STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Southwest Florida Regional Juvenile Detention Center

Department of Juvenile Justice

(State-Operated)
2525 Ortiz Avenue
Fort Myers, Florida 33905

Review Date(s): October 20-23, 2020

Promoting Continuous Improvement and Accountability
in Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Camelia Daley, Office of Accountability and Program Support, Lead Reviewer (Standard 1)
Rosa Flores, Office of Accountability and Program Support, Regional Monitor (Standard 2)
Patrick Morse, Office of Accountability and Program Support, Regional Supervisor (Standard 3)
Maryann Sanders, Office of Accountability and Program Support, Deputy Regional Supervisor (Standard 4)
Ron Warrick, DJJ Office of Education, Education Coordinator (Standard 2)
Darryl Wolf, Miami Dade Regional Juvenile Detention Center, Assistant Superintendent (Standard 5)

Program Name: Southwest Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: Lee County / Circuit 20
Review Date(s): October 20-23, 2020

MQI Program Code:1046
Contract Number: N/A
Number of Beds: 50
Lead Reviewer Code: 190

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

Overall Rating Summary

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

Standard 1: Management Accountability
Detention Rating Profile

Indicator Ratings

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

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

Standard 2: Youth Management
Detention Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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

Standard 4: Health Services
Detention Rating Profile

Indicator Ratings

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

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

Standard 5: Safety and Security
Detention Rating Profile

Indicator Ratings

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

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

Program Overview

Southwest Florida Regional Juvenile Detention Center is a state-owned detention facility, operated by the Department, located in Fort Myers, Florida. The center serves youth in Lee, Hendry, Glades, and Charlotte counties in Circuit 20. Male and female youth who are detained pending adjudication, disposition, or placement in a residential commitment program are housed in the fifty-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 Lee County Public School System. The center's management team includes the superintendent, two assistant superintendents, one administrative assistant, one food service director II (FSDII), and training coordinator. The center maintains a contract with Camelot Community Care, Inc. to provide mental health, substance abuse services, and psychiatric services. Mental health services are provided by a State of Florida licensed psychiatrist, licensed mental health counselor who serves as the designated mental health clinician authority (DMHCA), and two master's-level non-licensed mental health therapists. Clinical services provided at the center include mental health and substance abuse evaluations, mental health treatment planning, individual, group, and family therapy, mental health crisis intervention services, on-site psychiatric services, and availability for substance abuse services for youth with co-occurring disorders. The center has a current contract with Camelot Community Care, Inc. to assume responsibility for the provision of medical services to all youth. All healthcare staff are employed by Camelot Community Care, Inc. Medical services are provided by the osteopathic physician (DO) who serves as the center's designated health authority (DHA), advanced practice registered nurse (APRN), one registered nurse, and two licensed practical nurses. The medical clinic maintains nursing coverage Monday through Friday, from 7:00 a.m. to 7:00 p.m. and from 8:00 a.m. to 8:00 p.m. on weekends. 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 two living modules which are divided by male and female. A tour of the center was conducted by the annual compliance review team during the week of the review and observations found there are forty-five security cameras at the center, of which all were operational. The center was observed to be clean and free from insect infestation. Common areas, living modules, bathrooms, classrooms, kitchen, and dining areas were observed to be clean, organized, and well maintained. The center had minimal graffiti. The living and the common areas were observed to be newly painted by youth and volunteers. Outside grounds and the perimeter area appeared to be intact and did not have any observed security issues. At the time of the annual compliance review, the center had nine vacancies, which included six juvenile justice detention officers (JJDO I), one juvenile justice detention officer II (JJDO II), one clinic manager, and one administrative assistant.

Standard 1: Management Accountability

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

The center maintains a written policy and procedures ensuring all Department employees, contractors, volunteers, mentors, and interns are background screened prior to hire. The center had nineteen newly hired employees and four contractors since the last annual compliance review. The center did not have any new volunteers during the annual compliance review period. A review of the applicable twenty-three records confirmed background screenings were completed, by the Department's Background Screening Unit (BSU)/Clearinghouse, prior to the individual's date of hire and/or contact with youth or access to confidential information. Each newly hired staff's Florida Department of Law Enforcement (FDLE), criminal history, Staff Verification System (SVS) module, and Central Communications Center (CCC) Person Involvement Report was reviewed. Each direct-care staff is required to complete a pre-employment assessment and receive a passing score. The center had nineteen direct-care staff who required a pre-employment assessment. Reviewed documentation confirmed a pre-employment assessment was completed by each newly hired direct-care staff and a copy of the passing score was maintained in each staff's personnel record. One of the newly hired direct-care staff required an exemption from the Department prior to hire due to not having a passing score. Four contracted employee records were reviewed. All four contracted staff background screenings were processed and maintained in the Clearinghouse database. An Affidavit of Compliance with Level 2 Screenings Standard was submitted to BSU on January 07, 2020 and for school board teachers on January 22, 2020, meeting the annual requirement.

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

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

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

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

The center maintains a written policy and procedures ensuring all staff adhere to a code of conduct. The center utilizes the Department's employee handbook, which contains a code of conduct. Staff are required to adhere to a code of conduct which prohibits any form of abuse, profanity, threats, harassment, intimidations, or personal relationships with youth. Five applicable staff records were reviewed, and each contained a signed acknowledgement, receipt, and review of the Department's Code of Conduct and was conducted during their Phase I training period. An additional three personnel records were reviewed for disciplinary action to meet the minimum sample size. Documentation found one staff received an oral reprimand, one staff received a written reprimand, and one staff was terminated for violations of the Department's Code of Conduct. An additional three personnel records were reviewed for commendations. Documentation validated three staff received Rising Star awards for outstanding performance and dedication. A review of the internal incidents, Department's Central Communications Center, and Protective Action Response reports confirmed there were no incidents which should have been documented as a violation of Code of Conduct.

An interview with the center's superintendent was conducted and confirmed the center adheres to a strict Code of Conduct, inclusive of youth's confidentiality, prohibiting staff horseplay, verbal or physical abuse, and any personal relationships between staff and youth. Five staff were interviewed regarding the working conditions of the center. Two of the five staff reported they have never observed a co-worker use profanity when speaking to a youth. Three of the five staff reported they once saw a co-worker use profanity when speaking to a youth. Three of the five staff reported the working conditions at the center in the past year have been good. Two of the five staff reported the working conditions have been fair. Five youth were interviewed, and three reported staff are respectful when talking with them and other youth. Two youth reported they witnessed staff using profanity once. One youth reported occasionally hearing staff use

profanity. Additionally, each interviewed youth confirmed they have never been threatened by a staff or seen a staff member threaten another youth.

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

The center maintains a written policy and procedures ensuring all incidents are reported to the Department's Central Communications Center (CCC). The center shall notify the CCC within two hours of a reportable incident or within two hours of becoming aware of the reportable incident. The center had fifty-one incidents reported to the CCC since the last annual compliance review. The center indicated thirty-five reportable incidents during last year's annual compliance review; therefore, demonstrating an increase in reported incidents. An interview with the center's superintendent, regarding the increase of CCC's reported, indicates continued training will be administered throughout the center on the use of PAR and confinement. In addition, all new medical staff have been hired. The center had twenty incidents reported to the CCC during the last six months, of which five were reviewed. Documentation validated each incident was reported to the CCC within the mandatory two-hour time frame and in accordance with the CCC reporting procedures.

The center maintains a master control logbook for documenting reports to the CCC. A review of the logbook validated four out of five reports were documented. A review of internal incidents and grievances for the past six months determined there were no incidents which should have been reported to the CCC but were not. An interview was conducted with the center's superintendent and confirmed all staff must contact the Department's CCC within two hours of a reportable incident occurring. Additionally, all staff are mandated reporters and must contact the Florida Abuse Hotline if any abuse or neglect allegations are made. The center's superintendent reported all youth are afforded the opportunity to utilize the telephone to report any abuse or neglect allegations.

Five staff were interviewed and reported all youth have unhindered access to the Florida Abuse Hotline and CCC. Each interviewed staff confirmed they notify a supervisor when a youth wants to make a call to the Florida Abuse Hotline or CCC. Additionally, each staff can make a call the Florida Abuse Hotline or CCC if they feel a call is warranted. Five youth were interviewed, and each reported they have never been stopped from making a call to the Florida Abuse Hotline or CCC. Each interviewed youth reported feeling safe at the center.

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

The center maintains a written policy and procedures ensuring Protective Action Response (PAR) is in accordance with Florida Administrative Code. All administrators and officers shall be trained in PAR. A PAR report will be generated any time a PAR incident occurs. PAR reports shall include a review by a PAR certified instructor/supervisory staff, post-PAR interview, and a review of the PAR incident report by the superintendent or designee within twenty-four hours of the incident, excluding weekends or holidays. The center had fifty-three PAR reports completed since the last annual compliance review and five were reviewed. Reviewed documentation confirmed each report included statements from all staff involved and completed by the end of the staff member's workday.

A review of the PAR incident reports found documentation supports each report contained a review by a PAR-certified instructor and documented a post-PAR interview conducted within thirty minutes of the incident. None of the reviewed reports required a Mechanical Restraint Supervision Log to be completed. None of the reviewed PAR reports alleged any injuries or required a PAR medical review. Documentation confirmed each report was reviewed and processed within the mandated time frame by a juvenile justice detention officer supervisor (JJDOS) and PAR instructor to determine if the use of force was consistent with the center's procedures. Each post-PAR interview was dated, timed, and signed by the individual conducting the interview. Each post-PAR interview was filed in each youth's Individual Healthcare Record. None of the reviewed reports required a Mechanical Restraint Supervision Log to be completed. Reviewed documentation of five PAR incident reports contained a review by the superintendent or designee within seventy-two hours of the incident. None of the reviewed reports required a call to the Department's Central Communications Center (CCC), and there was no documentation to support any involved youth made a report to the Florida Abuse Hotline. Logbooks and internal incident/grievance reports were reviewed, and documentation did not reveal any additional PAR incidents occurred.

The center's PAR rate during the annual compliance review period was 11.45, which is below the statewide Detention PAR rate of 16.56. An interview was conducted with the center's superintendent, who confirmed PAR reports are entered in the Facility Management System (FMS). All PAR reports are reviewed by the JJDOS, the PAR instructor, and an administrator. Additionally, the center reviews logbooks and youth grievances regularly to determine if a reportable incident was not entered into FMS. Five staff were interviewed, and each confirmed they use verbal techniques prior to using physical or mechanical restraints.

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

The center has a written policy and procedures ensuring all newly hired staff are trained in accordance with Florida Administrative Code within 180 days of hire. Pre-service training is divided into two phases. Phase I consists of instructor-led and web-based courses. Phase II consists of 120 hours of academy instructor-led training. Five staff training records were reviewed for pre-service training. Four of the five reviewed records found four staff completed the certification process within 180 days of hire. One staff has not completed the certification process; however, has not been employed 180 days. All reviewed records found each of the five reviewed staff completed the required trainings inclusive of Protective Action Response (PAR), first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), mental health services, substance abuse services, suicide prevention, safety and security emergency plans, human trafficking, Department detention facility operations, supervision, active shooter, and Prison Rape Elimination Act (PREA) prior to having any contact with youth. A review of five training records found documentation to support each staff completed Phase I training. Four of the five staff completed Phase II training. One staff is currently pending test results from completing the academy and will complete Phase II training prior to their 180 days of hire. All training was conducted by qualified trainers and documented in the Department's Learning Management System (SkillPro). An interview with the center's superintendent was conducted which confirmed all juvenile justice detention officers are required to complete certification requirements within 180 days of hire date.

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

The center has a written policy and procedures ensuring all staff complete at least twenty-four hours of in-service training annually, including mandatory topics specified in Florida Administrative Code. Five applicable staff training records, which included two juvenile justice detention officer supervisors (JJDOS) training records, were reviewed for in-service training. Each staff training record documented the staff exceeded the twenty-four hours of in-service training requirements. Each staff had current certifications in first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), and Protective Action Response (PAR). Each staff completed training in professionalism and ethics. All staff completed the suicide prevention and active shooter training requirements. Two JJDOS training records reviewed confirmed the completion of eight hours of management and supervisory training inclusive of management, leadership, personal accountability, employee relations, communications skills, and fiscal. All trainings were delivered by qualified trainers and documented in the Department's Learning Management System (SkillPro). An interview with the center's superintendent confirmed staff are required to attend suicide prevention, PAR, CPR, and first aid training annually.

1.08 Grievances	Satisfactory Compliance

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

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

The center maintains a written policy and procedures ensuring all youth are treated fairly, respectfully, and without discrimination. The center ensures all youth have the right to file a grievance. The grievance process is posted in each module and explained to each youth during the admission and orientation process. The grievance process consists of three phases. The first step in the process is the informal phase which is completed by detention staff whereby the youth and staff attempt to resolve the youth's issue. A written grievance will be submitted to the juvenile justice detention officer supervisor (JJDOS) if the staff is unable to resolve the issue which begins the formal grievance process. Next, the appeal phase requires a response from the superintendent or designee. Grievance forms are electronically kept in the Facility Management System (FMS) for at least one year. Two grievances were filed in the last twelve months and each were reviewed. Each of the grievances were resolved at the formal phase. Each of the grievances were forwarded to the on-duty JJDOS within the required time frame, through the FMS, and the youth was informed of the findings by the end of the shift. An interview with the superintendent explained all youth have the right to file a grievance if they feel their rights have been violated. Five youth were interviewed regarding the grievance process. Two youth stated they have never submitted a grievance. Two youth stated the grievance process is good and they are aware of the grievance process. One youth stated the grievance process is good and explained the grievance process. Five staff were interviewed, and each were able to describe the center's grievance process.

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

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

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

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

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

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

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

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

The center maintains a written policy and procedures ensuring alerts are entered into the Department's Juvenile Justice Information System (JJIS) and the use of an internal alert system. Critical and special alerts are reviewed, updated, and responded to appropriately. Staff shall always keep a copy of the detailed alert list with them. An interview with the center's superintendent was conducted and confirmed medical alerts are entered at the time of admission and updated when necessary. Additionally, the JJIS alert reports and internal alerts are distributed and reviewed daily by the juvenile justice detention officer supervisors and administration. A current alert list is maintained in the medical clinic and kitchen. Five staff were interviewed, and each confirmed they are made aware of alerts through alert forms and shift debriefings. Each staff confirmed management informs staff about issues throughout the center through staff debriefings. All five staff reported issues and information from management is distributed through all-staff meetings. A review of five youth records found each was applicable to have an alert entered into the center's internal alert system and the JJIS alert system. Reviewed documentation supported each youth had the appropriate alert entered into the internal alert. Three youth were classified as Vulnerable to Victimization and/or Sexually Aggressive Behavior and were placed in a single occupancy room. The superintendent confirmed only medical staff can remove or downgrade a medical alert, only mental health staff are able to remove or downgrade a mental health alert, and only administrative staff can remove or downgrade safety and security alerts. Alerts are announced at shift briefings and hard copies are distributed to all direct-care staff.

Standard 2: Assessment and Performance Plan

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

The center maintains a written policy and procedures in place to ensure proper screening, evaluation, and documentation of each youth, ensuring all youth are admitted into the center in accordance with Florida Administrative Code. Five youth case management records were reviewed, and each had a completed Detention Risk Assessment Instrument (DRAI), Suicide Risk Screening Instrument (SRSI), and arrest affidavit or order to retain the youth in custody. Each contained an Admission Wizard from the Department's Juvenile Justice Information System (JJIS) completed for each youth. All five youth were electronically searched, frisk searched, and full body visual searched by an officer of the same gender as the youth.

Five reviewed case management records documented the youth were served a meal or a snack within the required time frame. All five youth case management records documented the youth making a telephone call at the center's expense to the youth's parent/guardian. Each reviewed record included documentation which validated each youth received a medical, mental health, and substance abuse screening. An observation of an admission process was conducted during the annual compliance review week. Observations reflected the admission process was explained to the youth and the youth appeared to understand the process. The juvenile justice detention officer (JJDO) reviewed the arrest affidavit, DRAI, and custody order. The youth viewed the Prison Rape Elimination Act (PREA) video and was given the opportunity to ask any questions. The youth was screened to identify medical, mental health, and substance abuse requirements. The youth was electronically searched, frisk searched, and full body visual searched by an officer of the same gender. The youth was offered a meal and was permitted to call their parent/guardian. All admission case records are reviewed by the shift supervisor for appropriate placement and for appropriate supervision levels. An informal interview was conducted with the youth. The youth reported the admission process was explained well and the staff were very nice and provided all the necessary information required for their stay.

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

The center maintains a written policy and procedures to ensure all youth admitted into the center are notified of the rules and regulations. Five youth case management records were reviewed, and each included an orientation packet which was completed within twenty-four hours of admission. Each reviewed record had documentation to validate the orientation was explained verbally and in writing by the juvenile justice detention officer. Each orientation packet included information on rules and regulations, youth rights, visitation, telephone calls, daily schedule, mental health, grievance procedures, access to medical, and substance abuse services, access to the Florida Abuse Hotline, the Department's Central Communications Center, and the behavior expectations and consequences. Each youth signed the orientation packet acknowledging they received the packet. Five youth were interviewed regarding the orientation process, and each confirmed they were provided information regarding the center's rules and regulations, daily schedule, education services, visitation, abuse reporting, and behavior management system. A youth orientation was observed during the week of the annual compliance review. The youth was able to observe the orientation video at the time of admission. An informal interview was conducted with the youth. The youth reported the orientation process was explained and had no questions.

2.03 Classification	Satisfactory Compliance

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

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

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

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

The center maintains a written policy and procedures ensuring all youth admitted into the center are classified to ensure the highest level of safety and security. All youth are placed in a room based upon their classification and may be reclassified if there are any changes in the status or behavior. The center considers several factors prior to placing the youth into a room inclusive of height, weight, age, gender, level of aggression, mental illness, development disabilities, physical disabilities, history of violence, gang affiliation, criminal history, history of sexual offenses, vulnerability to victimization, suicide risk identified or suspected, medical, and security and escape risk. All room assignments are documented in the Department's Juvenile Justice Information System (JJIS) and no more than two youth may occupy a room. All youth requiring a single room shall have an alert entered in JJIS.

A review of five youth case management records were reviewed for classification. Each reviewed record contained a copy of the Department's JJIS Admission Wizard documentation, which included the classification results and the screening for Vulnerability for Victimization and Sexually Aggressive Behavior (VSAB). Each reviewed youth case management records contained the VSAB form and the Suicide Risk Screening Instrument. Three out of the five youth were placed in single occupancy rooms due to the VSAB form or history of sexual offenses. Five youth case management records were reviewed and there were no applicable records which identified youth as gang members or affiliated with a gang. An informal interview was conducted with the center's superintendent. The superintendent reported youth are classified by several factors such as age, mental health status, physical health, cognitive performance, age, and prior victimization screening assists when assigning youth to a room. Youth with mental health issues may be placed on precautionary observation and youth with physical or cognitive performance issues will be placed on special needs status.

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

The center maintains a written policy and procedures ensuring all information regarding suspected gang involved youth admitted into the center shall be shared with the circuit gang representative. The center has designated the assistant superintendent to serve as the gang representative for the center, who communicates with the circuits liaison and shares all information regarding suspected gang activity. The assistant superintendent notifies the juvenile probation officer (JPO) representative, the superintendent, the juvenile probation officer supervisor (JPOS), and a liaison for Lee County Sheriff's Office on any gang activity by electronic mail. The center is required to enter the "other suspected gang affiliation" alert into the Department's Juvenile Justice Information System (JJIS) if there is a youth suspected to have gang affiliation. Staff are notified of all updates and alerts, daily at shift briefings. An informal interview with the assistant superintendent was conducted and confirmed the center's practice. Five youth case management records were reviewed, and none were applicable for gang involvement. Three additional records were requested from the center to meet the minimum sample size. Each of the applicable youth case management records were identified as having gang involvement. Each reviewed record contained a corresponding e-mail to a liaison from the Lee County Sheriff's Office, the assigned JPO, and JPOS. The e-mail included a description of the incident and any applicable pictures or a depiction of the gang affiliated event.

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

The center has a written policy and procedures in place related to ensuring the proper safe handling and security of each youth's personal property including valuables, which are collected and secured at the time of a youth's admission. The youth's property is itemized and documented in the Personal Property Receipt form in the Department's Juvenile Justice Information System (JJIS) module. The form is printed and verified by the youth for accuracy. Any personal valuable items, such as money, cellular phones, and/or jewelry are placed in a clear, tamper proof bag. The tamper proof bag includes the date, name of the youth, Department of Juvenile Justice identification number (DJJID), and a list of the items written on the bag. The date, youth's name, time, DJJID, and name of the juvenile justice detention officer (JJDO) which secured the property is written in the center's drop safe logbook. The youth's clothing and shoes were placed in a garment bag and identified with the youth's name, DJJID, and list of included items. The garment bag is placed in a secure property room located in the intake processing unit. Five youth records were reviewed and each contained itemized Personal Property Receipt forms signed by the youth and staff members. Five case management records

had a letter of acknowledgement regarding unclaimed property which was signed by the youth. Two of the five records were applicable for valuable property taken during admission. The property was documented on their itemized Personal Property Receipt form and signed by the youth and staff member. The personal property was logged into the logbook and the items were placed in a tamper proof clear bag. The safe is the initial drop for youth property and the safe is under camera surveillance with limited access to only the superintendent, assistant superintendent, and juvenile justice detention officer supervisor (JJDOS).

An admission process was observed during the annual compliance review. Observations revealed the detention staff searched and frisked the youth and took custody of any valuable property. The items were already placed in a clear tamper proof bag. The JJDO and/or JJDOS verified the items in the bag with the youth and the youth verified the information written on the bag and signed. The JJDOS then documented the date, youth's name, DJJID, time and their initials in the logbook. The JJDOS then proceeded to inventory the clothing and other property. The information was documented on the Personal Property Receipt form in the Department's Juvenile Justice Information System (JJIS). Five youth were interviewed regarding the admission process, and each reported staff checked their personal property upon admission, and youth signed a form stating their personal property was inventoried. An informal interview was conducted with the superintendent regarding the admission process. The superintendent reported all youth have their personal property inventoried upon admission, clothing is placed in garment bags and stored in the locked property room, and other items such as valuables are placed in a tamper-proof bag and placed in a safe under video surveillance which is located in the intake processing area. The superintendent informed only administrative staff have access to the safe and cabinet.

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 ensuring youth's personal property is secure and returned to them in a timely manner upon their release. Observation of the center's storage area during the annual compliance review week found all applicable personal valuable were placed in a clear tamper proof bag with the name, date, Department of Juvenile Justice Identification Number (DJJID), and itemized inventory list documented on the bag, then are properly secured in a locked safe box under video surveillance. The youth's clothing and shoes are placed in a garment bag with a property inventory attached and secured in a locked room under video surveillance. Access to the youth's garment property is available by all pertinent staff for a timely distribution upon release. The locked safe which holds all the youth's personal valuable property is accessible only by the superintendent and assistant superintendent. Items are removed daily, logged and stored in a locked cabinet in master control until the youth is released, or the youth's parent/guardian reports to the center to take custody of the property. The property is relocated to a safe box in master control in which the juvenile justice detention officer supervisors have access to in the event the superintendent or assistant superintendent are not be available during a scheduled release. A review of the Department's Central Communications Central reports for the past six months found no incidents regarding youth property. An interview with the center's superintendent was completed. The superintendent validated the center's property storage practice and informed youth and guardian(s)/parent(s) and juvenile probation officers are notified thirty days after a release of the destruction of any unclaimed property.

2.07 Release	Satisfactory Compliance

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

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

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

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

The releasing officer shall verify the identification of the youth.

The center has a written policy and procedures in place to ensure all releases from the center occur promptly and accurately. The juvenile justice detention officer (JJDO) completing the release shall verify the courts authorization to release the youth. The JJDO shall review all paperwork with the juvenile justice detention center supervisor (JJDOS) before releasing the youth. The JJDOS is responsible for verifying there are no holds, court orders, or other legal reasons not to release the youth from the center. Parent(s)/guardian(s) are confirmed, and a photo identification is placed in the youth case management record prior to release. A review of three closed youth case management records validated the center's practice. A review of the three closed youth records revealed each had the appropriate documentation including the Release Wizard, the court authorization to release, a copy of photo identification of the person taking custody, Release of Property Inventory form, youth and parent/guardian notifications to any future court dates, and all parties signed all required release forms.

Each reviewed record had documentation which confirmed the admission date and termination date in the case record correlated with the Department's Juvenile Justice Information System. An observation of a youth release was conducted during the annual compliance review. The youth's identification was verified by the JJDO and the JJDOS. The parent/guardian identification was verified, and a copy of their driver's license was taken. The JJDOS called the medical staff and verified if the youth was to be released with medication. The youth was processed for release and presented with their property. The youth verified receipt of all documented property listed on the Personal Property Receipt form and youth and parent/guardian signed the form. The Release Wizard was completed and signed by the youth and parent/guardian. The youth and parent/guardian were notified of any future court dates and/or instructions given by the courts as documented by their court order. A copy of the court order was presented to the youth and parent/guardian to ensure proper service of future court dates and instructions. A review of the Department's Central Communications Center reports from the past six months found there were no documented unauthorized releases at the center.

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

The center has a written policy and procedures in place to ensure all youth personal property is released to the youth or the youth's parent/guardian. The parent/guardian, youth, and staff must sign a receipt acknowledging all property was returned upon their release. A review of three closed youth case management records revealed each youth record had the required information and contained the youth and/or parent/guardian or responsible adult and staff member's signatures of the receipt of each youth's personal property. Youth sign a Property Letter of Acknowledgement form upon admission making them aware of the process. A letter is mailed to the youth, parent/guardian, and the assigned juvenile probation officer (JPO) regarding any property not claimed after thirty days of release. Personal property not claimed is inventoried and can be disposed of to a local non-profit charity. A review of inventoried unclaimed property by the youth and parent/guardian was reviewed during the annual compliance review. Documentation reviewed supported a notice was mailed to the youth and parent/guardian with a copy of the signed Property Receipt form. An observation of a youth release was conducted during the annual compliance review and confirmed the center's practice. The Release Wizard and the Property Inventory form was signed by the youth and parent/guardian.

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

The center has a written policy and procedures in place to ensure prescribed medication along with medication instructions are provided to the parent/guardian or responsible adult at the time the youth is released. The center utilizes the Department's Medication Receipt form for youth being release with medication. A review of three applicable closed youth case management records was conducted and reflected the Department's Juvenile Justice Information System (JJIS) Release Wizard indicated the youth had medication upon release. Each reviewed record contained a receipt of medication, signed by the parent/guardian or receiving Department staff, the type of medication, strength, dosage, quantity, any health or welfare issues regarding the medication, and any pending medical appointments. An observation of a release during the annual compliance review was conducted; however, the observation of the receipt/release of medication was not applicable as the youth was not released with any medication and the center did not have any additional records to be reviewed.

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

The center maintains a written policy and procedures ensuring detention reviews are conducted weekly for youth securely detained, placed on home detention, or electronic monitoring, to ensure proper management of youth and the sharing of information. The center has a designated staff appointed to coordinate the weekly detention reviews. Reviewed

documentation found the reviews were conducted with the center's staff including medical, education, mental health, and a representative from probation. A review of the past six months, of detention review documentation, confirmed the center conducts detention reviews on Thursdays and are held on weekly basis. Documentation from the meetings along with sign-in sheets, confirmed meetings are conducted and each youth in secure detention and home detention are reviewed. Placement status and updates on youth awaiting placement in a commitment program were discussed. The superintendent reported the detention review specialist conducts the weekly meetings where representatives from probation unit, medical, mental health, education and administration personnel attend. The superintendent reports detention reviews are held, and the information discussed is the youths' detention status, release date, future court date(s), medical, dietary, mental health, and education.

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

The center maintains a written policy and procedures ensuring youth are constructively involved in activities and adhere to a daily schedule. The center provides and maintains a weekday, weekend, and holiday schedule posted in all living areas. Wake up time starts at 6:45 a.m. every day and bedtime begin at 8:00 p.m., depending on the youth's level. Posted schedules included personal hygiene, mealtimes, visitation times, education, recreation and physical activities, indoor activities, shift changes, bedtimes, groups shift changes, and open program times. Visitation times are twice a week. During the morning and early afternoon hours, youth are participating in education. Observations during the annual compliance review revealed schedules are posted throughout the center in each living module. A review of the center's logbook and observations confirmed the center adheres to the daily activity schedule. Five youth were interviewed regarding the daily activity schedule, and each reported there is a daily activity schedule in the center.

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 has a written policy and procedures in place to ensure daily schedules are followed. Any significant changes to the schedules must be approved by administration. The daily activity schedule, logbooks, and movements were observed during the annual compliance review. A review of the center's shift reports and logbooks from the previous six months verified there were no major changes in the activity schedule. Reviewed logbooks and daily movements validated the center is adhering to the daily activity schedule. Five youth were interviewed regarding the daily activity schedule. Each youth confirmed the daily activity schedule is followed each day. Five staff were interviewed regarding the daily activity schedule. Each staff reported the daily activity schedule is followed every day.

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

The center has a policy and procedures to provide for educational access. The center integrates education into the daily schedule to ensure the youth are receiving the required minimum instruction time distributed over a twelve-month period. The Lee County School District and daily school calendars were reviewed and incorporated the required 250 days of instruction with five days used for teacher planning. This schedule provided five sixty-minute class periods fulfilling the weekly requirement of twenty-five hours of instructional time and receive credit for course completions as appropriate. An interview with the lead educator and superintendent verified the youth are attending school according to the daily schedule with minimal interference. In a review of the logbook, the center has resumed face-to-face instruction in all classrooms with no disruption of educational instruction.

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

The center has a policy and procedures to provide for career education. The center provides character education including lessons in life skills, citizenship, integrity, and good moral character traits. An interview with the lead teacher revealed the center offers and provides Type 1 career education development which includes career learning strategies such as: interviewing skills and techniques, career interest, inventories, budgeting, résumé writing, as well as completing employment applications.

2.15 Trauma-Informed Care	Satisfactory Compliance
The center is incorporating trauma-informed practice into current operations to deliver services and to provide care to youth in custody, acknowledging the role violence and victimization play in the lives of most of the youth entering the center. *Trauma-informed practice has many characteristics, which include the following:* • *A recognition of the high prevalence of trauma* • *Recognition of culture and practices which may be re-traumatizing* • *Collaboration of caregivers* • *Training of staff to improve trauma knowledge and sensitivity* • *Increased staff understanding of the function of behavior (rage, self-injury, etc.) as an expression of trauma* • *Use of objective and neutral language (avoids labeling of youth)*	

The center has incorporated trauma informed care practices into their current operations to deliver services and provide care to all youth in custody in the center. The center staff receive training in trauma-informed care as part of their pre-service and in-service requirements. Five staff training records were reviewed and reflected each were trained on trauma-informed care. Observations throughout the center during the annual compliance review confirmed the center has a soft room and numerous areas throughout the center painted in soft, soothing colors. The

center has a functioning garden on the property which includes fountains, flowers, and plants which are designed to help support youth who have experienced trauma. The center provides individual and group sessions with the youth in the center during their stay. An interview with the superintendent reflected the center's implementation of trauma-informed practices to address youth with a brighter, youth-friendly environment in the common areas, youth dorms and informed the center has a garden area and a quiet room which is utilized by the youth.

Standard 3: Mental Health and Substance Abuse Services

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

The center maintains a policy and procedures ensuring there is a single licensed mental health professional appointed as the designated mental health clinician authority (DMHCA) who is responsible for the coordination and implementation of mental health and substance abuse services. The policy was approved by the superintendent and the designated mental health clinician authority (DMHCA) on September 10, 2020. The Department maintains a contract with Camelot Community Care, Inc. to provide mental health and substance abuse services to all applicable youth in the center. Camelot Community Care provides a licensed mental health counselor to serve as the center's DMHCA and holds a clear and active license in the State of Florida, under Chapter 491, with an expiration date of March 31, 2021.

The DMHCA is full-time and scheduled to be on-site forty hours each week, Monday through Friday, from 8:30 a.m. to 4:30 p.m. A review of the Medical and Mental Health Logbook sign-in sheets confirmed the DMHCA was on-site as required. The DMHCA is available seven days a week, twenty-four hours a day, by way of telephone for consultation. A review of the Camelot Community Care job description found the DMHCA is responsible for oversight of all clinical and administrative operations ensuring clinical quality and integrity of the therapeutic program. An interview with the DMHCA indicated they are responsible for the overall direction, coordination, and evaluation of the mental health department and the two non-licensed master's-level therapists. The DMHCA assures the clinical quality and integrity of the therapeutic program as required by all applicable standards, regulations, and policies. The DMHCA identifies and analyzes problem areas in order to improve quality of care and oversees and monitors the implementation of therapeutic interventions being utilized in the center. The DMHCA updates the psychiatrist once a week on applicable youth receiving services to discuss behaviors, progress, and applicable medications. Reviewed documentation supported the DMHCA, non-licensed therapist, psychiatrist, registered nurse, and program administration meet weekly for mini-treatment team meetings. The center has a back-up DMHCA in the event of scheduled leave and/or absences. The back-up DMHCA is a licensed clinical social worker, licensed under Chapter 491 in the State of Florida, with an expiration date of March 31, 2021. Interview with the DMHCA indicated the back-up DMHCA served in this capacity for one week while the DMHCA was on scheduled leave during the annual compliance review period.

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

The center maintains a written policy and procedures ensuring services are provided by individuals with appropriate qualifications. The designated mental health clinician authority

(DMHCA) ensures the center's non-licensed master's-level therapists are working under direct supervision and providing services they are qualified based on education, training, and experience. The policy was approved by the superintendent and the designated mental health clinician authority (DMHCA) on September 10, 2020.

The center's contract with Camelot Community Care, Inc. provides for a full-time regional mental health director to provide detention center-specific technical assistance to each center, one full-time DMHCA, and a part-time psychiatrist. The psychiatrist is scheduled to provide services for approximately two hours each week. Since March 17, 2020, the psychiatrist has been providing weekly tele-psychiatry services. The center has a contract with an additional psychiatrist to serve as the back-up. The regional mental health director conducts weekly video-teleconference meetings with all of the detention center's DMHCAs and conducts an individual weekly call with the DMHCA to discuss youth receiving services. The regional mental health director is a licensed clinical social worker (LCSW), the DMHCA is a licensed mental health counselor, the back-up DMHCA is a licensed clinical social worker and reviewed licenses found each was clear and active in the State of Florida with an expiration date of March 31, 2021. The psychiatrist license was clear and active in the State of Florida with an expiration date of March 31, 2022 and the back-up psychiatrist license was clear and active with an expiration date of January 31, 2022.

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

The center maintains a written policy and procedures ensuring metal health and substance abuse services are provided by individuals with appropriate qualifications. The clinical supervisor ensures the clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience. The policy was approved by the superintendent and the designated mental health clinician authority (DMHCA) on September 10, 2020. The center is licensed through the Department of Children and Families under Chapter 397 to provide substance abuse outpatient services with an expiration date of April 1, 2021.

The center has two non-licensed bachelor's-level mental health and substance abuse clinical staff who work under the direct supervision of the licensed mental health counselor (LMHC). The LMHC serves as the center's designated mental health clinician authority (DMHCA). Both non-licensed clinicians hold master's-level degrees in applied addiction studies and counseling, respectively. One part-time non-licensed clinician is a registered mental health counselor intern in the State of Florida with an expiration date of July 11, 2025, and is scheduled to work Saturday and Sunday from 10:00 a.m. to 5:00 p.m. The full-time non-licensed clinician is a certified addiction professional (CAP) in the State of Florida with an expiration date of June 30, 2021 and is scheduled to work Monday through Friday from 7:00 a.m. to 3:00 p.m.

A review of training records supported each non-licensed therapist completed the twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. The training included five Assessments of Suicide Risk (ASR) or crisis assessments conducted on-site in the presence of the DMHCA. 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 abuse needs of youth are identified through a comprehensive screening process ensuring referrals are made when youth have identified mental health and/or substance abuse needs or are identified as a possible suicide risk. The superintendent has established procedures for a thorough review of preliminary screenings conducted by the Office of Probation and Community Intervention.	

The center maintains a written policy and procedures ensuring the mental health and substance abuse needs of youth are identified through a comprehensive screening process in which referrals are made when youth are identified with mental health and/or substance abuse needs or are identified as a possible suicide risk. The superintendent has established procedures for a thorough review of each youth's preliminary screening conducted by the juvenile probation officers and existing documentation of mental health or substance abuse problem needs or risk factors, administration of the Suicide Risk Screening Instrument (SRSI) upon the youth's admission, and referral to the center's mental health and substance abuse clinical staff. The policy was approved by the superintendent and the designated mental health clinician authority (DMHCA) on September 10, 2020.

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

Each of the five SRSIs were reviewed by a mental health clinical staff member and documented their recommendation. Each of the SRSIs had completed entries which included a summary and recommendations in the screening results section. Three of the five reviewed records documented a history of suicide risk and/or an override was documented due to the youth providing all negative responses and each applicable youth was placed on precautionary observation (PO) and a referral for an Assessment of Suicide Risk (ASR) was submitted. Each youth remained on PO until the ASR was completed by the center's clinical staff. The center's practice is to complete the Department's Mental Health and Substance Abuse Referral Summary form. The results of the ASR indicated each youth was placed on standard supervision. The center's staff completed the Department's Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) assessment for each youth upon their intake admission. An interview with the superintendent confirmed the intake officer completes the detention officer portion of the SRSI for each youth.

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

The center maintains a written policy and procedures establishing an intake and admission screening process ensuring youth identified through preliminary screenings in the juvenile assessment center (JAC) or upon admission to the center as having mental health and substance abuse issues or needs are referred for further in-depth mental health and/or substance abuse assessment. All youth identified by screening or by staff observations or behavior after admission are referred for further in-depth mental health and substance abuse evaluation. The center utilizes the Department's Mental Health and Substance Abuse Referral Summary form. Youth identified in the JAC as in need of further assessment are referred to a community provider for a comprehensive assessment. The policy was approved by the superintendent and the designated mental health clinician authority (DMHCA) on September 10, 2020.

The center maintains a contract with Camelot Community Care, Inc. to ensure youth identified during the preliminary screening process receive an in-depth mental health and/or substance abuse assessment shortly after intake. A review of five youth mental health and substance abuse records reflected none were applicable for referral for mental health and substance abuse services. A review of three additional youth mental health and substance supported each youth was screened, and a referral was made to Camelot Community Care for each to receive a comprehensive mental health and substance abuse evaluation based on the Massachusetts Youth Screening Instrument - Second Version (MAYSI-2) assessment and/or Suicide Risk Screening Instrument (SRSI). All three youth received a completed evaluation documented on the Substance Abuse and Mental Health Assessment (SAMH) form and completed within thirty days of the referral.

The assigned juvenile probation officer is responsible for ensuring pre-disposition comprehensive evaluations for detained youth are forwarded to the detention center in a timely manner. Reviewed documented practice did validate the clinical staff contacted the assigned juvenile probation officer by e-mail, requesting a status update on the comprehensive assessment completed by the community provider. A review of three comprehensive mental health and substance abuse evaluations completed by the community provider, PsyCare in Bradenton, Florida, indicated the new evaluations were completed by a licensed mental health counselor and a licensed clinical social worker, respectively, within thirty days of referral. Each evaluation was completed in full and contained all required information including the diagnostic impression, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, summary of findings, and recommendations.

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

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

Five youth mental health and substance abuse records were reviewed for mental health and substance abuse treatment services. Two of the five youth records were applicable for receiving treatment services during prior admissions. A review of one additional youth record validated all three applicable youth were assigned to a mini-treatment team and were referred for services utilizing the Department's Mental Health and Substance Abuse Referral Summary form. Each reviewed youth record was applicable for treatment with psychotropic medication management, individual therapy, supportive counseling, and family therapy sessions. An interview with the center's designated mental health clinician authority (DMHCA) indicated since the onset of the COVID-19 pandemic, the center has not been conducted groups; however, has increased individual therapy in its place.

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

Further review indicated one of the three youth were applicable for an individual treatment plan. Two additional applicable youth records were reviewed and all three documented the individualized treatment plan was developed within the required time frame. The practice is to utilize the Department's Individualized Mental Health/Substance Abuse Treatment Plan form. Reviewed documentation supported one of the three required one individual treatment plan review and it was conducted as required. The other two were not in the center long enough to require a review. Interview with the DMHCA indicated there were no applicable youth who was an alleged victim of a Prison Rape Elimination Act (PREA) event.

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

supported a copy was provided to the youth, parent/guardian, and assigned juvenile probation officer. Five youth were interviewed and two rated the mental health and substance abuse services provided as fair, one indicated as good, and one youth indicated they were not receiving mental health and/or substance abuse services while in the center.

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

The center maintains a written policy and procedures ensuring mental health and substance treatment planning focuses on providing mental health treatment and/or substance abuse treatment which will reduce or alleviate the youth's symptoms of mental disorder or substance abuse impairment and enable youth to function adequately in the juvenile justice setting. Each youth determined to need mental health treatment, including treatment with psychotropic medication or substance abuse treatment, must be assigned to a mini-treatment team. Youth may request to receive mental health and/or substance abuse treatment services. The policy was approved by the superintendent and the designated mental health clinician authority (DMHCA) on September 10, 2020.

Five youth mental health and substance abuse records were reviewed for mental health and substance abuse treatment services and none were applicable for receiving treatment services. A review of three additional youth records validated each applicable youth was assigned to a mini-treatment team and was referred for services utilizing the Department's Mental Health/Substance Abuse Referral Summary form. Each reviewed youth record was applicable for treatment with psychotropic medication management, individual therapy, supportive counseling, and family therapy sessions. Reviewed documentation confirmed each applicable youth requiring treatment was assigned to a mini-treatment team consisting of mental health, medical, education, direct-care staff, nursing, and administrative staff.

The contracted psychiatrist provides tele-psychiatry services on Tuesdays and discuss each youth receiving services with the clinical team. The DMHCA brings the discussed information to mini-treatment team for further discussion. The DMHCA maintained documentation of weekly treatment team meetings. Each applicable record had a valid Authority for Evaluation and Treatment (AET) form and proper consent for treatment and each signed the Department's Consent for Substance Abuse Treatment and Youth Consent for Release of Substance Abuse Treatment Records. Treatment notes were documented on the Department's Counseling/Therapy Progress Note form and in the Mental Health Chronological Notes. Treatment notes were documented on the Department's Counseling/Therapy Progress Note form and in the Mental Health Chronological Notes.

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

The center maintains a policy and procedures ensuring psychiatric services are provided to youth in need as indicated by symptoms of mental disorder or substance-related disorder, or youth who are being treated with psychotropic medication prior to or subsequent to admission. The policy was approved by the superintendent and the designated mental health clinician authority (DMHCA) on September 10, 2020. The center maintains a contract with Camelot Community Care, Inc. for the provisions of a licensed psychiatrist to provide psychiatric services for applicable youth in the center. Camelot Community Care provides a part-time psychiatrist who is contracted to provide services for two hours each week. The psychiatrist is an osteopathic physician with a clear and active license in the State of Florida, under Chapter 459, which expires on March 31, 2022. Camelot Community Care contracts with a medical doctor to serve as the back-up psychiatrist in the event the psychiatrist is on scheduled leave or out sick. The back-up psychiatrist has a clear and active license in the State of Florida, under Chapter 458, with an expiration date of January 31, 2022. The center does not utilize a psychiatric advanced practice registered nurse (APRN).

Reviewed documentation and the Medical and Mental Health Sign-In Logbook validated the psychiatrist is providing weekly services, as required, through tele-psychiatry. Due to the COVID-19 pandemic, the center began utilizing tele-psychiatry on March 17, 2020 and continues as of the annual compliance review. The center utilizes the Department's Mental Health/Substance Abuse Referral Summary form to request a psychiatric evaluation. The psychiatrist signs and dates the referral form. Psychiatric services include an initial diagnostic psychiatric interview, psychiatric evaluations, psychiatric follow-up assessments and consultations, coordination of services, crisis interventions, treatment planning, communication, and emergency procedures.

A review of five mental health and substance abuse records indicated two youth were applicable for receiving psychiatric services. One additional applicable youth record was reviewed. Each applicable record contained a current Authority for Evaluation and Treatment (AET) form. All three youth were admitted with prescribed psychotropic medications and each youth received an in-depth psychiatric evaluation which included all required elements. Each evaluation was documented on the Department's Clinical Psychotropic Progress Note (CPPN) and completed within fourteen days of the youth's admission. All reviewed mental health and substance abuse documentation was completed utilizing the Department's required forms. None of three youth required the monitoring of Tardive Dyskinesia.

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

The center maintains a written policy and procedures ensuring youth with elevated risk of suicide are safely screening, referred, monitored, and protected in the least restrictive means possible. The policy was approved by the superintendent and the designated mental health

clinician authority (DMHCA) on September 10, 2020. The plan outlines the center's procedures addressing the use of suicide precautions, suicide prevention training, and the process by which any youth identified as having suicide risk factors at any time must be placed on suicide precautions and receive an Assessment of Suicide Risk (ASR). The plan includes the identification and assessment of youth at risk of suicide utilizing the Department's ASR and Follow-Up ASR. The plan identifies the levels of supervision, referral process, communication, notification, and documentation requirements. In the event of a life-threatening suicide attempt, staff are to call 9-1-1 immediately. Decisions to use extra precautions are determined on a case-by-case basis based upon the individualized risk factors and needs of each youth. Clinical staff assist in training detention officers throughout the fiscal year on suicide prevention, including verbal and behavioral cues indicating a suicide risk. The plan outlined emergency contact telephone numbers to include the superintendent, on-call administrator, DMHCA, Lee County Sheriff's Office, designated health authority, licensed mental health professional, psychiatrist, emergency room, crisis stabilization unit, and Poison Control. The plan is located in the superintendent's office, medical clinic, DMHCA's office, and is accessible to all staff on the center's network drive and SharePoint.

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

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

The center maintains four suicide response kits. Observations found the kits located in B-1 sub-control, B-2 sub-control, master control, and in the medical clinic. A review of five youth mental health and substance abuse records validated each youth is screened upon admission for suicide risk factors. Each youth is screened utilizing the Department's Suicide Risk Screening Instrument (SRSI) and Massachusetts Youth Screening Instrument – Second Version (MAYSI-2). When further assessment is indicated by the SRSI or MAYSI-2 suicide ideation subscale, as well as any information obtained during the admission process which may suggest the youth is

a possible suicide risk, the youth is placed on suicide precautions and constant supervision until the ASR is completed by the licensed mental health clinician or trained master's-level clinician. Reviewed documentation found each youth was identified with an elevated risk of suicide identified during the admission screening process.

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

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

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

Five interviewed staff indicated in the event a youth expressed suicidal thoughts, staff indicated they would notify the mental health authority, place the youth on sight and sound supervision, and document the supervision. Five interviewed staff indicated the suicide response kit is located in sub-control and staff indicated there are kits located in the medical clinic and in master control. Five interview youth found three youth indicated they had been placed on suicide watch while in the center and all three youth indicated staff watched them the entire time.

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

The center maintains a written policy and procedures outlining staff supervision of youth placed on suicide precautions, one-to-one supervision, or when constant supervision must be maintained, including documenting the youth's behavior on the Department's Suicide Precautions Observation Log. The policy was approved by the superintendent and the designated mental health clinician authority (DMHCA) on September 10, 2020. Five reviewed youth mental health records found each youth was placed on precautionary observation (PO); however, the mental health clinical staff conducted the Assessment of Suicide Risk (ASR) immediately and subsequently placed the youth on Standard Supervision. Therefore, no Suicide Precaution Observation Logs were required.

A review of three additional applicable youth records found a Suicide Precautions Observation Log was maintained for the duration each youth was on PO and each was reviewed and signed daily by the shift supervisor, as well as the mental health clinician. Reviewed documentation reflected staff observations did not exceed the required intervals and were documented in real time. Safe housing areas were clearly documented on each log. The licensed mental health clinical staff member conferred with the superintendent prior to revising the supervision level, which was recorded on the ASR in the date/time sections. The center had one youth detained and placed on PO at the time of the annual compliance review. The interviewed youth indicated when on suicide precautions, staff watched them the entire time. Interviews with five staff indicated they received training in suicide prevention. A review of the two incidents of the youth returning to the center from a Baker Act determined the youth PO logs and subsequent Secure Observation Logs were completed as required.

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

The center maintains a written suicide prevention plan outlining the training requirements for all staff who work with youth. The plan was approved by the superintendent and the designated mental health clinician authority (DMHCA) on September 10, 2020. Camelot Community Care's designated mental health clinician authority (DMHCA) assists in training juvenile justice detention officers throughout the fiscal year on suicide prevention, including verbal and behavioral cues indicating a suicide risk. The plan outlines all staff who work with youth must receive six hours of annual training on suicide prevention and implementation of suicide precautions. Suicide prevention trainings are completed and documented in the Department's Learning Management System (SkillPro). The plan reflects all staff with direct contact with youth, on a day-to-day basis, must participate in at least one quarterly mock suicide drill semi-annually. The mock drills are designed to practice responses to a suicide attempt or incident of serious self-injury.

A review of five staff training records validated each staff completed at least two hours of suicide prevention training in SkillPro and four hours of instructor-led suicide prevention training. Reviewed documentation of mock suicide drills completed, since the last annual compliance review, reflected the center completed drills on Alpha, Bravo, and Charlie shifts at least

quarterly with some shifts conducting more often. Reviewed documentation supported the center had thirty-three applicable staff requiring participation in a mock suicide drill semi-annually; however, reviewed documentation supported there were seven staff who did not meet this requirement. Most staff participated on multiple drills. Staff who are not present during a drill have the opportunity to review each drill scenario, procedures, and critique in an effort to understand the process and receive the necessary training to respond to an incident of a suicide attempt or incident of serious self-inflicted injury. The provision of life saving measures such as cardiopulmonary resuscitation (CPR) was demonstrated at least one time on each shift and the use of a suicide response kit was documented for almost all reviewed suicide drills.

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

The center maintains a written mental health Crisis Intervention Plan ensuring the center will respond to youth in crisis in the least restrictive means possible to protect the safety of the youth and others while maintaining control and safety of the center. The plan was approved by the superintendent and the designated mental health clinician authority (DMHCA) on September 10, 2020. The plan details crisis intervention procedures including a notification and alert system, means of referral including youth self-referral, communication, supervision, documentation, and review. The center's procedures outline conducting a crisis assessment to evaluate a youth presenting with acute emotional or psychological distress which is extreme and does not respond to ordinary interventions conducted by a mental health clinician to determine the severity of the youth's distressing symptoms, level of risk to self or others, and recommendations for treatment and follow-up care. The Crisis Intervention Plan is placed in the superintendent's office, medical clinic, DMHCA's office, and on the center's network drive and SharePoint.

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

The center maintains a written Emergency Care Plan outlining mental health and substance abuse emergency procedures and ensuring youth who are believed to be an imminent danger to themselves or others because of mental illness or substance abuse impairment receive emergency mental health or substance abuse services. The plan was approved by the superintendent and the designated mental health clinician authority (DMHCA) on September 10, 2020. The center's plan reflects the superintendent, assistant superintendent, and DMHCA are to review all critical incidents and discuss the circumstances surrounding the incident, center procedures relevant to the incident, and recommendations. The center's plan includes procedures for immediate staff response, notifications, communication, supervision,

authorization to transport for emergency mental health or substance abuse services (Baker Act or Marchman Act), documentation, and training. The center utilizes Salus Care / Vista Center in Fort Myers, Florida for Baker Act crisis stabilization and Marchman Act emergency substance abuse assessment and treatment. A review of five staff training records supported each was trained on the center's emergency care plan. A copy of the approved plan is maintained in master control, both sub-controls, and in the supervisor's office.

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

The center maintains a written policy and procedures ensuring the center responds to youth in the least restrictive means possible to protect the safety of the youth and others while maintaining control and safety of the center. The plan was approved by the superintendent and the designated mental health clinician authority (DMHCA) on September 10, 2020. An interview was conducted with the DMHCA and the superintendent confirmed the center had one applicable youth requiring a Crisis Assessment in the last twelve months. Reviewed documentation reflected all phases of the center's Facility Operating Procedures (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. The youth was placed on Close Supervision due to having lost three family members in one month. The Crisis Assessment was completed by the licensed mental health counselor (LMHC) and was reviewed by the center's superintendent four days later.

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)	Satisfactory Compliance
The designated health authority (DHA) is clinically responsible for the medical care of all youth at the center.	

The center maintains a written policy and procedures ensuring there is a contract agreement with a licensed physician. The center maintains a contract with Camelot Community Care, Inc. who subcontracts with an osteopathic physician (DO) who holds an unrestricted license which expires on March 31, 2022 and meets all requirements for independent and unsupervised practice in the State of Florida. The DO has specialty training in family medicine. The DO serves as the center's designated health authority (DHA) and is clinically responsible for the medical care of all youth. A review of the contract with Camelot Community Care, Inc., indicates the DHA shall provide two hours on-site each week conducting periodic evaluations, Comprehensive Physical Assessments, sick call referrals, and administrative duties. Interview with the DHA supported this practice. The DHA is on-site on Fridays from approximately 9:00 a.m. to 11:00 a.m. and is available twenty-four hours a day, seven days a week, for consultation.

In addition, the center utilizes an advanced practice registered nurse (APRN) who is on-site ten to fifteen hours each week. The APRN signed the Collaborative Practice Protocol agreement on October 6, 2020 and the DHA signed on October 2, 2020. On-site nursing coverage is provided seven days a week from 7:00 a.m. to 7:00 p.m. Reviewed attendance logs found the DHA and the APRN were on-site weekly as required. The DHA is responsible for communication with center staff regarding youth medical needs and participates in weekly DHA meetings with the center's administration. Reviewed attendance logs supported nursing staff participated in the meetings. Interview with the DHA indicated Camelot Community Care, Inc. provides for back-up coverage when the DHA is on scheduled leave; however, the DHA attendance logs for the past six months did not indicate a need.

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

The center maintains Facility Operating Procedures (FOP) for all utilized health-related procedures and protocols. Reviewed documentation reflected the designated health authority (DHA) reviewed, signed, and dated the FOP on July 1, 2020 and the nursing protocol, and non-healthcare protocols on August 28, 2020. The center's contracted psychiatrist documented a review with signature and date for applicable FOPs. Camelot Community Care, Inc. has an established comprehensive clinical orientation for all newly employed healthcare staff which includes the Department's healthcare policies and procedures. Training records supported all newly employed healthcare staff received the clinical orientation conducted by a registered nurse (RN). Reviewed documentation validated the RN, DHA, and superintendent documented their review of the center's healthcare FOPs and protocols on a cover page on August 28, 2020, and the remaining clinical staff documented their reviews on August 30, 2020 and August 31, 2020.

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

The center maintains a written policy and procedures ensuring parent(s)/guardian(s) are afforded the right to give or withhold consent with regard to the healthcare provided to the youth. A review of five youth Individual Healthcare Records (IHCR) found four were applicable for requiring a signed Authority for Evaluation and Treatment (AET) and each reviewed IHCR contained the signed AET. One youth was eighteen years of age and did not required a signed AET. The center had no applicable youth who required a Limited Consent for Evaluation and Treatment. Each of the four youth IHCRs contained a copy of the signed AET which clearly documented "Copy" on the form. Each AET was obtained prior to providing medical services.

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

The center maintains a written policy and procedures outlining requirements for parental notification and written consent from the parent/guardian. The center notifies the parent/guardian of significant changes in the youth's condition and to obtain consent when new medications and treatments are prescribed. A review of five youth Individual Healthcare Records (IHCR) found one had significant changes to existing medications and/or changes in chronic conditions or was taking over-the-counter (OTC) medication not covered by the Authority for Evaluation and Treatment (AET); therefore, two additional records were requested and reviewed. None of the reviewed IHCRs required vaccinations/immunizations. Interview with nursing staff indicated there were no Religious Exemption from Immunization forms submitted since the last annual compliance review.

The center reported having two youth applicable to off-site emergency care and each record supported nursing staff notified the parent(s)/guardian(s) by telephone and, subsequently, in writing. Three reviewed records were applicable for new OTC medication and the chronological notes and the Parental Notification of Health-Related Care form documented the parent/guardian was notified as required. Written parental notices were sent regardless of telephone notifications. One youth was admitted on prescribed psychotropic medications and the medications continued; therefore, parental notification was not required.

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

The center maintains a written policy and procedures ensuring at the time of admission, each youth will receive a healthcare admission screening utilizing the Department's Medical and Mental Health Admission Screening form. A review of five youth Individual Healthcare Records (IHCR) found each contained a Medical and Mental Health Admission Screening form completed on the date of admission by a juvenile justice detention officer and each indicated the

screening was reviewed by a licensed practical nurse (LPN) within twenty-four hours. Each screening form was completed in the Department's Juvenile Justice Information System (JJIS) Admission Wizard. Interview with nursing staff validated this practice. None of the reviewed records were applicable for a change in physical custody since the youth's admission date. The center reported having no youth applicable for a change in physical custody during this annual review period. In addition, the center had one youth applicable for a qualitative urine pregnancy screening test and the test results were filed in the laboratory section of the IHCR. An interview with the center's superintendent reported all healthcare admission screenings are conducted by the doctor or nursing staff.

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

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

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

The center maintains a written policy and procedures ensuring the designated health authority (DHA) is notified when youth admitted required emergency care or routine notification in accordance with Department requirements. A review of five youth Individual Healthcare Records (IHCR) supported the DHA was notified within twelve hours of admission of any youth with a chronic medical condition, psychotropic medication, or medical concern. Notification was documented on the nursing admission chronological notes for each of the five reviewed records. Three of the five youth were applicable to be documented on the Chronic Conditions Log of DHA Notification and placed in the Physicians Referral Log for follow-up. In each instance, the youth was placed in the Chronic Conditions Log of DHA Notification and placed in the Physicians Referral Log for follow-up, and the DHA was notified within twelve hours or less of admission. One youth was admitted on prescribed psychotropic medications and the DHA was notified as required. Interview with the nursing staff indicated the DHA is notified by any nurse within twenty-four hours or less of the youth being admitted either through a telephone call or e-mail.

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

The center maintains a written policy and procedures detailing the process for conducting or reviewing admission history. The center utilizes and completes the standard Department Health-Related History (HRH) form for all youth admitted into the center's physical custody. A review of five youth Individual Healthcare Records (IHCR) found four contained an HRH form completed electronically by a licensed nurse within seven days or less of the youth's admission to the center. Each HRH was reviewed by the designated health authority (DHA) or advanced practice registered nurse (APRN) and was maintained in the youth IHCR. The HRH was completed before or at the same time as the Comprehensive Physical Assessment (CPA) for each youth and reflected the most current admission. One youth was a newly admitted and seven days had not passed at the time of the annual compliance review.

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

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

A review of five youth Individual Healthcare Records (IHCR) validated one youth had a current CPA on file at admission and four youth required the completion of a new CPA. Reviewed documentation supported the one current CPA documented a review by the designated health authority (DHA) and/or advanced practice registered nurse (APRN). The four reviewed CPAs indicated each was completed by the DHA. Each CPA was completed in full to include the medical grade, Tanner Stage, body mass index, visual acuity field, and most recent TST. There were no applicable refusals of the examination; therefore, no signed refusal forms were required. Reviewed practice reflected when the CPA was completed, the Department's Problem List was also updated. There were no applicable youth with any symptoms of active TB in the center at the time of the annual compliance review. The center's internal alert system coincides with the Department's Juvenile Justice Information System and each applicable alert was updated, as required.

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

The center maintains a written policy and procedures ensuring all youth are evaluated and treated, if necessary, for sexually transmitted infections (STI). All sexually active youth will be clinically screened and evaluated for an STI. After the screening, youth will be referred to the designated health authority (DHA) or advanced practice registered nurse (APRN) to determine if further testing is indicated. A review of five youth Individual Healthcare Records (IHCR) indicated four were screened for STI and each required further evaluation. One youth was newly admitted to the center and seven days had not passed at the time of the annual compliance review.

Interview with nursing staff indicated orders are obtained from the DHA for STI testing and a urine sample is collected to be sent to LabCorp for testing. The center maintains a written policy and procedures ensuring each youth is provided the opportunity to receive counseling, testing, and treatment for human immunodeficiency virus (HIV). All five reviewed youth records supported each youth was offered testing and one consented and four did not consent as documented on the Department's Human Immunodeficiency Virus Antibody Test Youth Consent form.

Two additional records were reviewed, and documentation supported each of the two additional youth consented to HIV testing. The center's registered nurse is a certified counselor and provides pre-test and post-test counseling. The nursing staff swabs the youth's mouth and sends to LabCorp. If the results are positive, a blood sample is tested, and the results are given to the Lee County Health Department. The HIV test results are placed in a sealed envelope marked "Confidential" and filed in the youth's IHCR. Five interviewed youth reported being able to request a HIV test if they wanted one.

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

The center maintains a written policy and procedures ensuring all youth will be able to make sick call requests and have their complaints treated through the sick call system. The sick call process responds to a youth's compliant of illness or injury of a non-emergent nature, but which requires a professional nursing assessment and possibly, a nursing intervention. The center provides sick call seven days a week, two times daily from 9:00 a.m. to 10:00 a.m. and from 4:00 p.m. to 5:00 p.m. daily.

A review of five youth Individual Healthcare Records (IHCR) indicated two youth a submitted sick call request; therefore, one additional applicable record was reviewed. Sick calls are documented by direct-care staff electronically and communicated to medical staff. Each youth was seen by the licensed practical nurse (LPN) for the sick call within twenty-four. Two of the three sick calls were reviewed on the same day by the registered nurse (RN) and one was reviewed by the advanced registered practical nurse (ARPN). None of the sick calls required treatment or referral off-site. There were no instances in which a youth presented a similar sick

call compliant three or more times in a two-week period or of a youth complaining of any severe pain with which staff were unfamiliar.

The center maintains treatment protocols appropriate to the level of the provider conducting sick call approved by the designated health authority (DHA) on July 23, 2019. According to an interview with the DHA, they will conduct sick calls while at the center, if necessary. All three applicable sick call events were documented on the Sick Call Index and Sick Call Referral Log. Sick Call forms documented the nature of the complaint, assessment, and plan to include subjective, objective, assessment, and plan format (SOAP). An interview with the RN indicated when there is not a licensed nurse on-site, the juvenile justice detention officer supervisor (JJDOS) will review the sick calls to determine the need for intervention. The JJDOS is trained to contact the DHA. There were no sick call requests submitted during the annual compliance review week; therefore, no sick calls to observe.

Five interviewed staff indicated sick call is conducted by nursing staff. Five interviewed youth found two indicated they can be seen immediately should they submit a sick call request, and two indicated within one day. One youth reported never having to submit a sick call request. Each of the applicable four youth reported sick call is conducted by either the nurse or the doctor and each stated the sick call process was either very good, good, or fair.

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

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

A review of five youth Individual Healthcare Records (IHCR) found two youth received episodic care conducted by nursing staff with one of the two youth having two separate incidents. Both applicable IHCRs documented problem-oriented elements which were used to capture pertinent information pertaining to the nature of the youth's ailment including identification of the subjective, objective, assessment, and plan (SOAP) to address the complaint for each incident. The center had no applicable episodic care events conducted by non-healthcare staff.

The center maintains eighteen first aid kits which are located in master control, four of the classrooms, the kitchen, the girl's module, the boys' module, the intake area, the maintenance shed, and eight are used for the center's vans utilized for transportation. A review of three first aid kits found each contained the required items identified on the designated health authority (DHA) inventory list. The center's medical records clerk conducts monthly reviews of the first aid kits and items are replenished upon use and/or expiration date. The medical clerk seals and dates the first aid kits after replenishment and review. The center has two automated external defibrillators (AED) located in the medical clinic and in master control. The AED procedures were located in the AED box as well as audio instructions. Nursing staff checks the AED batteries and pads weekly to ensure the AED is operational and document their review on a tracking sheet. The AED was self-tested in front of the annual compliance review team to ensure it was operational. The batteries in both AEDs expire in March 2024 and the pads expire

in March 2021. Both AEDs each contained the original batteries and pads. A review of five staff training records found each was trained in cardiopulmonary resuscitation (CPR), first aid, and AED and each held current certifications.

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

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

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

The center maintains a written policy and procedures to provide for timely referrals and coordination of medical services to ensure youth have timely access to off-site care services. A review of five youth Individual Healthcare Records (IHCRs) found two were applicable for off-site medical care; there for one additional applicable record was reviewed. Each youth was taken off-site for emergency care. The designated health authority (DHA) was notified for each emergency event. Each youth's IHCR contained a Summary of Off-site Care form, discharge documentation, and instructions. The DHA documented a review of the off-site care findings, instructions, and information. One youth required an additional referral for follow-up testing or appointment and documentation validated the referral was entered on the Sick Call/Referral Log for tracking and the follow-up was conducted as recommended.

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

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

conditions warranting periodic evaluations and follow-up care. A review of five youth Individual Healthcare Records (IHCRs) found three were applicable for the existence of chronic conditions. Reviewed documentation reflected each applicable youth was classified with a medical grade between two and five. One youth was classified with a body mass index (BMI) greater than thirty and each youth was undergoing treatment for a physical health condition.

None of the youth were applicable for taking anti-tuberculosis medication or were pregnant. Treatment orders were written so they are clearly distinguishable for clinical staff. There were no indications of lapses in care and none of the three youth were applicable for a periodic evaluation as they were each in the center for less than thirty-days. All three youth were placed on the chronic conditions roster. In addition, reviewed records reflected each Department Problem List was updated as required.

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

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

A review of five youth Individual Healthcare Records (IHCRs) identified three youth were taking prescribed medication upon admission and were applicable for medication management. Each applicable IHCR documented verification of prescription medication by the nurse. In each applicable record, the licensed nurse obtained an order from the designated health authority (DHA) to resume the applicable medication and all orders were signed by the practitioner. There was one applicable over-the-counter (OTC) medications not listed on the Authority for Evaluation and Treatment (AET) form administered and proper consent was obtained. The center maintains a contract with Diamond Pharmacy Services for procurement of medications and a Modified Class II Type B Pharmacy Permit with an expiration date of February 28, 2021. The center utilized Publix Pharmacy as a back-up. All medication is delivered to the center in blister packs.

The center utilizes the standard Department Medication Administration Record (MAR) for each youth receiving either prescription medications on a routine basis or OTC medications. Reviewed documentation reflected the staff initialed each administered medication entry and the four applicable youth documented their initials on the MAR. When the youth refused the medication administration, the refusal was clearly documented on the MAR and the Department's Refusal of Treatment form was completed. The center maintains a written policy and procedures to ensure the usage of the MAR by licensed healthcare staff and non-licensed staff. Each reviewed MAR clearly documented the youth's name, Department of Juvenile Justice Identification Number, date of birth, youth allergies, precautions, medical grade, medical alerts, and current picture of the youth. The MAR clearly indicated medication start and stop

dates and nursing staff documented weekly side-effect monitoring. There were no lapses or errors noted. No youth required parenteral medication.

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

A review of two applicable JJDOS training records found each received training on the MAR. The center did not have any standing orders for psychotropic medications, no pro-re-nata (PRN) orders for psychotropic medications, or emergency treatment orders for psychotropic medications. Three of the five reviewed youth records found the youth were admitted on prescribed medications of which one was prescribed psychotropic medications. The DHA and the designated mental health clinician authority (DMHCA) were notified of each admission. The psychiatrist was notified when the medication was received to obtain an order for continuation. Reviewed documentation supported the applicable youth received an initial diagnostic psychiatric interview conducted less than the required fourteen days of admission. Youth receiving psychotropic medications are reviewed weekly each time the psychiatrist is on-site.

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

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

The center maintains a written policy and procedures ensuring medications and any medical equipment classified as sharps will be secured and inventoried. The dose-by-dose daily administration and documentation of a medication is documented utilizing a perpetual inventory process for the daily distribution of non-controlled prescription medication and over-the-counter

(OTC) medication. Documentation of each individual dosage of medication administered to youth is maintained on the Medication Administration Record (MAR) to demonstrate the distribution of medications. Any medical equipment classified as sharps is secured and inventoried utilizing a routine perpetual inventory descending count as each sharp is utilized and disposed.

A review of the medical clinic found the clinic is secured under lock and key. Medical staff and trained juvenile justice detention officer supervisors (JJDOS) non-healthcare staff have access to the clinic. The JJDOS non-healthcare staff are trained by the registered nurse to assist youth with self-administration of OTC medication. A locked medication cart is located in the medical clinic and stores oral prescription and OTC medications prescribed for youth. Medication in the cart is separated by each youth. A second locked medication box is in the medication cart which stores controlled medication.

The center maintains an inventory of all sharps and medical equipment classified as sharps to include syringes, butterflies, scissors, needles, and suture removal kits. Items designated as sharps are stored in a designated locked cabinet in the medical clinic and are inaccessible to youth. A review of the perpetual inventory for the past six months found sharps inventory counts to be accurate. A review of three sharps found the counts were accurate. A review of three prescription medications and three OTC medications found the counts were accurate. A review of the running daily inventory of all prescription and OTC medications matched the count. The center had no controlled medications on-site during the annual compliance review.

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

The center maintains a written policy ensuring proper procedures are followed to prevent the spread of infectious diseases or illnesses and provide staff with the knowledge of appropriate prevention, containment, treatment, and reporting requirements of infectious diseases. The center maintains a separate Exposure Control Plan/Infection Control Plan approved by the designated health authority on October 16, 2020. A review of five youth Individual Healthcare Records reflected each youth received infection control training within twenty-four hours of admission. The infection control training included hand-washing techniques, universal/standard precautions, prevention/transmission of communicable diseases, vaccinations, and the Centers for Disease Control and Prevention (CDC) guidelines for infection control.

Reviewed documentation supported the Exposure Control Plan/Infection Control Plan was written in accordance with Occupational Safety and Health Administration (OSHA) guidelines to include risk assessment and methods of compliance. The plan addressed common childhood infectious diseases, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, tuberculosis, Hepatitis A, B and C, human immunodeficiency virus (HIV), bloodborne pathogens, other outbreaks and epidemics, and outbreaks of pediculosis. In addition, the plan included Methicillin Resistant Staphylococcus Aureus (MRSA) and other antibiotic-resistant micro-organisms, food-borne illnesses, bioterrorism agents, chemical exposures in the

workplace, and protocols for needlestick post-exposure intervention and treatment. The center ensures Hepatitis B immunization is made available for staff and staff have access to protective equipment. The local county health department, CDC, and the Department's Central Communications Center were notified of all incidents related to the COVID-19 pandemic. A review of five staff training records supported each staff received pre-service and in-service training on the center's Exposure Control Plan/Infection Control Plan.

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

The center has a written policy and procedures for the care of pregnant youth to include procedures for medical issues, nutrition, education, and medication. An interview with the nursing staff indicated the center had one pregnant youth since the last annual compliance review. Reviewed healthcare education information supported the pregnant youth received pre-natal education to include alcohol and drug use, smoking, nutrition, sexually transmitted infections, contraception, prenatal care, birthing process, postpartum care, basic baby care, child/infant development, and parenting skills. While at the center, nursing staff monitored the youth for weight and nutritional status. A review of five staff training records verified each staff received Girls Health training specific to working with pregnant youth. Staff training was provided by the registered nurse (RN) at the time of hire and annually, thereafter.

Standard 5: Safety and Security

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

The center maintains a written policy and procedures ensuring youth are actively supervised by staff. Two-way radios are used to communicate amongst the officers. The center utilizes a roster generated in the Department's Juvenile Justice Information System (JJIS) Daily Statistical Sheet to track the daily census of the youth. Daily observations of youth were conducted and observed which confirmed the active supervision of youth by juvenile detention officers (JDO). Staff were observed supervising youth during transport, school, lunch, line movement, and in the modules. Each observation indicated staff were positioned in a manner providing them full view of youth in the area, were aware of the number of youth being supervised, were in sight and sound of youth, and requested permission from master control prior to any youth movement. Observations indicated there were no inappropriate interactions between youth and staff, but rather a consistent positive interaction amongst staff and youth.

A review of the master control logbooks for the past six months prior to the annual compliance review validated youth headcounts have been completed consistently on the beginning and end of each shift, and prior to each youth movement. Five staff were interviewed, and all confirmed they believe there is enough staff at the center to provide for the safety and security of the youth and staff. Each interviewed staff reported youth counts are completed at the beginning of each shift, the end of each shift, before/after school, and before/after meals. Five staff were interviewed regarding steps taken to reconcile incorrect counts. Each interviewed staff reported a recount is completed immediately if counts are off and all movement ceases. Staff reported master control is notified in addition to a recount, if a count is off.

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

The center maintains a written policy and procedures ensuring there is a uniform behavior management system (BMS) offering a predictable set of rewards, privileges and consequences for behavior. The center has a system of rewards, privileges, and consequences to motivate youth to meet the center's expectations. Observations conducted during the annual compliance review week revealed the center has the BMS system posted in both living modules. The postings specify appropriate behaviors and rewards for such behavior, and inappropriate behavior and consequences for such behavior. Youth are informed of the BMS during the admission process through an orientation. The BMS is a three-level system. Each youth enter at level two when admitted, and their level moves up or down, depending on their behavior in the center. There are incentives for youth obtaining level three status, such as access to video games, special parties, additional phone calls, and extra snacks. The incentives can be changed or updated based on the center's needs. The center has an incentive calendar outlining the daily incentives for the month. A review of the level sheets and logbooks confirmed the center's practice.

Five youth were interviewed regarding the BMS. Four youth stated the BMS is very good. One youth stated the BMS is fair. Four youth reported the consequences they received in the center were fair. One youth reports they have never received a consequence during their admission into the center. Five staff members were interviewed regarding the BMS. All five interviewed staff members reported they feel the BMS is effective. Five staff stated they speak to the youth to discuss the consequences being imposed and alternative acceptable behavior. Each interviewed staff stated the youth are provided an opportunity to explain their behavior. Five staff reported points can be taken away as a consequence. Five staff members stated the juvenile justice detention officer supervisor (JJDOS) provides feedback to the staff regarding their implementation of the BMS as needed.

5.03 Unauthorized Use of Punishment (Critical)	Satisfactory Compliance

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

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

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

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

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

5.04 Ten-Minute Checks (Critical)	Satisfactory Compliance

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

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

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

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

The center maintains a written policy and procedures ensuring ten-minute checks are conducted when youth are in their rooms for sleeping or other reasons. The center has a total of forty-five operable cameras with a recording capacity of thirty days. The center utilizes Guard One Plus which is an electronic system to document ten-minute checks. Staff utilize the electronic Guard One Plus System. The juvenile justice detention officer (JJDO), when

conducting checks, take the wand and tap the wand on the check point sensor located on the outside of each youth's room door. Each day, data from the wand is downloaded to ensure no data is lost. The JJDO pauses at the door and looks into the room to observe the youth behind the closed door and this is conducted prior to tapping the sensor indicating the check was completed. This practice ensures there are no incidents associated with the youth in their rooms. The superintendent was interviewed and confirmed this practice. Observations of youth living modules and rooms during the annual compliance review validated there were no obstructions over windows and areas where direct line of sight is needed. Observations of the ten-minute checks by video observation was conducted on both modules, on all three shifts amounting to six days and times along with corresponding ten-minute log indicated checks were being conducted every ten-minutes, or less, and in real time. Five staff were interviewed, and each staff confirmed room checks are completed every ten-minutes; however, the center's practice is for room checks to be conducted every eight minutes.

5.05 Census, Counts, and Tracking	**Satisfactory Compliance**
Officers must know the exact number and location of all youth under their supervision at all times. Census counts of youth shall be taken, called into Master Control, and documented, at a minimum: • *At the beginning and end of each shift.* • *Following any emergency to include power outages, evacuation due to emergency drills, and any code called outside the secure walls. In the event a code is called in any location outside the main walls of a facility, it is critical all youth counts are reconciled prior to the movement of any group of youth.* • *Prior to and following routine group movement.* • *Any time a population change occurs.* • *Randomly, at least once on each shift.* *Staff should not include youth in the count who are not physically present with the staff person at the time of the count (e.g., court, clinic, confinement).*	

The center maintains a written policy and procedures ensuring headcounts are conducted as required. Staff must always know the exact number and location of all youth under their supervision. Census counts are taken, called into master control, and documented in the center's Master Control logbook. Living module counts are recorded in their assigned living module logbook. No youth movement is conducted until master control confirms the counts, reconciles the count, and authorizes movement. A review of the master control logbook book for the past six months validated headcounts are documented at the beginning and end of each shift, following any emergency, inclusive of any mock or emergency drills, prior to youth movements, whenever a population change occurs, and randomly at least once on each shift. Five staff were interviewed regarding when the center conducts youth counts. Five staff reported emergency counts are conducted after a major disturbance, when a youth is believed to be missing, when visibility is hindered, and during mock drills.

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

The center maintains a policy and procedures ensuring logbook reviews are conducted as outlined in policy. The superintendent, or designee, reviews the logbook on a weekly basis and will document any issues or negative findings in the logbook. A review of the last six months logbooks indicated this practice was completed as outlined in policy. The master control and modular logbooks were reviewed for the past six months and indicated the juvenile detention officer supervisor (JJDOS) from each shift did in fact review the logbook in master control before they accepted the shift and each JJDOS on each shift reviewed the modular logbooks as well.

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

The center maintains a written policy and procedures ensuring logbooks are maintained at master control and in each living area in accordance with Florida Administrative Code. There are separate logbooks in master control and for each living module, as well as one for visitors, and one for contracted staff. There are logbooks maintained in order to document emergencies and emergency drills. Observations of each logbook found they were bound together with numbered pages. A review of the last six months logbooks for each module and master control verified all entries were legible and written in ink, with no erasures or whiteout areas. Each logbook entry included the date and time of the event or incident, name of the staff and youth involved, brief description of the incident, as well as a.m. and p.m. denotations. All entries for the last six months indicated safety and security issues of the center, including medical, special needs, and mental health alerts were highlighted. Reviewed logbooks reflected all errors are struck through with a single line and dated and initialed by the person correcting the error. The master control logbooks reviewed included emergency situations, incidents, group movements,

admissions and releases, fire and escape drills, population counts at the beginning and end of each shift, the presence of law enforcement, juvenile probation officer, and name of youth placed in confinement, including the time confinement began and the time confinement ended, name of youth placed on precautionary/secure observation, including the time precautionary/secure observation began and the time precautionary/secure observation was discontinued.

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

The center maintains a written policy and procedures for key control. The policy ensures the key inventory and the control of all keys, including broken or lost keys are accounted for. The inventory includes each of the center's keys are color coded, on a tamper resistant ring, and includes the number of keys on the ring. Center keys, including restricted keys, are held in master control in a locked key box. The master control operator, juvenile justice detention supervisors (JJDOS), assistant superintendent, and the superintendent have access to the locked box. Emergency keys such as keys allowing egress through exterior doors are stored in master control and the sub controls located on each living modular staff are able to access. All keys are inventoried and maintained in the Facility Maintenance System (FMS).

The center maintains an active master key log inventory which allocates for all key rings by their number, the number of keys, what each key is capable of opening and the staff assigned to particular key. All personal keys of the on-duty staff are placed in a lock box which is located in the main lobby prior to them entering the secured area. The JJDOS keys are retrieved from master control and the JJDO's keys are distributed at briefings by JJDOS where a form is used to document the name and initials of the person assigned to the key, the shift, the time the key was provided and the time when the key was returned. The JJDOS's return their keys to master control and the officers return their keys to the supervisors and sign the form indicating their keys were returned. A review of the center's keys was conducted and indicated the inventory report matched the keys in use. Observations conducted indicate keys were on the person at all times, and youth did not have access to facility keys.

There were no reported lost keys during the annual compliance review. Staff training records indicated all staff were trained in key control. If a juvenile justice detention officer accidently takes keys home, there is a two-hour window in which they must return the keys. There was no indication of a staff taking their keys home during this review period. Visitor keys are stored in the visitor lockers or in master control in the non-secure area of the building. Five staff were

interviewed all stated the restricted keys do not provide access to medical or mental health records. Five staff reported they knew the key control process and were able to explain the process for missing and/or broken keys as outlined in the policy.

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

The center has a written policy and procedures ensuring vehicles to transport youth are properly maintained, have an annual inspection and are in good repair. The maintenance mechanic conducts weekly and monthly inspections. The center has a total of seven vehicles which are used to transport youth. During the annual compliance review, one vehicle, which was a new vehicle, was not operable at the time of the review as all safety and security equipment was not present in the vehicle. A physical inspection of each vehicle was conducted and all vehicles, minus the new vehicle, had all required equipment including seat belts, wire cutter, window punch, up to date fire extinguisher, seat belt cutter and first aid kit with current and approved items.

Each vehicle had a binder which included a vehicle mileage log, mechanical restraint key, gas card, vehicle policy and the vehicle registration. Each vehicle is inspected prior to transports utilizing the Department's approved check list. Each of the vehicles have a visual inspection conducted as well as maintenance sheets to inspect the levels for water coolant, lights, oils, emergency equipment, horn, cleanliness of the vehicle and the condition of the interior/exterior. Monthly inspections are conducted which includes inspection of the tires, battery, windows, windshield wipers, mirrors and other possible damage which is all documented on the Department's approved check list.

A visual observation was conducted during the annual compliance review confirmed the staff conducted pre-transport inspections to search for contraband, gasoline levels, and the security screen which was intact. All youth were searched prior to the transport, and all youth were securely fastened into their seatbelt. Staff were observed wearing seatbelts. The staff conducting the transport had a cell phone. The vehicle logbook, the transportation procedures and the binder which had the vehicle log as outlined in policy.

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

The center maintains a written policy and procedures ensuring all tools and equipment are properly maintained, stored, and inventoried. The center's maintenance tools are secured in a locked building, outside of the main building in a portable building, but within the secure fenced perimeter. Tools are maintained on a shadow board and marked with an identification number. A perpetual tool inventory list of tools and maintained by the center to document what tools are being used by the maintenance staff including the times the tools were checked-out, the location of the tools, and times the tools were returned.

An interview was conducted with the maintenance mechanic who reported inventory is conducted monthly by himself and reviewed by the superintendent and/or designee. The center's kitchen tools, inclusive of knives and scissors, are securely stored in a locked storage box with an inventory sheet, located in the food service manager's office. A perpetual inventory of kitchen tools is maintained, and counts are documented three times each day. If there is a need to replace or dispose of any kitchen or maintenance tool, a tool disposal/replacement report is completed which the maintenance or food service manager signs and gives to the superintendent for approval. When tools are lost or there is a suspicion a youth may be in possession of a tool, the juvenile justice detention officer supervisor (JJDOS) is notified immediately, and a thorough search is initiated.

A review of the monthly inventory sheets confirmed there were no missing maintenance or kitchen tools. An interview with the superintendent confirmed there have been no missing tools in the past six months. Five staff were interviewed regarding the center's practice for damaged or missing tools. Five staff reported a work order is completed for damaged or missing tools. Five staff reported administration and JJDOS are notified. Five staff reported there have been no missing tools.

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

The center maintains a written policy and procedures ensuring youth do not have access to any tools, including kitchen or medical equipment. The center only allows youth to use cleaning items such as mops, brooms, buckets, and other common household items for general cleaning. When cleaning and youth are involved, they are under close supervision ensuring no non-permitted items are used by the youth. Observation during the annual compliance review supported this practice. Five staff were interviewed and five indicated youth can use mops and brooms and are not permitted to use any tools. Five youth were interviewed, and five youth indicated they can use mops and brooms. One youth stated they do not use any tools.

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

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

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

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

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

The center maintains a written policy and procedures ensuring the proper inventory of flammable, toxic, caustic, and poisonous items. All flammable, toxic, caustic, and poisonous items are maintained in a locked, secure storage area outside of the main building which is clearly labeled and has limited access. The Safety Data Sheets (SDS) logbooks are located at the location in which the chemicals are stored. All items are inventoried weekly by the maintenance mechanic and securely stored when not in use. Each item observed had an SDS on record for each item stored. Observation of the secure storage area and the inventory list indicated all items matched the inventory list and are stored in the locked storage area within the secure area.

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

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

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

The center maintains a written policy and procedures ensuring limited access to flammable, toxic, caustic, and poisonous items. The center's policy does not permit any youth from accessing any materials which are flammable, toxic, caustic, and/or poisonous. The center maintains a list of authorized staff who are allowed access to the chemical storage. All toxic items are stored in a locked, portable, storage building within the secured fenced in area. Observations conducted during the annual compliance review found there were no toxic materials stored in any place accessible to youth.

An interview with the superintendent confirmed flammable, toxic, and caustic materials are securely stored in the storage unit within the secure perimeter and are only accessible to administrators and maintenance staff. Five staff were interviewed. All five staff confirmed youth are not allowed to use substances which are toxic, flammable, or poisonous. Five youth were

interviewed, and each reported they are not allowed to use any type of cleaning agents such as bleach, laundry soap, window, or toilet bowl cleaner.

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

The center maintains a written policy and procedures ensuring the proper disposal of toxic, caustic, and poisonous items. The center has a safety plan in place to address any chemic spills or leaks. Outside of the kitchen is an outdoor container specifically stores grease for which a contract is maintained with A-1 Gator for disposal. The plan addresses the proper procedures to follow in the event of a chemical leak, or spill. The maintenance mechanic confirmed materials are disposed of by evaporation, compaction or taken to Lee County's Topaz Solid Waste Annex. The detention center superintendent stated there have been no chemical spills or leaks within the annual compliance review period. If a chemical spill occurs, procedures indicate a staff will notify master control of the location of the spill, a juvenile justice detention officer supervisor and/or master control shall direct the shutdown of all air handlers, ventilation system, and close all windows and doors. The center contacts the necessary emergency contacts. Medical staff are responsible for the disposal of all biohazardous waste. The center's superintendent confirmed there have been no chemical spills or leaks since the last annual compliance review.

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

The center maintains a written policy and procedures ensuring confinements under twenty-four hours are used as an immediate, short term response strategy when a youth exhibits sudden or unforeseen behaviors threatens the physical safety of him/herself or others. The center has four designated confinement rooms. If a youth's behavior escalates, a youth will be placed in one of designated confinement rooms. Observations during the annual compliance review indicated the confinement rooms were free from obstruction and each room was free of non-fixed items. Youth who are in confinement have no contact with the general population; however, are afforded living conditions approximating those available to the general population. The center documents confinements under twenty-four hours in the Facility Management System (FMS).

A review of seven confinement reports documented rooms were searched prior to youth being placed in confinement. Each report indicated visual observations were conducted in accordance with policy and procedures. All seven reports were not completed by the juvenile justice detention officer (JJDO) within one hour of the incident. A review of seven confinement reports found documentation which confirmed the juvenile justice detention office supervisor (JJDOS) reviewed the report and indicated the reason for confinement. All seven reviewed confinements did not have a three-hour review completed by the JJDOS. All seven confinement reports had the superintendent or designee review completed within the required time frame. Each superintendent or designee review completed had documentation to support the need for continued confinement based on the severity of rule infraction, past disciplinary history, or behavior confinement. Each reviewed confinement report showed documentation of the report

being communicated to school personnel. Five staff were interviewed regarding confinements, and each staff reported they must search the confinement room prior to placing a youth in confinement. Five staff indicated a confinement report must be completed prior to the end of their shift. Five staff indicated ten-minute checks must be completed, but for the first hour five-minute checks are conducted.

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

The center maintains a written policy and procedures ensuring confinement over twenty-four hours are approved by the superintendent or designee as well as the regional director or designee. An interview with the superintendent was conducted who confirmed confinements are reviewed after two hours, and every three hours thereafter. The superintendent reviews any request to exceed twenty-four hours of confinement and follows the confinement review process. The chair of the review is the regional director or designee. The review must be held within two hours prior to the end of the twenty-four-hour period. A copy of the confinement report is provided to the chair. The center's superintendent and a member of the mental health team must meet with the youth prior to the review to discuss possible continued confinement. A decision then is made by the chair. All confinements are tracked in the Facility Management System (FMS). Additionally, regional detention management reviews the use of confinements through FMS reporting, video surveillance review, and logbook reviews as needed. The center had no confinements over twenty-four hours during the annual compliance review period.

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

The center maintains a written policy and procedures ensuring the management of various emergencies and disaster events. The center's Continuity of Operations Plan (COOP) was approved by the regional director on May 21, 2020. Documentation confirmed there was one COOP drill conducted, as required. A hurricane drill was conducted in May 2020 which was prior to the June 1, 2020 the start of hurricane season. There was documentation to support there was a written scenario and a drill form, critique forms, and e-mails used to document the drills. There was an e-mail trail of the drill sent to all facilities and regional staff with updates and possible evacuations. Drills are reviewed during staff meetings and shift briefings. An informal interview with the superintendent reflected the center conducts various safety, emergency, and medical drills monthly. All drills are documented on drill forms and in the logbook. Additionally, staff signs a roster acknowledging they have participated in the drill.

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

The center has a written policy and procedures ensuring the center is prepared to address youth escapes. The center requires escape drills to be conducted at least once a quarter. A review of the center's last six months of logbooks and drills confirmed the center completed quarterly escape drills over the previous twelve months; and documented the drills in the master control logbook. Drills are reviewed during staff meetings and shift briefings. All drills are documented on drill forms and in the logbook. Additionally, staff signs a roster acknowledging they have participated in the drill. A review of five staff training records showed all five staff completed the annual escape prevention training.

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

The center has a written policy and procedures ensuring fire prevention and safety of the center. The center has a contract with Cintas Fire Protection who conducts annual inspections of the fire detectors, fire alarms, and sprinkler systems. The center's disaster plan, fire prevention plan, and evacuation plan were reviewed and approved by the local fire marshal on September 21, 2020. A review of the emergency drills and logbook documentation for the past six months validated the center conducts fire drills every month, on each shift, during different times. Staff sign a roster acknowledging they have participated in the fire drills as well. Drills are reviewed during staff meetings and shift briefings. Five staff were interviewed, and each staff confirmed they have participated in fire drills monthly. Five youth were interviewed, and each reported they have been instructed on what to do in the case of a fire. A review of five staff training records showed all five staff received the annual fire prevention training.