewed five records were applicable for commendations. The center provided five staff records applicable for commendations. Each of the five records contained a copy of an award certificate. Four staff were recognized for leadership skills and one was recognized as the employee of the month. An interview with the center's superintendent reported awards are formally given to staff providing exemplary service during the monthly all staff meetings. Five youth were interviewed during the annual compliance review. Each youth reported staff are respectful when speaking to youth. Each of the five youth reported they have never heard staff use profanity when speaking to youth. All five youth also reported they have never been threatened by staff or heard staff threaten other youth. Five staff were interviewed regarding working conditions at the center. One staff rated the working conditions as fair, one staff reported the working conditions were very good, and three staff rated the working conditions as good. No staff offered additional comments. Five staff were questioned on how often they observed a co-worker using profanity when speaking to youth. Three staff reported neve, and two staff reported once. One staff commented they observed a co-worker using profanity but not towards a youth and talked to the staff member about the use of profanity. Another staff member reported "we're human and it's not often a word would slip." Five staff reported they have never observed a co-worker using threats, intimidation, and/or humiliation when interacting with the youth. An interview with the center's superintendent reported the employee code of conduct includes actions taken if physical abuse, threats, or profanity towards youth is used. The superintendent reported when there is an alleged violation of the code of conduct an officer is removed from youth contact and assigned a different post while the allegation is being investigated. If the allegation is

substantiated, the officer is retrained, reprimanded, and/or dismissed. Five interviewed youth each reported feeling safe at the center.

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 a total of nineteen incident's reported to the CCC during the past six months. There was a decrease of CCC reports at the center compared to the previous year. A review of five randomly selected CCC reports was conducted. Each incident was reported within the required two-hour time frame and was also documented within the center's master control logbook. There were no observed internal incident reports and/or grievances which should have been reported to the CCC. Five staff were interviewed and was able to explain the process for allowing staff and youth to call the Florida Abuse Hotline and/or the CCC to report suspected abuse. Four staff reported they would allow the youth to make the call, three staff reported they would notify a juvenile justice detention officer supervisor (JJDOS), and two staff reported the JJDOS would make the call. One staff also reported they would log the call in the center's logbook, another staff reported the JJDOS would dial the number for the youth, and a third staff reported they were not sure since they never had to make a call; however, the staff would dial the number for the youth. Five youth were interviewed regarding access to reporting abuse. Two youth reported they have never been stopped from reporting abuse since being at the center and two youth stated they never had to report abuse. An interview with the center's superintendent explained all incidents are reported to the CCC and/or Florida Abuse Hotline when noted or reported. The expectation is for all incidents to be reported in a timely manner. The center's shift supervisor will contact the superintendent and parent/guardian, if needed and call the CCC within the two-hour time frame.

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

The center 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 a total of forty-three PAR incidents during the past six months. Five randomly selected PAR incidents were reviewed. All reports were completed the same day as the PAR incident. Each contained between three and five staff documented statements regarding their involvement in the incident. There were no PAR incidents which resulted in the use of mechanical restraints. None of the reviewed PAR incidents indicated serious injury to youth or staff requiring contact to the Department's Central Communications Center (CCC). None of the reviewed incidents required contact to the Florida Abuse Hotline due to a youth

alleging abuse. Each of the five reviewed PAR incidents documented a PAR certified supervisory review and the completion of a Post-PAR Interview with the youth within thirty minutes of the incident. None of the five reviewed incidents indicated a PAR Medical Review was necessary due to youth distress or injuries. Each of the five reviewed reports documented review and comments by the superintendent or designee within seventy-two hours, as required. Five interviewed staff reported center staff try to talk with youth prior to using PAR. An interview with the center's superintendent reported when PAR events occur staff are required to complete a report within two hours and all reports are reviewed by administration and the center's field training officer. The superintendent further explained, if it is determined there was use of excessive force, the officer is placed on no youth contact. The center's PAR rate during the annual compliance review period was 5.64, which is below the statewide Detention PAR rate of 12.00. The center's PAR rate has decreased since the last annual compliance review.

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. Five randomly selected staff training records were reviewed for completion of pre-service training. Each reviewed staff member obtained a juvenile justice detention officer (JJDO) certification within 180-days of hire. Each staff record 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 being in the presence of youth. Each of the five reviewed records documented the completion of phase one training to include essential skills, orientation, information security awareness, legal, Department organizational training, communication skills, youth management, and active shooter. Each of the five 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. *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. Five randomly selected 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 five 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 on-line suicide prevention training, four hours of instructor-led suicide training, trauma informed care, emergency response, the center's emergency care plan, escape prevention, fire prevention, disaster procedures, and training in professionalism and ethics. Four staff records documented the completion of the annual active shooter training and one record documented the training was incomplete. Two of the five 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 superintendent training, CPR instructor training, and multiple trainings in leadership. The superintendent also reported all staff are required to complete CPR, first aid, women's health, medical, escape, fire, infection control, 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. *Upon completion of the Admission Wizard, the officer shall ensure all Critical and Special Alerts are listed in JJIS.* *The JJIS alert report shall be reviewed daily by supervisors and administrators to ensure it correctly reflects the status of youth.* *If the electronic system is inoperable, for any reason, the JJDO Supervisor shall ensure the last hard copy of the alerts shall have a written notification or update of the recent admissions or changes to existing alerts on the alert sheet and distribute to all staff within the center immediately.* *Medical and mental health staff shall review alerts to ensure each alert is correctly tracked and managed.* *The responses and updates by medical, mental health and other staff should be documented in JJIS alerts as they pertain to the specific alert.* *JJDOS's shall inform staff of alerts during shift briefing. When a JJDOS receives changes to the alert list, he/she shall notify the staff affected by changes and add the information to the shift briefing for the oncoming shift upon receipt of the information.*	

The center maintains a written policy and procedures to ensure the safety and well-being of youth with critical or special alerts are documented, reviewed, and responded to appropriately. Five youth records were applicable for seven 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, Prison Rape Elimination Act (PREA) status, security alerts,

mental health alerts, dietary restrictions, and activity/sports restrictions. The Department's Juvenile Justice Information System (JJIS) alert report is printed, reviewed, and distributed to direct care staff daily by supervisors and administrators. 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 also maintain a current alert list in the medical clinic and kitchen. An interview with the center's superintendent reported the center utilized JJIS print outs to share alerts with staff and all alerts are entered, updated, and reviewed by medical, mental health, and operations staff daily. Five interviewed staff reported they are informed of youth alerts during shift briefings and through alert printouts. Additionally, one staff reported through an alert board, another staff reported through the logbook, and two staff reported through JJIS. Five staff reported they are updated about important issues at the center through staff briefings and four staff reported through regular meetings. One staff also reported receiving updates through electronic mail and from shift supervisors throughout the day.

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 the proper screening, evaluation, and documentation is provided for each youth admitted. The Juvenile Assessment Center (JAC) and the center are co-located in the same building. A review of five youth case management records reflected the juvenile justice detention officer (JJDO) intake screeners completed the Admission Wizard in the Department's Juvenile Justice Information System (JJIS). Each reviewed youth case management record contained an arrest affidavit, Detention Risk Assessment Instrument (DRAI), and a completed Suicide Risk Screening Instrument (SRSI). Each youth record documented the completion of an electronic, frisk, and/or strip search by an officer of the same gender. Each record documented the youth received a telephone call and a meal upon admission. All five youth records contained the completed medical, substance abuse, and mental health admission screenings. The center was not accepting any admissions at the time of the annual compliance review due to the COVID-19 pandemic. In compliance with the Center 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.

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 advise youth of center rules and regulations, expectations for behavior, related consequences for failing to meet behavior

expectations, and youth rights within twenty-four hours of a youth being admitted into detention. A review of five youth case management records found each contained an orientation acknowledgment form signed by the youth, confirming orientation took place within twenty-four hours of the youth's admission. Documentation indicated orientation was explained to each youth verbally, in addition to each youth signing receipt of an orientation brochure packet. The center's orientation packet included 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. An interview with the center's superintendent reported all youth watch a Prison Rape Elimination Act (PREA) video upon admission. The center was not accepting any admissions at the time of the annual compliance review due to the COVID-19 pandemic. In compliance with the Center 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.

2.03 Classification	**Satisfactory Compliance**

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

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

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

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

The center maintains a written policy and procedures to ensure all youth admitted to the detention center are classified by the admitting officer to provide the highest level of safety and security. The center's considerations for classification include at a minimum, the youth's physical characteristics, age, level of aggressiveness, special needs, history of violent behavior, gang affiliation, criminal behavior, history of sexual offenses, Vulnerability to Victimization and/or Sexually Aggressive Behavior (VSAB), medical needs, suspected or identified suicide risk, escape risk, and security risk. Five youth records were reviewed. Each included documentation of the considerations of potential safety concerns prior to assigning the youth to a room. All youth were screened using the VSAB assessment and the Suicide Risk Screening Instrument

(SRSI). Each record contained a Secure Detention Admission Wizard completed in the Department's Juvenile Justice Information System (JJIS), which documented juvenile offense history and active alerts. Each reviewed youth record documented applicable mental health, medical, dietary, and suspected gang affiliation classification alerts were entered into JJIS during admission. 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. *A referral for youth with suspected gang involvement shall be shared, by e-mail, with the circuit gang representative, indicating suspicions of gang activity such as youth flashing gang signs, gang tattoos, gang-related drawings, or related activity.* *Center staff should include in the e-mail pictures (when appropriate), copies of written statements, drawings, graffiti, and a description of what gang signs the youth was "flashing."*	

The center has a screening process for newly admitted youth to determine if the youth is a gang member or gang affiliated. The center also documents and shares suspected gang behavior of youth in the center. The center's assistant superintendent serves as the gang representative who reviews identified youth for suspected gang involvement. The center's gang representative notifies the assigned juvenile probation officer (JPO) gang liaison by electronic mail when a suspected gang member is identified. Five youth records were reviewed and one was applicable for gang identification. An additional two records were provided by the center for a sample size of three. Reviewed notifications included photographs and an attached gang intelligence information form sent by electronic mail message to the gang liaison. Each gang affiliation alert was also entered into the Department's Juvenile Justice Information System (JJIS). The center also maintains a gang unit tracking log which was reviewed and confirmed the center's practice of documenting identified gang members. An interview with the center's assistant superintendent verified their role as the center's gang liaison and confirmed the process. Additionally, gang information is shared with all other pertinent parties through electronic mail, telephone, and 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 maintains a written policy and procedures to ensure all youth personal property is maintain securely and returned to them in a timely manner upon release. The center utilizes Personal Property Receipt forms for all youth. Valuable youth property is tracked utilizing the Valuable Property Receipt form. Five youth records were reviewed regarding the admission of youth personal property. Each of the five records contained a Personal Property Receipt form signed by the youth and intake staff. Each record also contained a letter of acknowledgement regarding unclaimed property signed by the youth. In instances where youth refuse to sign the Property Receipt form, the officer shall notify a supervisor and the supervisor shall document the youth's refusal on the form. Personal property including clothing, is stored in a closed green property bag within a secure room, inaccessible to youth under video surveillance. The center

utilizes a clear tamper proof property bag and a drop safe for all valuable property storage. Each of the five reviewed records contained a Valuable Property Receipt form and a copy of the tamper sealed bag within the youth's active record. Each tamper proof property bag documented the date, youth's name, youth's Department identification number, and a listing of the items within the bag. All youth valuable personal property is stored in a drop safe upon admission. 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. The center was not accepting any admissions at the time of the annual compliance review due to the COVID-19 pandemic. In compliance with the Center 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. Five youth were interviewed regarding signing for their personal property when arriving at the center. Four youth reported they had to sign for their property and one youth reported seeing the staff label the property. One youth reported signing for clothes and another youth reported signing a form allowing a cellular phone to be released to the parent/guardian. An interview with the center's superintendent reported all youth personal property is securely locked and maintained under video surveillance. The superintendent explained valuable property is stored in a drop safe upon admission. When youth attend a detention hearing and are court ordered to secure detention, the property is then moved to a locked cabinet within the detention review office. Valuable property is only accessible by authorized staff members. 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.

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

The center maintains a written policy and procedures to ensure all youth property is securely maintained. In compliance with the Center for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this review was conducted off-site; therefore, observation of youth storage was conducted through face-time teleconferencing and photographs. The center stores valuable property separate from general property. Upon admission, valuable property is inventoried, logged, sealed, and placed in a drop box safe under video surveillance. If a youth is court ordered to secure detention after the initial detention hearing, their valuable property is then relocated to a locked cabinet within the detention review office. General property is maintained in a closed green property bag within a secure room under video surveillance. The center's practice is to document all inventories on Personal Property Receipt forms and maintain a copy of the forms with the property and within the active youth record. A review of five youth records confirmed the practice. All youth property is only accessible by authorized supervisory staff. A review of property logs, tamper proof bags, and safe logbooks confirmed the center's appropriate logging and tracking of youth property. A review of incidents reported to the Department's Central Communication Center (CCC) during the past six months did not reflect any incidents regarding youth property. An interview with the superintendent confirmed the center's practice regarding youth property collection and storage. The superintendent also reported access to the property room is limited and only administration has access to remove valuables.

2.07 Release	Satisfactory Compliance

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

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

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

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

The releasing officer shall verify the identification of the youth.

The center maintains a written policy and procedures to ensure all releases from the center occur promptly and accurately. Three closed youth records were reviewed for release procedures. Each record documented the on-duty juvenile justice detention officer supervisor reviewed all paperwork related to release, reviewed the release paperwork provided by the court, and verified the youth's identification prior to release. Identification of parent/guardian is verified prior to the release by review of a state issued identification card. A copy of the identification card is then placed within the youth's record. Each reviewed record contained a copy of the parent/guardian identification and documentation of the supervisor reminding the youth and parent/guardian of any future court dates. Each of the three reviewed records documented all required signatures on all release forms. The date of admission and the date of termination documented in the case file correlated with the Department's Juvenile Justice Information System (JJIS). An observation of a youth being released could not be observed during the week of the annual compliance review. In compliance with the Center 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. A review of reports to the Department's Central Communications Center (CCC) for the past six months did not indicate any unauthorized releases.

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 maintains a written policy and procedures to ensure youth's property is maintained securely and returned in a timely manner upon release. Once a youth is released from the detention center, the releasing officer, the youth, and the parent/guardian shall review and sign the Personal Property Receipt form to claim the youth's personal property. Three closed youth case management records were reviewed and confirmed each youth, parent/guardian, and staff signed the receipt form upon release. An interview with the center's superintendent confirmed the center's practice for the release of personal property. All personal property not claimed within thirty days of a youth's release is considered abandoned and a letter is forwarded to the

youth and parent/guardian advising them of the property status. A review of personal property reports on the Department of Juvenile Justice Information System (JJIS) Facility Management System (FMS) module for the past six months did not indicate any property was left at the center over thirty days. In compliance with the Center 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 maintains a written policy and procedures to address the release of youth from secure detention with prescribed medication. The center utilizes the Department's Medication Receipt Transfer and Disposition form to document all medications accompany the youth upon their release. A review of three closed youth records in which youth were released with prescribed medication, was conducted. All three records had documentation verifying youth were released to the appropriate parent/guardian with a copy of a valid identification. All three youth records contained a receipt of medication signed by the center staff and the parent/guardian receiving the youth. All forms 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 maintains a written policy and procedures to address detention reviews of youth held in secure detention or who are awaiting placement to a residential facility. During detention reviews, the status of each youth is addressed and updates are provided as to the next court date, behavior while in detention, residential placement status, and release status. A review of the center's documentation for the past six months revealed the weekly meetings are being held and updates are noted for each youth staying at the center. There were notes taken on what was discussed, tasks assigned for follow-up, and the identified staff members responsible for those actions. Observations of a detention review meeting was conducted by telephone during the annual compliance review. Detention review meeting participants included the Circuit 15 chief probation officer (CPO), assistant chief probation officer (ACPO), juvenile probation officer supervisors (JPOS), representatives from the public defender's office, community providers, detention administration staff, and detention mental health and medical staff. Each youth's status was reviewed individually and included a review of behavior, medical status, projected release date, and other pertinent information relevant to keeping youth and staff safe. Based on the telephone conference, the detention review meeting process was followed according to the center's policy. An interview with the center's superintendent indicated the detention review meetings are held weekly on Wednesdays at the center and by conference call for those who cannot attend in person.

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

The center maintains a written policy and procedures regarding the daily activity schedule. A review of the center's schedule was conducted. The daily schedule outlines the days and times of youth activities, hygiene, schooling, life skills group, visitation, meals, and recreational activities. The center also has volunteers conducting life skills group once a week. Based on the center's schedule, youth are provided the opportunity to participate in constructive activities benefiting the youth which promote education and problem-solving skills. Documentation revealed visitation is conducted twice a week on Monday and Thursday from 5:30 p.m. to 8:30 p.m. The center provides alternate visitation days for families who may have circumstances preventing them from coming during scheduled visitation. In compliance with the Center for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this review was conducted off-site; therefore, observation of the center's schedule postings was conducted through photographs. The center has a posted schedule in each of the three youth living modules. Five youth were interviewed and each stated the center has a daily activity schedule. Five staff were interviewed and each stated the center's 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. *The on-duty supervisor must approve any significant changes in the activity schedule and shall document the reason for the change(s) in the shift report.* *Any cancellation of visitation shall be approved by the superintendent.*	

The center maintains a written policy and procedures to ensure daily schedules are followed. The procedures indicate the cancellation of activities may occur due to poor weather conditions or safety and security concerns., All cancellations are documented in the center's logbooks. A random review of logbooks for the past six months during the annual compliance review verified adherence to the daily activities schedule. The logbooks did not indicate any significant changes in the schedule except when hurricane Dorian disrupted the educational activities and contributed to the relocation of youth. An informal interview with the center's superintendent verified there are no major disruptions in the center's daily schedule unless there is a natural disaster. Also, the administration staff can authorize changes to the daily activity schedule. Five youth were interviewed and each stated the center has a daily activity schedule and it is followed. Five interviewed staff reported the center follows the daily activity schedule.

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

The center maintains a written policy and procedures regarding educational access. The center's educational program managed by the Palm Beach County School District operates on a

year-round basis, providing the youth within the center 240 days of instruction which is distributed over twelve months with a minimum of twenty hours weekly. School may be canceled due to natural disasters, emergencies, and other severe weather conditions. Upon review of the school's schedule, documentation revealed education staff are afforded ten days of teacher 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. This was verified during an informal interview with the superintendent during the week of the annual compliance review. The superintendent also reported the youth enrolled in the education program have the opportunity to earn course credits through the Palm Beach County School District. On April 6, 2020, the school changed to virtual learning due to the COVID-19 pandemic. The lead teacher outlined the current course offerings and alternate instruction methods provided. Five youth interviews indicated the school schedule is followed and they attend school Monday through Friday. Each interviewed youth was also aware of the courses they were enrolled in at the center.

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

The center has a policy and procedures regarding career education. The career education component offered is categorized as a Type 1 Career and Vocational curriculum. The Type 1 program integrates personal accountability skills and behaviors leading to the development of work habits to help maintain employment and living standards. The center utilizes a platform called MyCareerShines for students to plan, explore, discover, and make an education plan. Youth assessments are conducted in conjunction with an elective class and once completed, the eight standards are infused within the curriculums of both life skills and critical thinking classes. Youth engage in creating a student account online, taking interest assessments, and exploring occupations. Career education is inclusive of communication, interpersonal, and decision-making skills. The Exceptional Students Education (ESE) services are provided at the center in accordance with each youth's Individualized Education Plan (IEP) and specific needs. Additionally, the center's transition services are provided to all youth at the center. Five youth interviews validated educational career/vocational classes are offered Monday through Friday. The youth reported taking math, history, science, reading, and social studies. Also, one youth reported taking the General Equivalency Diploma (GED).

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

The center maintains a written policy and procedures addressing behavioral management to ensure the safety and security of youth and staff. The behavior management system (BMS) included rewards for positive behavior and consequences for inappropriate behavior. A review

of the center's BMS policy indicated a copy is to be given to all the youth entering the center and is also posted throughout the center for the youth to reference. The BMS guidelines are provided to all youth within the orientation brochure. The BMS is a leveled system where youth can gain or lose privileges. Upon admission into the center, all youth start at level two. The center's level two designation provides each youth with all basic rights and some additional activities and incentives, as determined by center administration. The center's level two incentives and activities include playing games, a 9:00 p.m. bedtime, and watching television or movies. The youth can progress to level three with positive behavior. The center's level three system provides youth with all basic rights and additional privileges such as a 10:00 p.m. bed time, an additional ten-minute telephone call each week, participation in the weekend youth event, and participation in work detail for community service hours. Five youth were interviewed in which two youth rated the BMS system as fair, two youth rated the BMS as good, and one youth rated the BMS as very good. No youth offered additional comments. Three interviewed youth reported the consequences received at the center were fair and two reported never receiving consequences. Each youth stated the level can be dropped as a consequence for poor behavior and reported points can be reduced. Five staff were interviewed and each reported the BMS system was effective. All of the staff reported they discussed consequences being imposed, speak with the youth about alternative behaviors, and give the youth the opportunity to explain their behavior. All five staff stated the youth's level is lowered as a consequence to negative behaviors. All five staff stated they receive feedback from their supervisor regarding the implementation of the BMS system. All five staff stated they received feedback quarterly, weekly, and as needed. An interview with the superintendent indicated the center utilizes a point system level card and both youth and staff have full knowledge of the behavior management system. Youth level information is maintained in a binder on each of the center's three living modules accessible to youth and staff.

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

The center maintains a written policy and procedures prohibiting the use of group punishment, corporal punishment, and the use of drugs to control the behavior of youth. If a youth is non-compliant and staff have exhausted all opportunities to assist the youth in changing their behavior, the youth's behavior management system (BMS) level will be lowered to level one. While on level one the youth's privileges are suspended and they do not earn any points. The center's level one system has an 8:00 p.m. bed time, the youth cannot participate in the weekly special youth events, and the youth must have three good days of behavior to move to level two. Five youth were interviewed and the annual compliance review team conducted three follow-up youth interviews. All five youth stated they had never been sent to their room for

punishment. Each youth reported youth are not allowed to punish other youth. Each youth reported they have never witnessed mechanical restraints used on out of control youth to prevent them from hurting themselves or others. Five staff were interviewed and each stated youth do not lose meals, clothing, snacks, sleep, or school attendance due to inappropriate behavior. All five staff reported they have never observed any staff encouraging youth to fight another youth.

2.17 Grievances	Satisfactory Compliance

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

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

The center maintains a written policy and procedures to ensure each youth has the right to grieve and to make certain all youth are treated fairly, respectfully, without discrimination, and their rights are protected. Youth at the center can request an electronic grievance form from staff, who will then input the grievance into the Facility Management System (FMS) module within the Department's Juvenile Justice Information System (JJIS) on behalf of the youth. The grievance process includes an informal phase, formal phase, and an appeal phase. The informal phase is completed by detention staff, whereby the youth and staff attempt to resolve the youth's complaint. If the staff is unable to resolve the issue, an electronic grievance will be submitted to the juvenile justice detention officer supervisor (JJDOS) beginning the formal grievance process. The electronic grievance requires a response from the JJDOS by the end of the shift if possible, or within twenty-four hours. Next, the appeal phase requires a response from the superintendent and/or designee. The superintendent will have seventy-two hours upon receipt to take action deemed necessary to resolve the issue. During the annual compliance review, the center's superintendent provided documentation to confirm there have been no grievances submitted since the last annual review. The superintendent attributed this to the center's staff ongoing positive communication with youth. An interview with the superintendent indicated the center staff are aware of the process and the three phases of the grievance procedures. Five youth were interviewed and none of the youth reported filing a grievance while at the center. Five 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 maintains a written policy and procedures related to trauma-informed care. A review of five in-service and five pre-service training records indicated all staff are trained on trauma-informed care. All training is completed and documented in the Department's Learning Management System (SkillPro). The center's practice is to treat all youth as being affected by trauma, recognize the high prevalence of trauma, assess for traumatic histories and symptoms, recognize each youth can be re-traumatized at the center, and use objective and neutral language when speaking with youth. An interview with the superintendent indicated the center has one soft room which is painted in soothing colors. The superintendent also explained the center has a butterfly garden for youth to use in the event of stressful situations. Reviewed photographs found the soft room contained comfortable furniture and carpeting, pillows, an aquarium, and colorful wall paintings. In addition to utilizing this space as a counseling and conference area, the soft room is utilized by staff to calm youth down and when a youth is experiencing any form of trauma. Additionally, all youth may request to spend quiet time in the soft room, if needed. A review of the soft room logbook confirmed regular use.

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 maintains a written policy and procedures ensuring there is a single licensed mental health professional identified as the designated mental health clinician authority (DMHCA) who is responsible for the coordination and implementation of mental health and substance abuse services provided at the center. The center maintains a contract with Camelot Community Care, Inc. to provide comprehensive mental health and substance abuse services. The DMHCA is a licensed mental health counselor (LMHC) and is on-site forty hours a week, Monday through Friday, from 9:00 a.m. to 5:00 p.m., and has a clear and active State of Florida license verified on the Florida Department of Health website with an expiration date of March 31, 2021. The DMHCA is available seven days a week, twenty-four hours a day for consultation, and also is available to work on Saturdays and Sundays on an as-needed basis. A review of the DHMCA's job description indicated they are responsible for overseeing all clinical and administrative operations to ensure clinical integrity, quality, contract compliance, utilization, budge/fiscal efficiency, and Council on Accreditation compliance. An interview with the DMHCA confirmed they are responsible for ensuring the clinical quality and integrity of the therapeutic program as required by all applicable standards, regulations, and policies. The DMHCA indicated they brief the detention supervisory staff to discuss any crisis issues and communicates with on-site mental health staff throughout the day to address any outstanding issues or process youth. The DMHCA has management and administrative oversight over mental health and substance abuse services throughout the center. The DMHCA updates the psychiatrist once a week on applicable youth receiving services to discuss behaviors, progress, and applicable medications. Clinical services provided by the DMHCA include mental health and substance abuse services, twenty-four-hour support for the center, and serves as a liaison between the center's education department and the juvenile probation officers.

3.02 Licensed Mental Health and Substance Abuse Clinical Staff [Contract Provider] (Critical)	Non-Applicable
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's policy, procedures, or contract does not require any other licensed clinical staff other than the individual serving as the designated mental health clinician authority (DMHCA); therefore, this indicator rates as non-applicable.

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 designated mental health clinician authority (DMHCA) ensures the center's non-licensed clinical staff are working under direct supervision and are providing services based on qualifications such as education, training, and experience. The center maintains a contract with Camelot Community Care, Inc. to provide comprehensive mental health and substance abuse services. The contract outlines the daily ratio of full-time mental health clinical staff to youth should be a minimum of one full-time staff to twenty youth. The center has one full-time non-licensed master's-level therapist who is a registered mental health counselor intern with a degree in mental health counseling. The center has a part-time master's-level non-licensed therapist who maintains a degree in forensic psychology. The full-time non-licensed therapist is scheduled to work Monday through Friday from 7:00 a.m. to 3:00 p.m. The part-time non-licensed therapist is scheduled to work on Tuesday from 5:30 p.m. to 8:30 p.m.; on Thursday from 4:30 p.m. to 8:30 p.m.; on Saturday from 10:00 a.m. to 5:00 p.m.; and on Sunday from 11:00 a.m. to 5:00 p.m. The sign in sheets supported the schedule was adhered to. The center maintains a Department of Children and Families, Chapter 397 license for outpatient treatment with an expiration date of June 28, 2020. Reviewed records demonstrated the non-licensed clinicians are qualified to provide services based on their education, training, and experience. A review of training records supported each non-licensed therapist completed the center's Assessment of Suicide Risk form and completed twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. Supporting documentation of clinical supervision logs confirmed the DMHCA provides weekly face-to-face clinical supervision which includes directions, instructions, and recommendations to non-licensed staff. A review of the past six months of weekly direct supervision logs documented both non-licensed therapists received weekly face-to-face supervision. Each reviewed direct supervision note was documented on the Department's Licensed Mental Health Professionals and Licensed/Certified Substance Professionals Direct Supervision Log form. The reviewed forms reflected a review of the clinician's case load, clinical services provided, documentation, miscellaneous directions, instructions, and recommendations.

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

The center 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. Upon each youth's intake to the Palm Beach Juvenile

Assessment Center (JAC), the youth is screened utilizing the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) and the Department's Suicide Risk Screening Instrument (SRSI). When the screenings indicate further assessment is required, the referral information is documented on the assessment and a referral is submitted to the center for a comprehensive assessment. The detention intake officer completes the sections of the SRSI designated for the detention officer and a mental health clinician completes the mental health and substance abuse SRSI sections. A review of five youth mental health and substance abuse records validated each youth documented the JAC juvenile probation officer (JPO) administered the MAYSI-2 and the SRSI upon the youth's admission/intake. All five reviewed youth records documented the SRSI and MAYSI-2 detention section was completed in the Department's Juvenile Justice Information System (JJIS). The mental health staff reviewed and completed the required sections of the SRSI in each of the five reviewed records. All five reviewed youth records indicated a need for further assessment based on the screenings. Two of the five assessments were overridden by the JPO and all five documented a referral was made to mental health therapists and the superintendent was notified. Each reviewed record had the summary and recommendations completed in full in the screening results section. Two of the five reviewed records were identified with an elevated suicide risk factor. Reviewed documentation validated both youth were placed on Precautionary Observation (PO) and a mental health referral and notification to the superintendent was completed for each. Reviewed documentation supported both youth had an Assessment of Suicide Risk (ASR) completed by the trained non-licensed therapist and reviewed by the center's designated mental health clinician authority (DMHCA). An interview with the superintendent validated the mental health, substance abuse, and suicide risk screenings are completed by intake staff, medical and mental health staff, and supervisory staff utilizing the SRSI, and the Department's Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB).

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 the mental health and substance abuse evaluations identified through preliminary screenings with youth as having mental health and substance abuse issues receive in-depth mental health and substance abuse assessment shortly after intake. The center is responsible for establishing procedures to track the receipt of comprehensive assessments. All youth identified through the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) and the Department's Suicide Risk Screening Instrument (SRSI) or by staff observations or behaviors after admission are referred for further in-depth comprehensive mental health (MH) and/or substance abuse (SA) evaluation. A review of five youth mental health and substance abuse records reflected one youth was identified after admission requiring a referral for a comprehensive mental health and substance abuse (MH/SA) evaluation. The reviewed record indicated the youth had a previous comprehensive MH/SA evaluation completed and the licensed mental health therapist documented a review and updated the evaluation. The center provided three additional youth records of the mental health therapists completing a new Substance Abuse and Mental Health Assessment (SAMH). Each reviewed SAMH was completed within thirty days of referral.

3.06 Mental Health and Substance Abuse Treatment [Detention Staff/Contract Provider]	Satisfactory Compliance

Mental health and substance abuse treatment planning in departmental facilities focuses on providing mental health and/or substance abuse interventions which will reduce or alleviate the youth's symptoms of mental disorder or substance abuse impairment and enable youth to function adequately in the juvenile justice setting.

Each youth determined to need mental health treatment, including treatment with psychotropic medication, or substance abuse treatment while at the center, must be assigned to a mini-treatment team.

The center maintains a written policy and procedures in place ensuring mental health and substance abuse treatment planning focuses on providing identified youth with mental health and/or substance abuse treatment services which will reduce or alleviate the youth's symptoms of mental disorder or substance abuse impairment and enable youth to function adequately in the center. Youth determined to have a serious mental disorder or substance abuse impairment and are receiving mental health and/or substance abuse treatment at the center must have an initial or individualized mental health or substance abuse treatment plan based upon the comprehensive mental health and/or substance abuse assessment/evaluation or psychiatric diagnostic interview and/or evaluation. 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 weekly to discuss each youth receiving services. Reviewed mini-treatment team documentation supported each applicable youth was assigned to a mini-treatment team which consists of the designated mental health clinician authority (DMHCA), non-licensed master's-level therapist, the center's administration staff, nursing staff when the youth is prescribed medication, an education representative, and a juvenile justice detention officer (JJDO) staff. Due to the annual compliance review being conducted off-site, an observation of a mini-treatment team meeting was not conducted. However, the annual compliance review team members were able to participate by telephone. Reviewed documented practice and interviews with the DMHCA and the center's superintendent validated consistent practice. A review of five youth mental health and substance abuse records (MH/SA) indicated four youth were applicable for mental health treatment services. Each of the four reviewed MH/SA records were applicable for the youth receiving individual therapy. Each reviewed record reflected the youth participated in treatment planning and treatment team meetings. Reviewed documentation supported each youth had a properly executed Authority for Evaluation and Treatment (AET) form and an additional AET consent for mental health, substance abuse, and/or psychiatric medications as required. A review of three additional youth MHSA records supported each youth was determined to be in need of substance abuse treatment and each received individual therapy. Reviewed documentation of group sign-in sheets for the past six months indicated the center did not have enough youth receiving services at any given time to conduct a mental health group and/or substance abuse group. An interview with the DMHCA confirmed the center offers mental health and substance abuse services. Mental health and substance abuse groups are facilitated by the clinical staff. The DMHCA reported they follow Florida Administrative Code (FAC) 63N to ensure substance abuse services are provided as required. Services are reviewed consistently by the DMHCA during the weekly supervision meetings to ensure fidelity and they are being delivered in a manner consistent with contractual requirements. Five youth were interviewed regarding the mental health and substance abuse services provided in the center. Four youth indicated they were not receiving mental health and/or substance abuse services. One youth reported receiving mental health and substance abuse services and rated the services as very good.

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

The center maintains a written policy and procedures ensuring mental health and substance abuse treatment planning focuses on providing mental health treatment and/or substance abuse services. The center's superintendent and designated mental health clinician authority (DMHCA) or mental health and substance abuse clinical staff are responsible for ensuring the development and review of an initial and individualized mental health/substance health treatment plan of each youth receiving mental health/substance abuse treatment. Each youth receiving mental health and substance abuse treatment shall have a discharge summary completed documenting the focus and course of treatment and recommendations for mental health and/or substance abuse services upon the youth's release from the center. A review of five youth mental health and substance abuse records (MHSA) reflected four youth were applicable for requiring an initial treatment plan completed within seven days of initiation of treatment. Each reviewed record documented an initial treatment plan was completed on the Department's Initial Mental Health/Substance Abuse Treatment Plan form and contained all required elements. Each reviewed initial treatment plan documented the reason for treatment, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, initial treatment methods, and initial treatment goals. Two of the five reviewed MHSA records were applicable for psychiatric services. Each reviewed record documented signatures by the mental health staff, youth, and mini-treatment team members involved in the development of the plan. The center provided three additional applicable records of youth receiving MHSA services and each initial treatment plan was completed within the required time frame and contained all required signatures. There was no documentation in any of the youth records to indicate any youth was an alleged victim of a Prison Rape Elimination Act (PREA) event. A review of five youth MHSA records found two youth were applicable for individual treatment plans. The center provided two additional applicable records of youth receiving MHSA services and all four applicable individual treatment plans were developed within thirty days of the youth's admission and were signed by the licensed mental health clinician within the ten days of completion, as required. Each plan was signed either the same day the plan was developed or within three days of development. Each reviewed individual plan identified the youth's DSM-5 diagnosis, symptoms which are treatment focused, treatment goals, strengths, and abilities. One of the four applicable individual treatment plans reviewed was applicable for psychiatric services and/or psychotropic medication monitoring and pharmacological interventions. A review of the documentation supported psychiatric treatment and services were provided by the licensed psychiatrist. Documentation supported each reviewed record had progress notes which validated youth were receiving treatment services as outlined on the treatment plan. Each reviewed individual treatment plan was signed and dated by the youth, mental health staff, mini-treatment team members, and parent/guardian when possible. During visitation, clinical staff meet with the parent/guardian to discuss the treatment plan and obtain their signatures. When parent/guardians do not visit, attempts are made upon the youth's release and the parent/guardian picks up the youth. Clinical staff mail a copy of the plan to the parent/guardian

requesting their review and provide a signature. The center conducts mini-treatment team meetings weekly for applicable youth receiving mental health and substance services. The mini-treatment team meets weekly to discuss each youth receiving services. Reviewed mini-treatment team documentation supported each applicable youth was assigned to a mini-treatment team which consists of the designated mental health clinician authority (DMHCA), non-licensed master's-level therapist, the center's administration staff, nursing staff when the youth is prescribed medication, an education representative, and a juvenile justice detention officer (JJDO) staff. Due to the annual compliance review being conducted off-site, an observation of a mini-treatment team meeting was not conducted. However, the annual compliance review team members were able to participate by telephone for one youth. A review of the documented practice and interviews with the DMHCA and the center's superintendent validated consistent practice. The center provided four applicable closed youth records each with a completed Mental Health/Substance Abuse Discharge Summary. Each discharge summary was provided to the youth, assigned juvenile probation officer, and parent/guardian.

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

The center maintains a written policy and procedures ensuring psychiatric services are provided to youth in need. The center provides psychiatric services which includes psychiatric evaluations, psychiatric consultations, tele-psychiatry, medication management, and medical supportive counseling. The center maintains a contract with Camelot Community Care, Inc. to provide mental health and substance abuse services as well as psychiatric services. Camelot Community Care, Inc. maintains an Independent Contract for Psychiatric Services with a licensed medical doctor (MD). The psychiatrist education is in child and adolescent psychiatry and is a member of the American Board of Psychiatry and Neurology, Inc. Reviewed license with the Florida Department of Health found there were no disciplinary actions taken by a specialty board or licensing board in the last ten years. The psychiatrist's license was free and clear in the State of Florida with an expiration date of January 31, 2022. The current independent contract expires April 30, 2020; however, according to the Department's regional director, a new contract is being developed. The Department executed a temporary tele-psychiatry agreement on April 6, 2020 with the psychiatrist due to the COVID-19 pandemic. Tele-psychiatry is provided through Doxyme.com in allocation which supports the confidentiality of the youth. The location had been approved by the center and the psychiatrist. The psychiatrist utilizes a tracking log to record all tele-psychiatry hours and submits it to the health services manager on the first of each month. Tele-psychiatry is only utilized for youth who agree to participate in the tele-psychiatry session and the parent/guardian has provided consent. A review of the sign-in and sign-out logs validated the psychiatrist was providing services; however, the Department's Office of Health Services through their quarterly reviews determined the psychiatrist was not on-site for the required two hours for each visit. There is a current open deficiency within the Department's Program Monitoring and Management System. Five reviewed youth mental health and substance abuse (MHSA) records found two youth were admitted on currently prescribed psychotropic medications. The center provided three additional applicable youth records for youth admitted on prescribed psychotropic medications. All five applicable youth received an initial psychiatric interview within fourteen days of admission. The psychiatrist completed an in-depth psychiatric evaluation for all applicable youth. Each reviewed psychiatric evaluation documented the reason for referral, history, mental status examination,

the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, treatment recommendations, applicable prescribed medication, explanation of the need of psychotropic medication, and frequency of medication monitoring. Each reviewed psychiatric evaluation also included developmental history, psychiatric history, individual, contributing family or environmental factors, and the signature of the practitioner. The Department's Clinical Psychotropic Progress Note (CPPN) form was completed in full for each applicable youth. Each reviewed record was applicable for the continuation of a prescription of psychotropic medication and each documented the medication's identifying data, medication target symptoms, evaluation and description of effect of prescribed medication on target symptoms, prescribed medication, side effects, youth's adherence to the medication regime, youth's height/weight, laboratory findings, applicable parent/guardian contact, and the signature and date of the psychiatrist. All five reviewed youth records had a current Authority for Evaluation and Treatment (AET) form. Each completed evaluation documented monthly monitoring of Tardive Dyskinesia. None of the reviewed records were applicable for youth in foster care or reaching eighteen years of age while at the center and requiring additional consents. There were no applicable youth for significant changes in dosage of the prescription of medications after admission. The psychiatrist was not available for an interview during the annual compliance review week. The center's designated mental health clinician authority (DMHCA) reported the psychiatrist is on-site weekly and the clinical staff communicate any concerns, medication issues, and process other youth when needed. The DMHCA indicated the psychiatrist is on-call and available for twenty-four hours a day, seven days a week.

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 there is a suicide prevention plan in place to safely screen, refer, assess, monitor, and protect youth with elevated risk of suicide in the least restrictive means possible. The plan outlines the center's procedures addressing the use of suicide precautions, suicide prevention training and the process by which any youth identified as having suicide risk factors at any time must be place on suicide precautions and receive an Assessment of Suicide Risk. The center's suicide prevention plan includes identification and screening assessment of youth at-risk of suicide, suicide risk alerts, levels of supervision, suicide precautions, referrals, notifications and communication, immediate staff response, use of extra precautions, staff training and mock suicide drills, review processes, and emergency contact telephone numbers. The plan was revised and approved by the designated mental health clinician authority (DMHCA) on July 31, 2019 and the center's superintendent on August 4, 2019. Copies of the plan were located in the superintendent's office, medical clinic, mental health office, and on the center's K-drive which is 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. *Any youth exhibiting suicide risk behaviors must be placed on suicide precautions (precautionary observation or secure observation), and a minimum of constant supervision.* *All youths identified as having suicide risk factors by screening, information obtained regarding the youth, or staff observations must be placed on suicide precautions and receive an assessment of suicide risk.*	

The center maintains a written policy and procedures ensuring a suicide prevention plan is in place to safely screen, refer, assess, monitor, and protect youth with an elevated risk of suicide in the least restrictive means possible. All youth identified as having suicide risk factors by screening, information obtained from the youth, or staff observations must be placed on suicide precautions and receive an Assessment of Suicide Risk (ASR). A review of five youth mental health and substance abuse records indicated one youth was identified during the admission screening process with elevated suicide risk factors. The clinical staff conducted an ASR on the youth's date of admission, and it was determined the youth was not at risk of suicide and was placed on Standard Supervision. One of the reviewed records was applicable for a youth with an elevated suicide risk who was placed on Precautionary Observation (PO) after the completion of the ASR and the center provided two additional records for a sample size of three. Each reviewed record documented the completion of an ASR by a non-licensed master's-level therapist. Each completed ASR documented the immediate notification to the center's superintendent and/or designee and the completion of the Suicide Precaution Observation Logs. No reviewed record was applicable for the youth being released from the center while on PO status. Each applicable youth record documented a referral was made to the mental health clinical staff, an alert was entered into the Department's Juvenile Justice Information System (JJIS), and the youth was maintained on PO until assessed by a licensed therapist. All three youth remained on PO until a Follow-Up ASR was completed by the clinical staff and it was determined the youth could be stepped down to Close Supervision. Discontinuation of Close Supervision was documented in accordance with the center's suicide prevention plan. Each youth record documented the youth was transitioned to Standard Supervision after consultation with the designated mental health clinician authority (DMHCA) and the center's superintendent and/or designee as outlined in the center's suicide prevention plan. According to the superintendent and the DMHCA, the center had one applicable youth placed on Secure Observation (SO) in the last twelve months. A review of the applicable youth record found the placement was authorized by the center's superintendent and the DMHCA. The center documented the Health Status Checklist was completed and the Suicide Precaution Observation Logs were completed, as required. The youth's parent/guardian and assigned juvenile probation officer were notified, as required. The DMHCA provided the youth with supportive counseling while on SO and after consultation between the DMHCA and the superintendent, the youth was removed from SO in less than twenty-four hours. A review of the center's master control logbook reflected beginning and end times were documented for youth placed on precautions. Five staff were interviewed regarding suicide prevention in the center. All five staff indicated they would contact mental health staff and document the supervision. Four staff indicated they would place the youth on constant sight and sound. Two staff indicated they would search the youth and their room for sharp objects. One staff also indicated they would

document the event in the center's logbook. An interview with the center's superintendent reported the center only utilizes SO if a youth is actively aggressive towards other youth and staff. Youth placed on SO are placed in a confinement cell and staff stand at the door monitoring the youth's actions.

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 youth placed on suicide precautions must be maintained on one-to-one or constant supervision. While on an increased level of supervision, Suicide Precaution Observation Logs are maintained for the duration of time the youth is on suicide precautions, with all sections of the form accurately filled in. When warning signs are noted on the logs, the superintendent/designee and the licensed mental health therapist must be recorded on the log with the instruction from the clinical staff record on the form. The staff assigned to observe the youth must provide the appropriate level of supervision and record observations of the youth's behavior at intervals of no more than thirty minutes. A review of five youth mental health and substance abuse records indicated one youth was identified during the admission screening process with elevated suicide risk factors. The clinical staff conducted an ASR on the youth's date of admission and it was determined the youth was not at risk of suicide and was placed on Standard Supervision. One of the seven reviewed records was applicable for youth with an elevated suicide risk who were placed on Precautionary Observation (PO) after the completion of the ASR. Two additional records were provided by the center for a sample size of three. The three reviewed records contained the Department's Suicide Precaution Observation Log with documentation of the youth's behavior in real time and documented the safe housing requirements. Each reviewed log documented all observations at or below thirty-minute intervals. None of the reviewed records were applicable for having warning signs which required notification to administration and/or mental health consultation. Each youth record had completed logs which were reviewed and signed by the juvenile justice detention officer supervisor (JJDOS) and mental health clinical staff daily.

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 who work with youth must be trained to recognize verbal and behavioral cues indicating suicide risk, suicide prevention, and implementation of suicide precautions. All staff who work with youth must receive a minimum of six hours of annual training on suicide prevention and implementation of suicide precautions. The mental health clinical staff assist in training the detention staff on suicide precautions including verbal and behavioral cues which indicate suicide, throughout the calendar year. A review of five in-service staff training records found each staff received the required four hours of instructor-led training and two hours of computer-based training of suicide prevention and implementation of suicide precautions training in the Department's Learning Management System (SkillPro). The center is required to conduct mock suicide drills on each shift at least quarterly. All staff with direct youth contact must participate in at least one mock suicide drill semi-annually. A review of staff training records and completed mock suicide drills found most staff completed the required drills and emergency response training, as required.

Staff members who are not present during a quarterly mock drill must have the opportunity to review each mock drill scenario and procedures during shift meetings. According to staff interviews, staff who are unable to participate in the mock drills are briefed at their next shift meeting and the scenario evaluation form is posted in the staff breakroom for their review. A review of the quarterly mock suicide drills conducted since the last annual compliance review found drills were conducted quarterly on each shift and all staff participated in a least one drill semi-annually, as required. Documented use of life saving techniques such as the use of cardiopulmonary resuscitation (CPR), first aid, suicide response kit, and automated external defibrillator (AED were documented to have been used during the drill events. Five interviewed staff indicated the center's suicide response kits are located in master control and each sub-control. Three staff indicated a suicide response kit is located in the medical clinic and two staff indicated in the shift supervisor's office. According to the center's policy and procedures, suicide response kits are located in master control, each sub-control, and in shift change office.

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 all staff 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 center. The center must be able to differentiate a youth who has an acute emotional problem or serious psychological distress from one who requires emergency services. The center's Crisis Intervention Plan detailed verbal de-escalation and Protective Action Response techniques, the notification and alert system, means of referrals including self-referral, crisis assessment and follow-up mental health status examination, communication, supervision, mental health supportive services, documentation, and review. The center's Crisis Intervention Plan was reviewed and approved by the superintendent and the designated mental health clinician authority (DMHCA) on January 27, 2020. The Crisis Plan is located in the center's superintendent's office, medical clinic, and mental health therapist's office. The plan is also located on the center's K-drive ensuring accessibility 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 policy and procedures ensuring there is an Emergency Care Plan outlining the mental health and substance abuse emergency procedures and ensuring youth who are believed to be an imminent danger to themselves or others will receive emergency mental health or substance abuse services. The Emergency Care Plan outlines the procedures for immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport

for emergency mental health evaluation and treatment 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 review. The center utilizes John F. Kennedy Hospital for Baker Act crisis stabilization and for Marchman Act. The center's Emergency Care Plan was approved and updated on September 17, 2019 by the superintendent and the designated mental health clinician authority (DMHCA). The plan is maintained in the center's superintendent's office, medical clinic, and in the mental health therapist's office. The plan is also located on the center's K-drive ensuring accessibility to all staff. Five staff training records were reviewed and confirmed each staff received training in emergency response procedures.

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

The center maintains a written policy and procedures ensuring the center responds to youth in the least restrictive means possible to protect the safety of the youth and others while maintaining control and safety of the center. An interview was conducted with the designated mental health authority clinician authority (DMHCA) and the superintendent confirmed the center had one applicable youth requiring a Crisis Assessment in the last twelve months. Reviewed documentation reflected all phases of the center's facility operating procedures (FOPs) within the Emergency Care Plan were followed. The completed Crisis Assessment documented the reason, the youth's mental status, risk to self and/or others, initial clinical impression, supervision recommendations, treatment recommendations, and a follow-up evaluation. Notification of the youth's parent/guardian was documented and an alert was entered into the Department's Juvenile Justice Information System (JJIS). The youth was placed on Constant Supervision due to having a reported anxiety attack on March 14, 2020 and a history of suicide ideation. The Assessment of Suicide Risk was also completed on March 15, 2020 at the same time as the Crisis Assessment. The ASR does document consultation between the non-licensed therapist and the licensed mental health counselor (LMHC) to place the youth on Precautionary Observation. The Crisis Assessment documented a review by the licensed mental health counselor (LMHC) and the center's superintendent nine days later. The youth was placed on Constant Supervision and documented the mental health therapists followed-up daily.

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 and Marchman Act proceedings during the annual compliance review period; therefore, this indicator shall be rated 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 five youth healthcare records and five mental health and substance abuse records supported each contained a copy of a signed Authority for Evaluation and Treatment (AET). Each was clearly stamped as a copy. The center provided two additional records of Limited Consent for Evaluation and Treatment (LCET) for review. Both youth were in the custody of the Department of Children and Families (DCF). Each AET or LCET was obtained prior to providing medical services.

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. There are 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. An interview with the superintendent 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. Five interviewed staff indicated nursing staff conduct sick call. One staff indicated the JJDOS will respond with nursing staff are not available.

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

The center has a written policy and procedures for the provision of episodic care and first aid treatment inclusive of requirements for episodic care performed by non-healthcare staff. There are designated health authority (DHA) approved non-licensed protocols appropriate to the level of the juvenile justice detention officer staff. An interview with the superintendent and nursing staff indicated there was no documented practice of detention officer staff providing episodic, first aid, and/or emergency care in the last twelve months. Five interviewed staff indicated they all are able to call 9-1-1 if they feel it is necessary.

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. Eight 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. A review of five youth healthcare records found no examples of JJDOS staff assisting in the delivery of medication to youth when licensed nursing staff were not on-site. The center was able to provide two records of trained JJDOS staff assisting in the delivery of medication. The medication was delivered as ordered and there were no documented refusals. The non-licensed staff and youth initialed the delivery of medication on the Medication Administration Record (MAR). However, there was one delivery on April 12, 2020 where the youth did not initial the MAR. Five staff were interviewed and three indicated they do not deliver medication. Two JJDOS staff indicated they assist in the delivery 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 compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this review was conducted off-site; therefore, this indicator shall be rated as Non-Applicable as observations were unable to be completed, during this fiscal year.

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 compliance with the Centers for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic this review was conducted off-site; therefore, this indicator shall berated as Non-Applicable as observations were unable to be completed, during this fiscal year.

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 ensuring 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, any time a population change occurs, and randomly on each shift. A sampling review of master control logbooks and module logbooks for living units B-1, B-2, and G-1 for the past six months found the center documented the daily census counts, new admissions, releases, transfers, and visitors into the center. The center's superintendent reported all movement is communicated to master control. When conducting center counts, no youth movement is permitted until master control confirms the counts, reconciles counts, and authorizes activities to resume. Interviewed staff confirmed this practice. Five staff were interviewed regarding when emergency counts are conducted. All five staff reported emergency counts are conducted when a youth is believed to be missing and after a major disturbance. Four staff reported counts are also conducted when visibility is hindered, such as an electrical outage. Five interviewed staff reported when counts are conducted at the beginning of shifts, at the end of shifts, and before and after meals. Interviewed staff also reported when counts are inaccurate all movement is stopped, a recount is conducted, and if applicable, the superintendent and law enforcement are contacted.

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 sequential record of events, incidents, and activities in logbooks maintained at master control and in each living area. The center is required to maintain a logbook in master control and one for each living unit, van, and for visitors and contracted staff. The center maintains master control logbooks, three module logbooks, a Department's Central Communications Center (CCC) logbook, soft room logbook, visitor logbook, and a Silver Guard logbook to document when ten-minute checks are downloaded. A review of a random sampling of logbooks for the past six months indicated all logbooks were bound with numbered pages and with the date documented at the top of the page. Observed logbook entries were legible and written in ink. Reviewed documentation revealed errors were struck through with a single line, dated, and initialed by the person correcting the error. Master control logbook entries included transportation, emergency situations, incidents such as contacts to the Florida Abuse Hotline, contact to the Department's Central Communication Center (CCC), drills, documentation of medical and mental health alerts, population counts, emergency situations, group movement, admissions and releases, presence of law enforcement, youth placed in confinement, and youth placed on and/or removed from Precautionary Observation or Secure Observation.

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

The center 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 documents a review of the logbook. The center's practice is to have supervisory and administrative staff conduct regular logbook reviews. Supervisory staff document daily review and administrative staff document 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. 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. Center keys for juvenile justice detention officer (JJDO) staff are securely maintained in the staff break room outside of master control. 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. Observations by face-time teleconference and reviewed documentation found the center assigns keys by names and number. Staff are required to lock their personal keys in their assigned locker prior to entering the secure area. An interview with the superintendent and assistant superintendent indicated emergency egress keys providing an outlet through the exterior doors are stored in each sub-control under the desk, inaccessible to youth, and accessible to staff with their assigned keys. In addition, a spare set of all keys is securely maintained in the staff assistant office. Interviews with youth and staff indicated youth do not have access to center keys. Key inventory and issuance of keys is documented on each shift to include the date, time, name of person receiving the keys, time keys were returned, and name of supervisor issuing the keys. In the event a key is lost or missing, staff shall immediately report the issue discretely away from the youth, to the on-duty juvenile justice detention officer supervisor (JJDOS). The on-duty JJDOS shall ensure all youth movement stops. The superintendent is notified immediately and a search of the center is initiated, which may include electronic and/or full body searches of youth. According to the superintendent, the center has had no incidents of lost keys or broken keys since the last annual compliance review. An interview with the superintendent indicated if a key becomes lost the policy is for the Department's Central Communications Center (CCC) to be contacted. Five staff were interviewed regarding which center keys are restricted. Four staff indicated the center maintains restricted keys for medical records, youth property area, the kitchen, and mental health records. Three staff indicated case management records and one staff indicated only the JJDOS's keys are restricted. An interview with the superintendent reported the center does not issue

permanent keys for any staff. In compliance with the Center for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this review was conducted off-site; therefore, an observation of the center's collection and distribution of keys was not possible. A face-time teleconference observation of three staff key rings exhibited each corresponded with 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 multi-passenger vans awaiting surplus by the Department. The center also has four functional multi-passenger vans being used to transport youth. The four applicable vans utilized to transport youth were observed through a face-time teleconference with staff. Observations found the vans were locked in the secure sally port when not in use. Each vehicle was equipped with the appropriate number of seat belts, seat belt cutter, window punch, fire extinguisher, and a first aid kit. The center utilizes a vehicle maintenance monthly inspection checklist, weekly vehicle checklist, daily vehicle checklist, and a pre-trip vehicle inspection sheet. Prior to vehicles being used, documentation reflected vehicle inspections were completed and included a check of the presence of leaking fluid, inflation of tires, excessive or uneven wear of tires, presence of objects hanging down from the carriage, damage to windshield or windows, damage to mirrors, damage to headlights, turn signal, or tail lights, worn belts, low oil or steering fluid, seatbelts in proper working condition, any unusual noises coming from the vehicle, and any other items needing to be reported. The center maintains a transportation logbook. The acknowledgment of an inspection, destination, time of transport, time of return, and the name and number of officers and youth is documented for each trip. Reviewed documentation reflected each of the four vehicles utilized to transport youth received a satisfactory annual vehicle inspection. The center's transportation coordinator, supervisory staff, and/or maintenance staff 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.

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 center's maintenance department was observed through a face-time teleconference with the superintendent and all tools were observed securely located in a separate closet on a shadow board. No tools were observed out of place. All center tools were marked with an identification code identifying the tool as property of the Department. A perpetual tool inventory is maintained in the Facility Maintenance System (FMS) within the Department of Juvenile Justice Information System (JJIS) by the center's administrative staff, supervisory staff, and/or maintenance staff. When a

tool is needed, center staff sign the tool in and out on the tool list. There were no tools listed on the inventory which were missing and no tools present which were not on the inventory. Reviewed inventories supported the superintendent's review, as evidenced by their signature. The center's kitchen staff conduct an itemized daily inventory and a perpetual log of all kitchen tools. Kitchen knives and other utensils are stored in a pad-locked two-drawer system with an inventory maintained on the desk. A review of inventory logs supported inventories are conducted daily. When vendors and service providers visit the center they are positively identified, escorted throughout the center, and all tools are checked prior to entry and upon departure. An interview with the superintendent reported when items are lost or there is reasonable suspicion a youth may be in possession of a tool; a search is initiated by the juvenile justice detention officer supervisor (JJDOS). The assistant superintendent indicated there have been no instances where a tool has been missing in the past six months. Five staff were interviewed regarding the center's practice for damaged or missing tools. All five staff reported the JJDOS would be contacted and a center wide search would be conducted for the missing tool.

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

The center maintains a written policy and procedures regarding youth access to tools and cleaning items. Youth are forbidden access to kitchen and/or medical equipment. 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. In compliance with the Center for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this review was conducted off-site; therefore, an observation of youth using cleaning tools was not possible. Five interviewed youth reported they only use brooms and mops in the center. Five interviewed staff reported youth are permitted to use brooms and mops at the center. Two staff reported youth are also allowed to use scrub brushes.

5.10 Inventory of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory Compliance

The Superintendent is responsible for the implementation of a safety plan addressing proper use, storage, and disposal of chemicals, including flammable, toxic, caustic, and poisonous items.

All flammable, toxic, caustic, and poisonous items shall be inventoried and secured when not in use. The use of hazardous material shall be consistent with the manufacturers' instruction and all safety precautions shall be followed.

All flammable, toxic, caustic, and poisonous items shall have the Material Safety Data Sheets (MSDS) on hand in the facility. Toxic or caustic materials shall not be allowed to enter into the facility unless an MSDS is on file in an MSDS logbook and posted near items. A master copy of the MSDS logbook shall be maintained in an accessible binder for all personnel to review at all times.

No hazardous chemicals should be mixed, as this could result in an explosion or emission of toxic gas.

The center 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. In compliance with the Center for Disease Control and Prevention (CDC) guidelines regarding the COVID-19 pandemic, this review was conducted off-site; therefore, observation of the center's maintenance room was conducted through a face-time teleconference. Observations and reviewed documentation found the center's flammable, toxic, caustic, and poisonous items are stored in the maintenance room, flammable liquids locked cabinet located outside inaccessible to the youth. Inventories and Safety Data Sheets (SDS) were located in the laundry room and a locked closet within the kitchen. A master SDS binder for all chemicals were maintained in the assistant superintendent's office along with the Poison Control telephone number inside the binder.

5.11 Access to all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory Compliance

Flammable, toxic, caustic, and poisonous fluids and other dangerous substances may only be drawn or acquired by authorized personnel.

Youth shall not be permitted to use, handle, or clean-up dangerous or hazardous chemicals or respond to chemical spills. Youth shall not be permitted to clean, handle, or dispose of any other person's bio hazardous material, bodily fluids, or human waste.

The center maintains a written policy and procedures to ensure flammable, toxic, caustic, and poisonous fluids, and other dangerous substances may only be acquired by authorized staff. Youth shall not be permitted to clean, handle, or dispose of any other person's bio-hazardous material, bodily fluids, or human waste. Youth shall not be permitted to use, handle, or respond to chemical spills. All flammable, toxic, caustic, and poisonous materials are stored in the maintenance room within the flammable liquids locked cabinet located outside and inaccessible to the youth. Five interviewed staff reported youth are not allowed to clean with toxic, flammable, or poisonous substances. Five youth were interviewed regarding the use of

chemicals at the center. Three youth reported youth do not clean with chemicals and two youth reported staff would spray the chemicals.

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

The center 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. An interview with the superintendent reported all food is cooked on the stovetop or baked in the oven and there is no grease trap in the kitchen. All other kitchen liquid waste is disposed in the kitchen drain. Liquid waste resulting from work details is disposed of in the center's two utility sinks. Bio-hazardous medical waste is the responsibility of medical staff. All bio-hazardous waste is placed in bio-hazardous waste containers and all bio-hazardous solid waste is placed in a tear-resistant red bag clearly marked as bio-hazardous. The center's policy indicates the spill kits shall be strategically placed throughout the facility and shall be used in the event of an emergency in which large amounts of blood, vomit, or other bodily fluids are present and pose a threat to the health of youth and/or staff. Reviewed documentation supported the center maintains four bio-hazard spill kits placed in the medical clinic and one in each of the three sub-controls. An interview with the superintendent indicated there were no chemical spills since the last annual compliance review.

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 has a written policy and procedures addressing confinement under twenty-four hours. Staff are required to utilize behavioral confinement as an immediate, short term response strategy during volatile situations in which a youth's sudden or unforeseen behavior threatens the physical safety of self or others. Youth who are in confinement have no contact with the general population. The center documents confinements under twenty-four hours in the Facility Management System (FMS). A review of twelve confinement reports documented youth placed in confinement were afforded the same services as youth in the general population which includes medical, mental health, education, exercise, showers, meals, clothing, bedding, and hygiene items. Documentation reflected confinement rooms were searched prior to youth being placed, no more than one youth was placed in a confinement room, and all confinements were approved by a juvenile justice detention officer supervisor (JJDOS). None of the reviewed confinement reports indicated the youth were at risk of suicide. All reviewed confinement reports were reviewed by the JJDOS within the required two-hour time frame. Each of the twelve confinement reports indicated the superintendent and/or designee reviewed the confinement report within forty-eight hours, as required. Confinement shall be communicated to the school personnel for appropriate record keeping and tracking of school assignments. The center's teachers are required to take attendance daily at the beginning of each class period. This practice allows the teachers to be informed of any absences whether for court, medical, or

confinement purposes. Once teachers are made aware of any issues, the teacher or the JJDOS will contact the school site administrator. Teachers are required to provide the site administrator daily lesson plans and are also required to provide sufficient assignments to confinement students. The confined students will receive the same lesson as the students who are not in confinement. Teachers will make each student aware of the time they are available to answer and respond to any questions. Five staff were interviewed regarding staff responsibilities when a youth is placed in confinement. Five staff reported the room would be searched prior to use. Three staff reported ten-minute checks would be documented and two staff reported five-minute checks would be documented for the first hour followed by ten-minute checks. Reviewed confinement observation logs confirmed the center's practice of conducting five-minute checks for the first hour and ten-minute checks, thereafter.

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

The center has a written policy and procedures to address youth placed in confinement over twenty-four hours. Staff shall use behavioral confinement as an immediate, short term response strategy during volatile situations in which a youth's sudden or unforeseen onset of behavior imminently and substantially threatens the physical safety of others or self. Confinements should not exceed twenty-four hours; however, if a youth continues to exhibit behavior which poses a risk to himself or herself, staff, or others, a confinement review must be conducted. Five applicable confinement reports over twenty-four hours were reviewed and each was approved by the superintendent or designee. The center's practice is to e-mail the Department's regional director for confinement approval every twenty-four hours after placement. Reviewed e-mail correspondence supported permission was granted for each youth confinement. No youth remained in confinement to exceed three days. The juvenile justice detention officer supervisor (JJDOS) completed reviews evaluating the youth every three hours and documented the need for continued confinement based on the severity of the rule violations, past disciplinary history, or behavior while in confinement. All five reviewed confinements did support a mental health professional reviewed the status of the youth in confinement every twenty-four hours.

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

The center 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 Continuity of Operations Plan (COOP) which was approved by the regional director and superintendent on August 13, 2019 and contains a comprehensive approach to effectively manage emergencies and disaster events. Mock hurricane COOP drills were conducted on May 8, 2019 and August 30, 2019. A review of documentation found there were written scenarios, findings, and recommendations on the center's emergency drill reporting forms. Five staff were interviewed regarding their participation in drills. Staff reported participating in weather, major disturbance, bomb threat, hostage situation, chemical spill, flooding, terrorism, escape, fire, medical, and mental health drills in the past six months. An informal interview with the superintendent indicated COOP drills are conducted twice a year.

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

The center 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 mock escape drills quarterly. Reviewed documentation of drills for the past twelve months supported mock escape drills were conducted quarterly on each shift. Reviewed logbooks contained documentation of when escape drills were conducted. A review of five staff in-service and five pre-service training records verified annual escape training was completed by all staff. Five 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. *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 fire safety and prevention. In addition, the center maintains a separate fire prevention plan ensuring the facility fire regulations are met and preventative maintenance occurs. Reviewed documentation validated the fire prevention plan was approved by the fire marshal on December 16, 2019. The annual fire alarm inspection was conducted on December 16, 2019. The fire marshal inspection was conducted on April 03, 2020 with no identified major fire safety violations. The center conducts monthly checks on the fire extinguishers and conducts a monthly fire safety and emergency light inspection. A review of the emergency drill forms and the logbook documentation for the past six months verified the center conducted fire drills every month on each shift except for "B" shift in

the month of January 2020. Each completed drill documented an evaluation and recommendations for improved emergency response. Five interviewed staff indicated each fire drills take place at least monthly at the center. Five interviewed youth indicated they have been instructed on what to do in case of a fire.