STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Saint Lucie Regional Juvenile Detention Center

Department of Juvenile Justice

(State-Operated)
1301 Bell Avenue
Fort Pierce , Florida 34982

Review Date(s): December 8-11, 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:

Yvrose Sylvain, Office of Accountability and Program Support, Lead Reviewer (Standard 1, 5, and Interviews)
Nicos Antonakos, Office of Accountability and Program Support, Regional Monitor (Standard 2 and 5)
Patrick Morse, Office of Program Accountability, Regional Monitor Supervisor (Standard 3 & 4)
Welton Sanders, Palm Beach Regional Juvenile Detention Center, Assistant Superintendent (Standard 5)

Program Name: Saint Lucie Regional Juvenile Detention Center
Provider Name: State Operated
Location: Fort Pierce County / Circuit 19
Review Date(s): December 8-11, 2020

MQI Program Code: 225
Contract Number: N/A
Number of Beds: 50
Lead Reviewer Code: 125

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

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

Limited Ratings	Failed Ratings
5.19 Fire Drills	

Standard 1: Management Accountability
Detention Rating Profile

Indicator Ratings

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

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

Standard 2: Youth Management
Detention Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Detention Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Detention Rating Profile

Indicator Ratings

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

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Program Overview

St. Lucie Regional Juvenile Detention Center is a state-owned detention facility, operated by the Department, located in Fort Pierce, Florida. The center serves youth in St. Lucie, Martin, Indian River, and Okeechobee Counties in Circuit 19. The St. Lucie Juvenile Assessment Center (JAC) is connected to the center. 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 St. Lucie County School District. The center's management team includes the superintendent, one assistant superintendent, two administrative assistants, eight juvenile justice detention officer (JJDO) supervisors, and thirty-eight JJDOs. The center maintains a contract with Camelot Community Care, Inc. to provide comprehensive mental health, substance abuse services, and psychiatric services. Mental health services are provided by one licensed designated mental health clinician authority (DMHCA) and two non-licensed staff. Clinical services provided in the center include mental health and substance abuse evaluations, mental health treatment planning, individual, group, and family therapy, mental health crisis intervention services, on-site psychiatric services, and availability for substance abuse services for youth with co-occurring disorders. Medical services are provided by one designated health authority (DHA), one advanced practice registered nurse (APRN), one full-time and one part-time registered nurse (RN), one full-time licensed practical nurses (LPN), and two part-time LPNs.

The medical clinic maintains nursing coverage seven days a week. The clinical director is scheduled to work Monday through Friday from 7:00 a.m. to 3:30 p.m. The part-time RN is scheduled to work on Saturdays from 8:00 a.m. to 4:30 p.m. and is also scheduled pro re nata (PRN). One LPN is scheduled to work Monday through Friday from 11:45 a.m. to 7:45 p.m. and the one part-time LPN is scheduled to work on Sunday from 8:00 a.m. to 4:30 p.m. The remaining LPN is scheduled PRN. Staff are responsible for the custody and control of youth in their care, providing youth supervision twenty-four hours a day, seven days a week.

The center has three living modules which are divided by male and female. There are sixty-four security cameras at the center of which sixty-two were operational during the annual compliance review week. Two cameras were reported inoperable due to maintenance repair of the area. 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. A tour of the center was conducted by the annual compliance review team and observations found there was no graffiti. Common areas were observed to be hygienic, organized, and well preserved. At the time of the annual compliance review, the center had no vacancies.

Strengths and Innovative Approaches

- The center holds bi-weekly and monthly incentive celebrations for youth with a Behavior Management System (BMS) level of three and a half or higher where youth enjoy extra snacks and entertainment. Celebrations included a monthly meal incentive whereby the youth will be able to eat their meal with the superintendent.

- The center has a greeting cards program where the youth send cards to the local nursing homes and veteran's hospital monthly.

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 has a written policy and procedures requiring compliance with the Department's background screening requirements. A review of initial background screenings for twenty-seven newly hired employees and six contracted staff found the center received background screening from the Department's Background Screening Unit (BSU)/Clearinghouse prior to each staff's hire date and contractor start date. Documentation revealed the program added all staff to the program's roster in the Clearinghouse. None of the staff were applicable for background screening exemption. The center utilizes an ergometric pre-employment assessment tool for all direct-care applicants. Documentation indicated each applicant received a passing score and a copy of the pre-employment assessment was maintained within the staff record. The Annual Affidavit of Compliance with Level 2 Screening Standards was submitted to the Department's BSU on January 7, 2020, meeting the annual requirement. The Annual Affidavit of Compliance with Level 2 Screening Standards for School Board Teachers was submitted to the BSU on January 30, 2020. There were no volunteers who required an initial background screening since the last annual compliance review.

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

The center maintains a written policy and procedures to ensure all employees, contracted providers, and volunteers with access to youth undergo a criminal history background check every five years. The center had seven staff applicable for a five-year rescreening. Each staff's re-screening was completed and submitted to the Department's Background Screening Unit (BSU)/Clearinghouse within the required time frame. There were no volunteers or contracted staff applicable for five-year re-screening.

1.03 Staff Code of Conduct	Satisfactory Compliance

Center staff adheres to a code of conduct prohibiting any form of abuse, profanity, threats, harassment, intimidation, "horseplay," or personal relationships with youth.

Officers shall maintain the confidentiality afforded to all youth and shall not release any information to the general public or the news media about any youth in the center or who has been in the custody of the Department.

Officers shall not verbally abuse, demean or otherwise humiliate any youth, and shall not use profanity in the performance of their job.

Officers shall not engage in or allow horseplay, either verbal or physical, with and/or between any youth.

Officers shall not engage in personal relationships nor discuss personal information related to themselves or other officers with any youth.

Management takes immediate action to investigate or address all allegations or violations of the code of conduct.

The center has a written policy and procedures addressing the staff code of conduct. A review of seven staff personnel records documented staff signed a code of conduct prohibiting any form of abuse, profanity, threats, harassment, or intimidation. The code of conduct also addressed officer professionalism, poor performance, negligence, insubordination, conduct unbecoming a public employee, and misconduct. Reviewed documentation supported management took immediate corrective action to address the staff code of conduct when staff violated policies and procedures. In three reviewed instances with three different staff; two staff received written reprimand and one staff was retrained and received a verbal reprimand. Seven youth were interviewed and each reported feeling safe at the center. Seven youth reported staff are respectful when talking with youth. Two youth reported once hearing staff use profanity when speaking to a youth, two reported occasionally, and three reported never. All seven youth reported never hearing any staff threaten any youth at the center. Seven staff were interviewed and each was able to explain the process for allowing youth to call the Florida Abuse Hotline and/or Central Communications Center (CCC). Three staff reported once hearing staff use profanity when speaking to a youth, two reported occasionally, and two reported never. None of the staff reported observing a co-worker using threats, intimidation, or humiliation when interacting with a youth. All seven staff rated the working conditions at the center from fair to very good.

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 regarding response to incidents in accordance with Florida Administrative Code. The program had thirty-three reportable incidents since the last annual compliance review. A review of seven incidents found all were reported to the Department's Central Communications Center (CCC) within two hours of the incident or when staff became aware of the incident, as required. The seven incidents were documented in

the center's master control logbook. A review of the center's internal incident/grievance reports found there were no incidents which should have been reported to the CCC. The program has experienced a decrease in the number of regular reportable incidents to the Department's CCC compared to the last annual compliance review period. Seven youth were interviewed regarding access to reporting abuse. Three youth reported they have never been stopped from reporting abuse since being at the center and four youth stated they never had to report abuse. Seven staff were interviewed and each were able to explain the process of allowing a youth to call the Florida Abuse Hotline and/or the CCC.

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

The center maintains a written policy and procedures to ensure all detention staff use physical intervention techniques in accordance with Florida Administrative Code. The center had a total of seventy-six Protective Action Response (PAR) incidents reports in the past six months prior to the annual compliance review date. A review of seven PAR reports found all involved staff completed appropriate statements prior to the end of their shift. Each PAR report was reviewed and processed within seventy-two hours by all required parties. Each PAR report documented a Post-PAR interview was conducted with the youth by the center's administrator within thirty minutes after the incident. A review of internal incident/grievance reports and logbooks indicated there were no additional PAR incidents which did not have a report. The center has experienced an increase in the number of PAR reports compared to the last annual compliance review period. An informal interview with the center's superintendent reported the center had an increase due to several committed youth awaiting placement from programs closure. The program's PAR rate during the annual compliance review period was 13.00, which is below the statewide Detention PAR rate of 16.56. Seven interviewed staff reported the center's staff try to talk with youth prior to using PAR. An interview with the center's superintendent reported PAR incidents and mechanical restraints are monitored and tracked through the Facility Management System (FMS). The center's superintendent reported when PAR events occur, the staff must generate the report on the same day. Also, each PAR report must be reviewed by the center's superintendent or designee within seventy-two hours of the incident.

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

The center maintains a written policy and procedures regarding a pre-service training plan for all new staff. The pre-service training is divided into two phases. The first phase consists of instructor-led and web-based courses. The second phase consists of 120 hours of academy instructor-led training. Seven staff training records were reviewed for pre-service certification training. All seven reviewed training records documented each staff completed the certification process within 180-days of hire. The staff completed the required trainings related to Protective Action Response (PAR), first aid, cardiopulmonary resuscitation (CPR), and automated external defibrillator (AED) within ninety days of hire. All completed trainings were documented in the

Department's Learning Management System (SkillPro) within thirty days of training completion and were delivered by qualified trainers.

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

The center maintains a written policy and procedures regarding in-service training for all staff. The center had a current training calendar, which is updated as necessary. Seven staff training records were reviewed for in-service training. All reviewed staff training records documented each staff exceeded the twenty-four hours annual training requirements. All seven staff had up-to-date certifications in Protective Action Response (PAR), first aid, automated external defibrillator (AED), and cardiopulmonary resuscitation (CPR). All seven staff had professionalism and ethics and suicide prevention training. Three applicable staff were reviewed for eight hours of management/supervisory training and each completed the training as required except for one staff. The staff completed five and a half hours of supervisory training instead of the required eight hours. All trainings were documented in the Department's Learning Management System (SkillPro) within thirty days of training completion. An interview with the center's superintendent reported all staff completed their in-service training requirement based on the Department's training plan.

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 to ensure each youth has the right to grieve and to make certain all youth are treated fairly, respectfully, without discrimination, and their rights are protected. The grievance process includes an informal phase, formal phase, and an appeal phase. The informal phase is completed by detention staff, whereby the youth and staff attempt to resolve the youth's complaint. If the staff is unable to resolve the issue, an electronic grievance will be submitted to the juvenile justice detention officer supervisor (JJDOS) beginning the formal grievance process. The electronic grievance requires a response from the JJDOS by the end of the shift if possible, or within twenty-four hours. Next, the appeal phase requires a response from the superintendent and/or designee. The superintendent will have seventy-two hours upon receipt to take action deemed necessary to resolve the issue. Grievance forms were easily available to the youth in each living module. The center had five grievances filed by the youth since the last annual compliance review and each were entered in the Facility Maintenance System (FMS). Four of the five youth grievances were addressed

within twenty-four hours and were resolved. One youth grievance was addressed three days late. All five grievances forms were signed by the youth and the administration staff. An interview with the center's superintendent indicated the staff are aware of the grievance process and the three phases of the procedures. The center's superintendent also reported youth handwritten grievances are scanned in FMS system and hard copies are retained for one year. Seven youth were interviewed and each reported never filing a grievance. Seven staff were interviewed and each were able to explain the center's grievance process.

1.09 Entering Alerts (JJIS) and Sharing of Alert Information (Critical)	Satisfactory Compliance
Superintendents shall ensure critical and special alerts are reviewed and responded to appropriately. *Upon completion of the Admission Wizard, the officer shall ensure all critical and special alerts are listed in JJIS.* *The JJIS alert report shall be reviewed daily by supervisors and administrators to ensure it correctly reflects the status of youth.* *If the electronic system is inoperable, for any reason, the juvenile justice detention officer supervisor (JJDOS) shall ensure the last hard copy of the alerts shall have a written notification or update of the recent admissions or changes to existing alerts on the alert sheet and distribute to all staff within the center immediately.* *Medical and mental health staff shall review alerts to ensure each alert is correctly tracked and managed.* *The responses and updates by medical, mental health, and other staff should be documented in JJIS alerts as they pertain to the specific alert.* *JJDOS 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 enters an alert into the Department's Juvenile Justice Information System (JJIS) for youth who require an alert which may not have been previously identified prior to the youth's admission. The alerts entered into JJIS are verified by medical staff, juvenile justice detention supervisors, or the mental health staff as applicable. Seven youth records were reviewed for case management, medical, mental health, and substance abuse alerts. Each reviewed youth records was determined all alerts were accurately entered into JJIS. The JJIS alerts are printed daily by the on-duty supervisor, copies are provided to all staff during their shift, and all staff have access to the alert system. Reviewed documentation indicated alerts were discussed during shift briefing and an observation of a shift briefing meeting supported the youth alerts information were consistently discussed with the juvenile justice detention officers at the meeting. All applicable alerts were downgraded and removed by the medical staff and/or the mental health staff. Alerts were also documented in a small board in the supervisor's office. The alert board in the supervisor's office has the youth who have been identified for critical alerts, arranged by youth dorm, and the alert associated with the youth. Seven staff were interviewed. Each staff reported being informed of youth alerts through the shift debriefing, logbooks, JJIS alert forms, small alert board in the supervisor office, and email. All staff reported management

informed staff about issues within the center through email, shift debriefing meetings, logbooks, and staff meetings.

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 to ensure all youth are admitted to the detention center in accordance with the Florida Administrative Code. The St. Lucie Juvenile Assessment Center (JAC) and the detention center are co-located in the same building. Seven youth case management records were reviewed. Each reviewed record included an arrest affidavit/custody order, a Detention Risk Assessment Instrument (DRAI), and Suicide Risk Screening Instrument (SRSI). All seven youth records included documentation to confirm the youth were frisked and searched by a juvenile justice detention officer (JJDO) the same sex as the youth. All youth received medical, mental health, and substance abuse screenings upon admission. Each youth record reflected the youth were offered telephone calls and staff documented if a youth refused to make the call. All seven records documented a meal was provided to each youth upon intake. An observation of three youth intakes were observed during the annual compliance review. One youth was admitted to the detention center and two youth were processed at the JAC. Each youth was frisked search and electronic searched by a same sex officer. The nurse completed a Covid-19 pre-screen and took the temperature of the youth. The youth admitted to the center was able to call the parent/guardians twice. All processed youth were administrated the DRAI and SRSI. The two youth processed at the JAC were given a brown bag meal and the youth staying at the center was provided a hot meal. The interviewed detention review specialist was knowledgeable and able to explain the entire admission process in accordance to the center's policy.

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

The center maintains a written policy and procedures to advise youth of center rules and regulations, expectations for behavior and related consequences for failing to meet those expectations, and youth rights within twenty-four hours of a youth being admitted into the center. A review of seven youth case management records found each contained an orientation acknowledgment form signed by the youth confirming orientation took place within twenty-four hours of the youth's admission into the center. Each reviewed record revealed all youth were advised both verbally and in writing of the orientation process. Each youth signed the orientation packet acknowledging they received the packet. Each packet included information regarding rules and regulations, youth rights, visitation policies, telephone call policies, grievance procedures, access to medical treatment, mental health and substance abuse services, access to the Florida Abuse Hotline, the Department's Central Communications Center (CCC), and behavior related consequences/rewards. During an informal interview, the detention review specialist indicated all youth watch a Prison Rape Elimination Act (PREA) video upon admission. Seven youth were interviewed and each reported receiving information about the center's rules and regulations, daily schedule, education services, visitation, abuse reporting, and behavior management system (BMS) when admitted. An admission with orientation was observed during the annual compliance review. The staff explained the rules and regulations, expectations for behavior, youth rights, and policies to the youth. In addition, the youth watched the PREA video.

2.03 Classification	Satisfactory Compliance

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

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

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

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

The center has a written policy and procedures regarding classification and orientation to ensure each youth is protected from harm, violence, and/or victimization. The policy takes into consideration the youth's gender, age, weight, level of aggression, special medical or mental health needs, criminal behavior, history of violent behavior, gang affiliation, history of sexual offenses, and security and escape risk. Seven youth records were reviewed and each included the required classification elements. All youth were assessed using the Vulnerability to Victimization Sexually Aggressive Behavior (VSAB) form, Secure Detention Admission Wizard, juvenile offense history, active alerts, and the Suicide Risk Screening Instrument (SRSI). Each reviewed youth record documented appropriate classification alerts were entered into the Department's Juvenile Justice Information System (JJIS).

A review of seven youth case management records verified the youth's classification was considered when assigning a room. In a formal interview, the superintendent stated all factors are taken into consideration when assigning youth to a room and supervisors make room assignments. Due to the COVID-19 pandemic, all youth are assigned single rooms. The center also has a screening process for youth newly admitted into the center to determine if the youth is a gang member or gang affiliated. The center's practice is to enter all suspected gang affiliation alerts into JJIS and notify the youth's juvenile probation officer (JPO). Seven youth case management records were reviewed and five youth were identified as suspected gang members. All five applicable youth had gang alerts entered into JJIS.

2.04 Notification of Juvenile Probation Officer Circuit Gang Representative	Satisfactory Compliance

Each center shall identify the juvenile probation officer (JPO) designated as the circuit gang representative to communicate suspected gang activity.

A referral for youth with suspected gang involvement shall be shared, by e-mail, with the circuit gang representative, indicating suspicions of gang activity such as youth flashing gang signs, gang tattoos, gang-related drawings, or related activity.

Center staff should include in the e-mail pictures (when appropriate), copies of written statements, drawings, graffiti, and a description of what gang signs the youth was "flashing."

The center has a screening process for youth newly admitted into the center to determine if the youth is a gang member or gang affiliated. The center's gang representative is responsible for notifying the circuit's juvenile probation officer (JPO), St. Lucie County Sheriff's Office, and superintendent regarding any indication of gang activity by e-mail. The center's assistant superintendent and one shift supervisor serve as the gang representatives who review identified youth for suspected gang involvement. The identified staff also collaborates with the Circuit 19 gang liaison. Gang alerts are discussed weekly at the center's detention review meetings with the JPO supervisors, detention staff, school board representatives, and social service agencies. An observation of a detention review meeting verified this practice. The center's gang representatives enter all suspected gang affiliation alerts into the Department's Juvenile Justice Information System (JJIS). All staff are made aware of the alerts during daily shift briefings. A review of seven youth case management records found four were applicable for suspected gang affiliation and required a notification to the assigned JPO and local law enforcement agency. Three of the four reviewed records contained an e-mail notification to the St. Lucie County Sheriff's Office and the assigned JPO. A notification to law enforcement and the JPO was not sent for one youth with a suspected gang affiliation until the week of the annual compliance review.

2.05 Admission of Youth Personal Property	Satisfactory Compliance

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

The center maintains a written policy and procedures to ensure a youth's personal property is maintained securely and returned to the youth in a timely manner upon their release. The youth's property is itemized and documented on the personal property receipt form in the Department's Juvenile Justice Information System (JJIS). Each of the seven reviewed youth case management records contained a property receipt. Each receipt documented the youth and staff names and signatures, letter of acknowledgement of unclaimed property form, and a property receipt for the youth's personal property. The center places personal property such as clothing and footwear in a brown bag in a secured locker. Two of the seven reviewed youth records documented valuable property. All valuable property is placed in a clear tamper-proof bag, logged into the logbook with date, time, name of the youth, Department identification number (DJJID), name of the juvenile justice detention officer (JJDO) securing the property, and the officer's initials. The center's practice is to place the clear bag into a drop safe, which is under video surveillance twenty-four hours a day. None of the reviewed youth refused to sign the property receipt forms.

An observation, during the annual compliance review, of an intake was conducted and verified the center safely stored the youth's personal and valuable property according to the policy. Seven interviewed youth verified staff checked their personal property upon intake and had the youth sign a form stating the personal property was correct. During an interview, the superintendent stated upon a youth's admission to the center all youth valuables are inventoried and secured by staff. The valuables are placed in a tamper-proof property bag, both youth and staff signatures are required. The youth's DJJID number, name, date, and inventory is documented on the property bag. The property is documented in the logbook and dropped in a secured safe inside master control.

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

The center maintains a written policy and procedures to ensure a youth's personal property is maintained securely and returned to the youth in a timely manner upon their release. The center safeguards each youth's personal property until returned to the youth and/or parent/guardian. Observations of the center's storage area, during the annual compliance review week, found non-valuable property such as clothing and shoes placed in a brown bag, stapled shut, and secured in a locked room under video surveillance. Each youth's personal property had a signed receipt form. Observations revealed valuable property is placed in clear tamper-proof plastic bags, signed by youth and staff, dated, and logged by the master control operator. The valuable property is then dropped in the initial drop safe located inside master control under video surveillance. A copy of the property receipt is placed in the youth's record. The center administrators then remove the property and place the property in a storage safe located in the file/property room in a secured locker which is under video surveillance. The items remain in the secured locker until the youth is released or the property is released to parent/guardian. A review of the Department's Central Communications Center (CCC) reports for the past six months did not document any reported incidents regarding youth property. An observation of a youth admission into the center validated the center's property storage practice. An interview with the superintendent verified the youth's property is safeguarded until the youth is released. The property is secured with limited access to shift supervisors and administrative staff. Property is stored in master control and the property room, which are both under video surveillance.

2.07 Release	Satisfactory Compliance

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

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

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

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

The releasing officer shall verify the identification of the youth.

The center maintains a written policy and procedures to ensure all releases from the center occur promptly and accurately. Seven youth case management records were reviewed and one was applicable for release procedures; therefore, three closed records were reviewed. All three closed records documented the on-duty supervisor reviewed all release paperwork prior to the youth's release. All three youth were released to a parent/guardian. A copy of the parent/guardian's driver's license and/or identification card was placed in the record, the youth and the parent/guardian were notified in writing of the youth's next court date. The parent/guardian signed the property receipt report acknowledging receipt of the youth's property. The date of admission and the date of termination were documented in the youth's record and the Department's Juvenile Justice Information System (JJIS). An observation of a youth's release process was conducted during the annual compliance review week. Detention staff and the supervisor identified the correct youth, and detention and court orders were reviewed by the supervisor. The nurse verified the youth was released with the prescribed medication which was given to the youth's parent/guardian. The parent/guardian's driver's license was copied and placed inside the youth's record and all parties signed the required release forms. An electronic ankle monitor was placed on the youth and both the parent/guardian and youth were explained the rules of intensive home detention. The personal and valuable property were released to the youth's parent/guardian and the youth was released back to their parent/guardian in their original clothing. The Department's Release Wizard was completed and the release information was updated in JJIS. The Department's Central Communications Center (CCC) reports were reviewed for the past six months and there were no negligent releases at the center since the last annual compliance review.

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 maintains a written policy and procedures to ensure a youth's personal property is maintained securely and returned to the youth in a timely manner upon their release. The policy outlines each youth and their parent/guardian are required to sign the property receipt,

acknowledging receipt of youth's personal property. Seven youth case management records were reviewed and one was applicable for release of valuable property; therefore, an additional two closed records were reviewed. All three closed records documented the youth and parent/guardian signed the property receipt acknowledging receipt of each youth's personal property. An interview with the superintendent was conducted. The superintendent advised the center ensures the youth's property is returned safely with verification and the youth and parent/guardian signs a receipt form. All unclaimed property is disposed of after thirty days. The center donates all unclaimed property to Safe Space which is a local charitable organization. This practice is explained to each youth through the signed property letter of acknowledgement which is given to each youth upon admission. Examples of property disposal forms, logs, and receipts were observed during the annual compliance review. An observation of a release process was conducted during the annual compliance review which confirmed the center's practice.

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

The center maintains a written policy and procedures regarding release of youth with prescription medications. Seven youth case management records were reviewed and one was applicable for release from the center with prescription medications. An additional three closed youth case management records were reviewed. All four reviewed records verified each youth was released to a parent/guardian which was verified with a copy of their driver's license and/or identification card. Each record contained a receipt of medication, the type of medication, strength, dosage, quantity, and any pending medical appointments. Documentation verified the parent/guardian signed the receipt of medications. An observation of a release, during the annual compliance review, confirmed the parent/guardian was given the youth's medication and signed the receipt of medication form. Staff provided medical instructions to the youth and parent/guardian upon release from the center.

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 to ensure proper management of youth and the sharing of information. During the annual compliance review, an observation of a detention review meeting was conducted. All parties were present from all required departments. The detention review specialist chairs the meetings. Staff in attendance included mental health staff, medical staff, education staff, commitment manager, juvenile probation officer supervisor (JPOS), chief juvenile probation officer (CPO), assistant superintendent, and the superintendent. The center reviews all securely detained youth, alerts, Interstate Compact for Juveniles (ICJ) youth, and Prolific Juvenile Offender (PJO) youth. In addition, waiting lists which include youth waiting for placement in a commitment program and youth currently in adult jail are discussed. During the detention review, staff discussed all medical and mental health updates. Reviewed documentation for the past six months of detention review meetings confirmed the center's practice. An interview with the center's superintendent verified the detention review specialist leads the meetings and staff present include the superintendent or designee, JPO supervisors,

chief of probation, commitment manager, medical staff, mental health staff, education staff, and Department of Children and Families (DCF) staff.

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 to address the daily activity schedule. Youth are provided the opportunity to participate in constructive activities benefiting the youth and the center. The center's superintendent develops a daily activity schedule, which is posted in each living area and outlines the days and times for each youth activity. Youth wake up at 6:30 a.m. every day and bedtime begins at 8:00 p.m., depending on the youth's level on the behavior management system (BMS). Observations during the annual compliance review week, revealed schedules are posted throughout the center and in each living module. Posted schedules include recreation, education, visitation, hygiene, times for meals, groups, and open program time. Visitation times are scheduled twice a week on Saturdays and Sundays between the hours of 9:00 a.m. to 3:00 p.m. Youth were observed attending school, having lunch, and participating in groups during the week of the annual compliance review. Seven interviewed youth confirmed the center has a daily activity schedule.

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

The center maintains a written policy and procedures which outlines adherence to a daily schedule. The daily activity schedule, logbooks, and movements were reviewed during the week of the annual compliance review. A review of center's logbooks entries verified the center was adhering to the posted activity schedule. Observations of youth attending school, having lunch, attending groups, participating in yoga classes, and level three snack distribution was conducted during the week of the annual compliance review. All changes to the schedule require approval from administration. Seven youth were interviewed and each reported the center follows the daily activity schedule. Seven staff were interviewed and each reported the daily schedule is followed.

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

The center maintains a written policy and procedures ensuring educational access to youth in the center. The center offers an education component operating on a year-round basis. The center ensures daily education for qualified youth through St. Lucie County School District. An interview with the lead educator in comparison with the center's logbooks, confirmed the center's educational program is scheduled on-site Monday through Friday from 8:00 a.m. to 2:30 p.m. The center provides 240 days of classroom interaction plus ten days are used as

teacher training planning days of instruction for the year. Youth enrolled in the educational program can earn course credit for completion of the education and training experience.

A review of the program's daily schedule, school instructional schedule, youth and staff interviews, and logbook confirmed minimal interference of instructional programming. The education department at the center follows the State of Florida common core standards and the Scope and Sequence of St. Lucie County Schools. All teachers are responsible for common core content such as reading, writing, listening, and speaking across the content. Core content classes include English/reading, science, social studies, mathematics, social emotional learning, and career development. Content classes are taught daily according to the student's individual schedules and grade levels. Resources include the use of the content libraries, current textbook adoptions, and Edgenuity (E2020) platform for computer assisted teaching utilizing smart boards. Positive Behavior Support (PBS) strategies are utilized daily within all classrooms in addition to the Department's behavior management system (BMS). The Reissuance curriculum, Star test, is administered as the entry test to all students enrolled for over forty-five days. Exceptional Student Education services are provided in accordance with the student's Individual Education Plans (IEP) and specific student needs. Transition services are provided by the St. Lucie County School's alternative education transition specialist to all students upon their admission or discharge from the center.

A video observation of movements to and from school on four randomly selected days during the week of the annual compliance review, verified youth were attending school as scheduled. Seven youth were interviewed regarding how well the center is preparing youth for general equivalency diploma (GED), high school, vocational school, employment, and/or college. Two youth stated very well, four youth stated well, and one youth stated not well, because there is no age difference in the classroom but youth attend by grade; therefore, there is a lot of distraction in the classroom. Also, everyone gets the same school assignments and the schoolwork is not on the grade level. Each youth reported attending school Monday through Friday while in the center. All seven youth were able to identify the educational classes provided at the center. Seven staff and the superintendent were interviewed regarding educational interference, each staff reported there is minimal interference during educational instruction time.

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 career education competency development program provided by St. Lucie County School District for all youth in secure detention. The center offers Type I career education. Career education programming is based on the youth's age, assessed educational abilities, the goals of the youth, and the typical length of stay to which each youth is assigned. Youth are given the opportunity to complete interest inventories, conduct career explorations, participate in career and social emotional learning curriculum which is taught daily by core content teachers and weekly by the school counselor. The school counselor also conducts individual and group counseling sessions weekly. Sessions include transcript analysis and review, career counseling, school counseling, and Florida State assessments.

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

The center maintains a written policy and procedures which addresses trauma-informed care. Seven staff training records confirmed the center is incorporating trauma-informed practices into current operations to deliver services and to provide care to youth in custody, acknowledging the role which violence and victimization play in the lives of most youth entering the center. A tour of the center during the annual compliance review week, confirmed the center has a soft room and numerous areas throughout the center painted in soft soothing colors. The soft room is utilized to help de-escalate and calm the youth. The center continues to improve the appearance of the facility making it more youth friendly by adding several murals to the walls, along with inspirational messages. Seven reviewed youth case management records verified each youth admitted to the center received a trauma risk assessment upon intake. An interview with the center's superintendent indicated all staff are required to complete the trauma-informed care training. All youth are treated as if they have experienced trauma. In addition, mental health staff is a big part in ensuring youth needs are being addressed.

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 DMHCA on August 20, 2020. The Department maintains a contract with Camelot Community Care, Inc. to provide mental health and substance abuse services to all applicable youth in the center. Camelot Community Care, Inc. provides a full-time licensed mental health counselor (LMHC) to serve as the center's DMHCA which 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, Wednesday, Thursday, and Friday from 9:00 a.m. to 5:00 p.m., and on Tuesday from 10:00 a.m. to 6:00 p.m. A review of the Medical and Mental Health Logbook sign-in sheets confirmed the DMHCA was on-site as required. The DMHCA is available seven days a week, twenty-four hours a day, by telephone for consultation. A review of the Camelot Community Care, Inc. job description found the DMHCA is responsible for the 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 works directly with the psychiatrist and provides face-to-face updates once a week on applicable youth receiving services to discuss behaviors, progress, and applicable medications. Reviewed documentation supported the DMHCA, non-licensed therapist, psychiatrist, registered nurse, and program administration meet weekly for mini-treatment team meetings. The program has a back-up DMHCA in the event of scheduled leave and/or absences. The back-up DMHCA is a licensed clinical social worker, licensed under Chapter 491 in the State of Florida, with an expiration date of March 31, 2021.

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

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

(DMHCA) ensures the center's non-licensed master's-level therapists working under their direct supervision are providing services they are qualified to provide based on education, training, and experience. The policy was approved by the superintendent and the DMHCA on August 20, 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. As of April 7, 2020, the psychiatrist has been providing weekly tele-psychiatry services. The center has a contract with an additional psychiatrist to serve as the back-up. The regional mental health director conducts weekly video-teleconference meetings with all of the detention center's DMHCAs and conducts an individual weekly call with the DMHCA to discuss youth receiving services. The regional mental health director is a licensed clinical social worker (LCSW), the DMHCA is a licensed mental health counselor, and the back-up DMHCA is regional mental health director. Reviewed licenses found each was clear and active in the State of Florida with an expiration date of March 31, 2021. The psychiatrist and the back-up psychiatrist licenses was clear and active in the State of Florida with an expiration date of January 31, 2022. Both psychiatrists had education backgrounds in child and adolescent psychiatry and were members of the American Board of Psychiatry and Neurology.

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

The center maintains a written policy and procedures ensuring metal health and substance abuse services are provided by individuals with appropriate qualifications. The clinical supervisor ensures the clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience. The policy was approved by the superintendent and the designated mental health clinician authority (DMHCA) on August 20, 2020. The center is licensed through the Department of Children and Families under Chapter 397 to provide outpatient substance abuse treatment services with an expiration date of April 1, 2021.

The center has two non-licensed master's-level mental health and substance abuse clinical staff who work under the direct supervision of the licensed mental health counselor (LMHC). The LMHC serves as the center's DMHCA. The non-licensed master's-level clinicians hold degrees in social work and clinical mental health counseling, respectively. One clinician is a registered clinical social worker intern in the State of Florida with an expiration date of March 31, 2022. One non-licensed clinician is full-time and scheduled to work Monday through Friday, 8:20 a.m. to 4:20 p.m. and the remaining non-licensed clinician is part-time, with approximately twenty scheduled hours and is scheduled to work Wednesday and Thursday from 2:00 p.m. to 6:00 p.m. and Saturday and Sunday from 10:00 a.m. to 4:00 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. A review of direct supervision logs verified the DMHCA provided at least one-hour of weekly face-to-face supervision documented on the Department's Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log form. The reviewed forms reflected a review of the clinician's case load, clinical services provided, documentation, miscellaneous directions, instructions, and recommendations. Reviewed documentation supported each ASR completed by the non-licensed clinician was reviewed by the DMHCA within twenty-four hours of the referral for assessment.

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

The center maintains a written policy and procedures ensuring the mental health and substance abuse needs of youth are identified through a comprehensive screening process in which referrals are made when youth are identified with mental health and/or substance abuse needs or are identified as a possible suicide risk. The superintendent has established procedures for a thorough review of each youth's preliminary screening conducted by the juvenile probation officers (JPOs) 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 August 20, 2020.

A review of seven youth mental health and substance abuse records indicated while the youth was in the juvenile assessment center (JAC), the 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 seven SRSIs were reviewed by a mental health clinical staff member and documented their recommendation. Each SRSI had completed entries which included a summary and recommendations in the screening results section. One of the seven reviewed records documented a history of suicide risk and five required an override due to the youth providing all negative responses. However, the center's practice is to place a referral for each youth for an Assessment of Suicide Risk (ASR). Reviewed documentation supported each youth was placed on precautionary observation (PO) and remained on PO until the ASR was completed by the center's clinical staff. The center's practice is to complete the Department's Mental Health and Substance Abuse Referral Summary form. The results of the ASR indicated four of seven youth were placed on standard supervision and three youth remained on constant supervision. The center's staff completed the Department's Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) assessment for each youth upon their intake admission. An interview with the superintendent confirmed the intake officer is

responsible for completing the detention officer portion of the SRSI and the mental health staff complete the clinical portion 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 August 20, 2020.

The center maintains a contract with Camelot Community Care, Inc. to ensure youth identified during the preliminary screening process receive an in-depth mental health and/or substance abuse assessment shortly after intake. A review of seven youth mental health and substance abuse records reflected two were applicable for referral of mental health and substance abuse services. One additional applicable record was reviewed to meet the minimum sample size requirement. A review of the three applicable youth mental health and substance records supported each youth was screened and a referral was made to Camelot Community Care, Inc. for a comprehensive mental health and substance abuse evaluation based on the Massachusetts Youth Screening Instrument - Second Version (MAYSI-2) assessment and/or Suicide Risk Screening Instrument (SRSI). All three youth received a new evaluation documented on the Substance Abuse and Mental Health Assessment (SAMH) form. Each evaluation was completed in full and contained all required information including the diagnostic impression, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, summary of findings, and recommendations. Reviewed documentation supported each was completed within thirty days of the youth's admission into the center. A review of three applicable youth records where a comprehensive mental health and substance abuse evaluation was conducted by a community provider found each was a new evaluation. Two were completed by Shanlis Inc. Clinical forensic and Neuropsychological Services of Fort Pierce, Florida and one was completed by Gerena and Associates out of Pompano Beach, Florida. All three youth were committed and awaiting placement. The center's practice found the DMHCA reviewed each evaluation and documented a Comprehensive Assessment Addendum and attached it to the original comprehensive evaluation.

The assigned juvenile probation officer (JPO) 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 JPO by e-mail, requesting a status update on the comprehensive assessment completed by the community provider. The request is discussed during the weekly detention review meetings.

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

The center has a written policy and procedures ensuring all youth who receive mental health and/or substance abuse treatment while in the center shall have a discharge summary completed documenting the focus and course of the youth's treatment recommendations for mental health and/or substance services upon the youth's release. The policy was approved by the superintendent and the designated mental health clinician authority (DMHCA) on August 20, 2020. A review of the contract indicated mental health clinical staff are required to be on-site seven days a week. Reviewed schedules supported clinical staff are on-site, as required.

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

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

Further review indicated there were four applicable youth requiring an individual treatment plan. Reviewed youth records documented the individualized treatment plan was developed within the required time frame and in full. The practice is to utilize the Department's Individualized Mental Health/Substance Abuse Treatment Plan form. Reviewed documentation supported none of the youth required individual treatment plan reviews. A review of three additional applicable youth records supported each was receiving services, had an individualized treatment plan developed within the required time frame, and each required one individual treatment plan review. Reviewed practice and observation of mini-treatment team meetings supported the reviews were conducted, as required. None of the reviewed records required any modifications to the individualized treatment plan.

An interview with the DMHCA indicated there were no applicable youth who was an alleged victim of a Prison Rape Elimination Act (PREA) event. A review of three applicable closed youth records supported a Mental Health/Substance Abuse Treatment Discharge Summary was

completed for each youth. Reviewed documentation supported a copy was provided to the youth, parent/guardian, and assigned juvenile probation officer.

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

The center maintains a written policy and procedures ensuring mental health and substance treatment planning focuses on providing mental health treatment and/or substance abuse treatment which will reduce or alleviate the youth's symptoms of mental disorder or substance abuse impairment and enable youth to function adequately in the juvenile justice setting. Each youth determined to need mental health treatment including treatment with psychotropic medication or substance abuse treatment, must be assigned to a mini-treatment team. Youth may request to receive mental health and/or substance abuse treatment services. The policy was approved by the superintendent and the designated mental health clinician authority (DMHCA) on August 20, 2020. In addition, Camelot Community Care, Inc. maintains general substance abuse policies last updated September 2020.

Seven youth mental health and substance abuse records were reviewed for mental health and substance abuse treatment services and four were applicable for receiving treatment services. A review of the four youth records validated each applicable youth was assigned to a mini-treatment team and was referred for services utilizing the Department's Mental Health/Substance Abuse Referral Summary form. Each reviewed youth record was applicable for treatment with psychotropic medication management, individual therapy, supportive counseling, group therapy, and when applicable family therapy sessions. Reviewed documentation confirmed each applicable youth requiring treatment was assigned to a mini-treatment team consisting of mental health, medical, education, direct-care staff, nursing, and administrative staff. Reviewed group therapy attendance logs for the past six months indicated groups ended on April 18, 2020 due to the COVID-19 pandemic and resumed on October 25, 2020. During this period of time youth received individual therapy.

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

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

The center maintains a policy and procedures ensuring psychiatric services are provided to youth in need as indicated by symptoms of mental disorder or substance-related disorder, or youth who are being treated with psychotropic medication prior to or subsequent to admission. The policy was approved by the superintendent and the designated mental health clinician authority (DMHCA) on August 20, 2020. The center maintains a contract with Camelot Community Care, Inc. for the provisions of a licensed psychiatrist to provide psychiatric services for applicable youth in the center. Camelot Community Care, Inc. provides a part-time psychiatrist. A review of the independent contract for psychiatric services signed on April 30, 2020 outlined for the provision of services for a minimum of 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, Inc. 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 Tele-Psychiatry Log 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 April 7, 2020 and continues as of the annual compliance review. The center utilizes the Department's Mental Health/Substance Abuse Referral Summary form to request a psychiatric evaluation. The psychiatrist signs and dates the referral form. Psychiatric services include an initial diagnostic psychiatric interview, psychiatric evaluations, psychiatric follow-up assessments and consultations, coordination of services, crisis interventions, treatment planning, communication, and emergency procedures.

A review of seven youth mental health and substance abuse records indicated three youth were applicable for receiving psychiatric services. 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 one week of the youth's admission. All reviewed mental health and substance abuse documentation was completed utilizing the Department's required forms. None of the reviewed youth records 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 August 20, 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, 9-1-1, 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 August 20, 2020 and the psychiatrist on September 1, 2020.

The center maintains two suicide response kits located in master control and the supervisor's office. A review of seven 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 seven applicable youth was placed on precautionary observation (PO) until the ASR was completed. Each ASR was completed within twenty-four hours by a trained master's-level non-licensed clinician and was reviewed by the DMHCA, as required. A review of the completed ASRs found five of the seven youth placed on PO were stepped down to standard supervision and two remained on constant supervision. One additional applicable record of a youth placed on PO due to staff observations was reviewed and all three applicable youth placed on constant supervision 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 PO and actively trying to harm themselves, the youth will be placed on secure observation. All items are removed from the youth and an officer is assigned to the youth to maintain constant visual observation while the youth is in a secure room. The supervisor then completes the necessary documentation in JJIS; such as the health checklist, producing a secure observation log, and a JJIS incident report. The center's administration is notified of the incident.

A review of three applicable youth placed in secure observation in the last twelve months was conducted. 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. Each youth was removed from secure observation within twenty-four hours of placement. A review of JJIS indicated the appropriate alert was entered and removed, as required. A review of the center logbooks validated the youth placed on precautions had documentation regarding the beginning and ending times of their precaution periods.

Seven interviewed youth found four indicated they were placed on suicide precautions while in the center and three youth indicated they had not. Three of the four youth placed on suicide watch indicated the staff watched them the entire time they were on suicide precautions. The remaining youth who indicated not applicable was interviewed again and indicated the staff did watch them the entire time they were on suicide precautions.

Seven interviewed staff indicated in the event a youth expressed suicidal thoughts; staff indicated they would notify the mental health authority, search the youth and their room for sharp objects, document supervision, and place the youth on constant sight and sound supervision. Five of seven staff provided additional responses to include one of seven staff indicated the shift supervisor would be notified, one staff indicated notifying master control, and three staff indicated they would talk to the youth until mental health staff arrived.

Seven interviewed staff indicated the suicide response kits are located in master control and the shift supervisor's office. Five staff indicated the suicide kits are in medical and two indicated in the intake area.

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 August 20, 2020 and the psychiatrist on September 1, 2020.

Seven reviewed youth mental health records found each youth was placed on precautionary observation (PO); however, the mental health clinical staff conducted the Assessment of Suicide Risk (ASR) immediately and subsequently placed three of the seven youth on standard supervision; therefore, no Suicide Precaution Observation Logs were required for the youth placed on standard supervision. A review of the four youth records for the youth placed on PO 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 program had two youth detained who had been placed on PO at the time of the annual compliance review. The interviewed youth indicated when they were on suicide precautions, staff watched them the entire time.

Seven interviewed staff indicated they received training in suicide prevention. A review of the three incidents of youth placed in secure observation validated the Secure Observation Logs were completed, as required. A review of three applicable youth records of youth returning to the center from a Baker Act proceeding determined the Suicide Precaution Observation Logs were completed, as required.

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

The center maintains a written suicide prevention plan outlining the training requirements for all staff who work with youth. The policy was approved by the superintendent and the designated mental health clinician authority (DMHCA) on August 20, 2020 and the psychiatrist on September 1, 2020. Camelot Community Care, Inc.'s 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 seven staff training records validated each staff completed at least two hours of suicide prevention training in SkillPro and four hours of instructor-led suicide prevention training. Reviewed documentation of 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 forty-four applicable staff requiring participation in a mock suicide drill semi-annually; however, reviewed documentation supported there was one staff who participated in one and not the second semi-annual drill, as required. Most staff participated 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 and calling 9-1-1 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 policy was approved by the superintendent and the designated mental health clinician authority (DMHCA) on August 20, 2020. The plan details crisis intervention procedures including a notification and alert system, means of referral including youth self-referral, communication, supervision, documentation, and review. The center's procedures outline conducting a Crisis Assessment to evaluate a youth presenting with acute emotional or psychological distress which is extreme and does not respond to ordinary interventions conducted by a mental health clinician to determine the severity of the youth's distressing symptoms, level of risk to self or others, and recommendations for treatment and follow-up care. The Crisis Intervention Plan is placed in the superintendent's office, medical clinic, DMHCA's office, and is accessible to all staff on the center's network drive and SharePoint.

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

The center maintains a written Emergency Care Plan outlining mental health and substance abuse emergency procedures and ensuring youth who are believed to be an imminent danger to themselves or others because of mental illness or substance abuse impairment receive emergency mental health or substance abuse services. The policy was approved by the superintendent and the designated mental health clinician authority (DMHCA) on August 20, 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 New Horizons in Fort Pierce, Florida for Baker Act crisis stabilization and Marchman Act emergency substance abuse assessment and treatment. A review of seven staff training records supported each was trained on the center's emergency care plan. A copy of the approved plan is maintained in the superintendent's office, medical clinic, DMHCA's office, and is accessible to all staff network drive and on SharePoint.

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

The center maintains a written policy and procedures ensuring the center responds to youth in the least restrictive means possible to protect the safety of the youth and others while maintaining control and safety of the center. The policy was approved by the superintendent and the designated mental health clinician authority (DMHCA) on August 20, 2020. An interview with the DMHCA and the superintendent confirmed the center did not have any applicable youth requiring a Crisis Assessment in the last twelve months.

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

The center maintains a written policy and procedures ensuring there is a written plan which outlines mental health and substance abuse emergency procedures and ensure youth who are believed to be an imminent danger to themselves or others because of mental illness or substance abuse impairment receive emergency mental health or substance abuse services. The policy was approved by the superintendent and the designated mental health clinician authority (DMHCA) on August 20, 2020

A review of seven youth mental health and substance abuse records found no youth requiring crisis stabilization. The center provided three applicable youth records whereby each youth was transported by law enforcement for Baker Act proceeding to New Horizons in Fort Pierce, Florida. All three reviewed applicable records documented each youth was placed on suicide precautions prior to being transported to New Horizons and upon return to the center. Each youth received a Mental Status Examination completed by the licensed mental health counselor (LMHC). Each youth was placed on constant supervision until the completion of the Assessment of Suicide Risk (ASR) and subsequent Follow-Up ASRs were completed and determined the youth was eligible to transition to a lower level of supervision. A review of the Department's Juvenile Justice Information System (JJIS) determined an alert was placed for each youth and closed prior to their discharge from the center.

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 contractual agreement with a licensed physician to serve as the designated health authority (DHA). The policy was signed by the superintendent and the DHA on September 3, 2020. In addition, the center maintains a written policy and procedures ensuring credentials and licensing to the various types of healthcare provides/disciplines. The policy was signed by the superintendent and the DHA on September 3, 2020. The center maintains a contract with Camelot Community Care, Inc. who subcontracts with a medical doctor (MD) who holds a clear and active unrestricted license in the State of Florida with an expiration date of January 31, 2022. The DHA has specialty training and education in pediatrics and meets all requirements for independent and unsupervised practice in the State of Florida and is a member of the American Board of Pediatrics. The DHA is clinically responsible for the medical care of all youth and has the final clinical decision-making about the provision of healthcare. The DHA is responsible for the development, review, and approval of all health-related procedures and protocols utilized in the center.

A review of the contract with Camelot Community Care, Inc., indicates there is a provision for an advanced registered practice nurse (APRN). A review of the APRN's credentials indicated they have an advanced degree of doctor of nursing practice (DPN) in addition to being licensed as an APRN. The APRN holds a clear and active unrestricted license in the State of Florida with an expiration date of July 31, 2022. The APRN signed the Collaborative Practice Protocol agreement on November 3, 2020 and the DHA signed on November 4, 2020. Camelot Community Care, Inc. has a contract with a MD to serve as a back-up DHA in the event the primary DHA is on scheduled leave or sick leave. The MD holds a clear and active unrestricted license in the State of Florida with an expiration date of January 31, 2023. The back-up DHA has specialty training and education in pediatrics and meets all requirements for independent and unsupervised practice in the State of Florida and is a member of the American Board of Pediatrics.

The DHA is scheduled to be on-site two hours each week and the APRN is scheduled to be on-site six hours each week. The DHA and/or APRN provide periodic evaluations, Comprehensive Physical Assessments, sick call referrals, and administrative duties. 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. An interview with the DHA supported this practice. On-site nursing coverage is provided seven days a week from 7:00 a.m. to 7:45 p.m. The center has one full-time registered nurse (RN) serving as the clinical manager. In addition, the center has a part-time RN, full-time licensed practical nurse (LPN), and two part-time LPNs. The clinical director is scheduled to work Monday through Friday, 7:00 a.m. to 3:30 p.m., and the part-time RN is scheduled to work on Saturday, 8:00 a.m. to 4:30 p.m. and is also scheduled pro re nata (PRN). One LPN is scheduled to work Monday through Friday, 11:45 a.m. to 7:45 p.m. and the one part-time LPN is scheduled to work on Sunday, 8:00 a.m. to 4:30 p.m. The remaining part-time LPN is scheduled PRN. The reviewed contract included a full-time medical records clerk medical liaison scheduled to work Monday through Friday, 7:00 a.m. to 4:30 p.m.

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 written Facility Operating Procedures (FOPs) for all utilized health-related procedures and protocols. The superintendent and the designated health authority (DHA) reviewed, signed, and dated the FOP on September 3, 2020. The DHA signed the non-healthcare staff protocols and nursing protocols on September 9, 2020. Reviewed documentation supported three nursing staff signed their annual review of the nursing protocols on September 3, 2020 and two signed the nursing protocols on September 8, 2020. Interviews with nursing staff indicated there were no changes to the approved protocols from last year; therefore, the nursing staff signed prior to when the DHA was on-site to provide their signature of approval. The center's contracted psychiatrist documented a review with signature and date for applicable FOP on September 1, 2020. 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).

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/guardians are afforded the right to provide or withhold consent with regard to the healthcare provided to the youth. The policy was signed by the superintendent and the designated health authority (DHA) on July 1, 2020. A review of seven youth healthcare records found each contained a clearly stamped copy of the Authority for Evaluation and Treatment (AET) signed by the youth's parent/guardian. The nursing staff maintain a chronology of efforts made to secure signatures on the AET form. The center had no applicable youth who required a Limited Consent for Evaluation and Treatment; however, the nursing staff were able to provide three applicable records of youth requiring limited consent and one with a court order of final judgment for termination of parental rights and the court providing consent for medical care while the youth was in the center. 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 informs the parent/guardian of significant changes in the youth's condition and obtains consent when new medications and treatments are prescribed. The policy was signed by the superintendent and the designated health authority (DHA) on July 1, 2020. A review of seven youth healthcare records found three 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). Two applicable healthcare records indicated required off-site

care for dental and orthopedic care and each record supported nursing staff notified the parent/guardians by telephone and subsequently, in writing. Four youth were prescribed medications and parental notification and consent was obtained prior to administration. Reviewed practice indicated nursing staff utilized the Department's Parental Notification of Health-Related Care form as well as documentation in the chronological progress notes. Interview with nursing staff indicated written parental notices were sent regardless of telephone notifications. None of the reviewed youth healthcare records required vaccinations/immunizations. Interview with nursing staff indicated there were no Religious Exemption from Immunization forms submitted since the last annual compliance review.

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 facility entry healthcare admission screening utilizing the Department's Medical and Mental Health Admission Screening form in the Juvenile Justice Information System (JJIS) Admission Wizard. The policy was signed by the superintendent and the designated health authority (DHA) on July 1, 2020. A review of seven youth healthcare records found each contained a Medical and Mental Health Admission Screening form completed on the date of admission by a juvenile justice detention officer and three indicated the screening was reviewed by the registered nurse and four by a licensed practical nurse (LPN) within twenty-four hours. Each screening form was completed in JJIS Admission Wizard, as required. Three youth admitted with medications indicated the DHA was notified and an order was obtained to continue the medications as prescribed. Interview with nursing staff validated this practice. The sample reviewed found one applicable female youth who received a qualitative urine pregnancy screening test and screening for Chlamydia Trachomatis and Neisseria Gonorrhoeae. The center's nursing staff provided two additional applicable youth records for female youth who received a qualitative urine pregnancy screening test and Chlamydia Trachomatis and Neisseria Gonorrhoeae. All test results were filed in the laboratory section of the youth's healthcare record. 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 the annual compliance review period. An interview with the center's superintendent reported all healthcare admission screenings are conducted by the doctor, nursing staff, and detention officer 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. The policy was signed by the superintendent and the designated health authority (DHA) on July 1, 2020. A review of seven youth healthcare records 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 seat belt usage, alcohol and drug-related problems, human immunodeficiency virus (HIV), sexually transmitted disease/infections, tobacco products and smoking cessation, and dental hygiene. Reviewed documentation supported each youth received healthcare orientation on basic personal hygiene, immunizations, infection control, prevention of sexual and other physical violence, nutrition, breast and testicular self-examinations, parenting skills, and if applicable, prenatal, post-partum, and parenting education. Reviewed practice supported each youth signed a Medical Services/Access/Orientation form validating they received an orientation to the center's healthcare services and instructed to notify the detention staff or medical staff if they exhibit any medical issues.

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 of all youth admitted with chronic health conditions or the youth is in need of emergency care. The procedures outline a minimum of twenty-six different medical conditions requiring routine notification to the DHA. The policy was signed by the superintendent and the DHA on July 1, 2020. A review of seven youth healthcare records 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 seven reviewed records. Three of the seven 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. Three youth were 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 electronic mail (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 each youth's 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. The policy was signed by the superintendent and the designated health authority (DHA) on July 1, 2020. A review of seven youth healthcare records found each contained a new HRH form completed electronically by a licensed nurse within seven days or less of the youth's admission to the center. Six of the seven reviewed HRH supported each was reviewed by the DHA or advanced practice registered nurse (APRN) and was maintained in the youth healthcare record. One reviewed HRH was last reviewed during a previous admission. 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.

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 policy was signed by the superintendent and the designated health authority (DHA) on July 1, 2020. The center maintains a written policy and procedures ensuring each youth receives a routine screening for latent and active tuberculosis (TB) as well as environmental controls in the case of a youth with active TB. The policy was signed by the superintendent and the DHA on September 3, 2020. 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 safety and security of the youth. The policy was signed by the superintendent and the DHA on September 3, 2020.

A review of seven youth healthcare records indicated each youth had a current CPA with two on file at admission and five youth required the completion of a new CPA. Reviewed documentation supported one CPA on file was last reviewed by the DHA on September 16, 2020 and not for the admission on November 19, 2020. Documented practice supported the DHA and/or advanced practice registered nurse (APRN) completed the new CPA in full. Two reviewed CPAs indicated the DHA/APRN documented “deferred by clinician – not medically necessary” for one youth and “deferred by clinician – asymptomatic” for the other youth. One youth refused a portion of the examination and the youth did not sign a refusal form and/or sign the CPA indicating their refusal on the date of the examination. The Department’s Problem List was updated each youth.

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 (STIs) 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. The results of the STI will be noted on the Department’s Infectious and Communicable Disease (ICD) form and the lab results will be filed in the youth’s healthcare record. The policy was signed by the superintendent and the DHA on July 1, 2020. A review of seven youth healthcare records indicated each screened for STI and one required further evaluation and was referred to the DHA/APRN. Nursing staff updated the ICD form after each screening. Two additional applicable youth healthcare records were reviewed and each required further evaluation and was referred to the DHA/APRN. One youth consented to a gynecological examination and results were filed in the youth’s healthcare record. There were no applicable youth who were out of the Department’s custody for thirty days or more; therefore, there were no rescreening’s required.

A review of seven youth healthcare records indicated each youth was offered the opportunity to receive human immunodeficiency virus (HIV) testing and counseling as documented on the Department’s Human Immunodeficiency Virus Antibody Test Youth Consent form. One youth

consented to testing and counseling. An additional two applicable youth healthcare records were reviewed and documented practice supported each youth received the pre-counseling, testing, and post-test counseling. Each youth receiving HIV testing and counseling was documented on the Department's Health Education Record form. The center's registered nurse (RN) is certified through the Florida Department of health and maintains current certifications in 500 The Basics: HIV Prevention Program and 501 HIV Prevention Counseling, Testing and Linkage – Introduction. counselor and provides pre-test and post-test counseling. The RN swabs the youth's mouth and sends the specimen to LabCorp. Should the results come back as positive, a blood sample is drawn and tested, and the results are given to the local health department. The HIV test results are placed in a sealed envelope marked "Confidential" and filed in the applicable youth's healthcare record. The nursing staff maintain a HIV/STI Testing Log to track the date requested, youth names, Department identification number, date of birth, date of applicable HIV test conducted, and date of applicable STI test conducted. Seven interviewed youth indicated 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 complaint of illness or injury of a non-emergent nature, but which requires a professional nursing assessment and possibly, a nursing intervention. The policy was signed by the superintendent and the designated health authority (DHA) on November 17, 2020. The center's policy indicates sick call is provided Monday through Friday at 8:00 a.m., 12:00 p.m., 4:00 p.m., and 6:00 p.m. and on Saturday and Sunday at 8:00 a.m. and 12:00 p.m. However, interview with nursing staff and reviewed documentation supported sick call is conducted Monday through Friday from 9:00 a.m. to 11:00 a.m. and 4:00 p.m. to 5:00 p.m. Sick call on Saturday and Sunday is conducted 9:00 a.m. to 11:00 a.m. The center maintains treatment protocols appropriate to the level of the provider conducting sick call approved by the designated health authority (DHA) on September 9, 2020. According to an interview with the DHA, they will conduct sick calls while at the center, if necessary. All sick call events are documented on the Sick Call Index and Sick Call Referral Log. Sick Call forms document 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. Each JJDOS is trained to contact the DHA.

A review of seven youth healthcare records indicated five youth submitted a sick call request. Sick call requests are electronically documented by the direct-care staff, which is electronical mailed (e-mailed) to the nursing staff for review. Three reviewed ick call request events were conducted by the licensed practical nurse (LPN) and reviewed by the registered nurse (RN) on the same date. Each sick call event was documented on the Sick Call Referral Log. There were no instances in which a youth presented a similar sick call complaint three or more times in a two-week period or of a youth complaining of any severe pain with which staff were unfamiliar. During the annual compliance review week there was one applicable sick call request submitted, the annual compliance review team with the youth consent, observed the sick call process. The youth's privacy was ensured as only one youth at a time is permitted in the

medical clinic. The nursing staff followed the established sick call protocols, called the DHA with the results of the sick call event, and subsequently the youth was placed in medical isolation. Five of seven interviewed youth indicated nursing staff conducts sick call and two indicated they have not submitted a Sick Call Request form. Three of seven interviewed youth indicated they can be immediately seen should they submit a Sick Call Request form and three indicated they will be seen within one day of submission. One youth indicated they never requested a sick call. One of seven interviewed youth rated the medical care at the center as very good, four rated as good, one rated as fair, and one indicated they never received medical services.

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 and first aid care. The policy was signed by the superintendent and the designated health authority (DHA) on July 1, 2020. The center maintains a separate written policy and procedures ensuring all direct care staff and healthcare staff always have an obligation to protect the health and safety of the youth. All staff have the right and responsibility to call 9-1-1 at any time a youth's condition appears compromised. The policy was signed by the superintendent and the DHA on July 1, 2020. 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 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 seven youth healthcare records found two youth received episodic care conducted by nursing staff. An additional applicable youth healthcare record was reviewed where a youth received episodic care conducted by nursing staff. All three applicable reviewed healthcare records 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. Parental notification was made and documented in the healthcare record. One of the three youth required a follow-up evaluation which was conducted by the designated health authority. The center had no applicable episodic care events conducted by non-healthcare staff.

The center maintains fifteen first aid kits which are in master control, supervisor's office, mechanical room, foyer, and juvenile assessment center (JAC). Two first aid kits were in the kitchen and one in each of the seven vans. Review of three first aid kits found each contained the required items identified on the DHA approved inventory list dated September 9, 2020. The nursing staff conducts a monthly review of the first aid kits and items are replenished upon use and/or expiration date. The review is documented on the First Aid Kits Check List form. The center maintains 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 the AED, Batteries and Pads Weekly Check List form. The AED was self-tested in front of the annual compliance review team to ensure it was operational. The batteries in both AEDs and pads were last changed on August 20, 2018. The batteries expire in August 2022 and the pads expire in March 2021.

A review of seven staff training records found each was trained in cardiopulmonary resuscitation (CPR), first aid, and AED and each held current certifications. Reviewed documentation

supported the DHA, the advanced practice registered nurse (APRN), and all nursing staff maintained current certifications in CPR and AED. The center has trained eleven non-healthcare supervisory staff to assist youth in self-administration of an inhaler and for emergency use of Epinephrine Auto Injector. Emergency contact numbers were observed to be posted in the medical clinic, supervisor's office, master control, superintendent's office, and assistant superintendent's office to include the number for the statewide Poison Information Center. Nursing interviews validated this practice. 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 at least once a quarter on each shift. Reviewed documentation supported CPR and AED demonstration was practiced at least annually. Reviewed practice supported A-shift conducted two drills with CPR/AED demonstration, B-shift conducted three drills, and C-shift conducted two drills. 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. Seven staff were interviewed to determine if they can call 9-1-1 if necessary and each stated they can call 9-1-1 if necessary.

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

The center 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. The policy was signed by the superintendent and the designated health authority (DHA) on July 1, 2020. A review of seven youth healthcare records found one was applicable for off-site medical care; therefore, two additional applicable records were reviewed. The DHA was notified for each off-site medical event. Each reviewed healthcare contained a Summary of Off-site Care form, discharge documentation, and instructions. The center documented the off-site care event on the Episodic (First Aid/emergency) Care Log for each youth. The DHA documented a review of the off-site care findings, instructions, and information. Two youth required an additional referral for follow-up testing or an appointment. Documentation validated the referral was made for each youth and 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. Recommendations are for re-evaluations every thirty days while the youth is in detention; however, in no case is the interval

between periodic evaluations by the designated health authority (DHA) and/or advanced practice registered nurse (APRN) to exceed three months. The policy was signed by the superintendent and the DHA on July 1, 2020. A review of seven youth healthcare records 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. 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. Nursing staff documented all three youth on the Department's Chronic Physical Health 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 policy was signed by the superintendent and the designated health authority (DHA) on July 1, 2020. The center has a policy and procedures ensuring the standard Department Medication Administration Record (MAR) will be utilized for each youth receiving either prescription medications on a routine basis or over-the-counter (OTC) medication. Treatment which has been ordered to include vital signs, will also be listed on the MAR. The policy was signed by the superintendent and the DHA on July 1, 2020. The center maintains a policy and procedures ensuring medication administration by licensed and non-licensed staff shall occur as scheduled in a comprehensive, accurate, and organized manner. The policy was signed by the superintendent and the DHA on July 1, 2020. The center maintains a written policy and procedures ensuring the monitoring of psychotropic medications and ensuring the youth's safety through a comprehensive process. The policy was signed by the superintendent and the DHA on July 1, 2020. 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 Department's 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 seven youth healthcare records indicated three youth were taking prescribed medication upon admission and were applicable for medication management. One additional reviewed youth record indicated the youth was prescribed a medication for a seven-day period and completed the medication while in the center. Each applicable youth healthcare record documented verification of prescription medication by the nurse. In each applicable record, the licensed nurse obtained an order from the DHA to resume the applicable medication and all orders were signed by the practitioner.

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 MAR or the Controlled Medication 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. Each reviewed MAR clearly documented the youth's name, Department 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. 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 and according to nursing interviews, there were no applicable medications requiring refrigeration at the time of the annual compliance review. Nursing staff track daily temperatures of the refrigerator. The center maintains a separate refrigerator for specimens and nursing staff track daily temperatures. The center has authorized and trained the superintendent, the two assistant superintendents, and eight 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 during the hours of medication administration 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. 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 seven reviewed youth records found the youth were admitted on 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 through tele-psychiatry. Observations of one medication administration validated the JJDOS escorted the youth to the medical clinic. The nurse had the medication cart stored under the counter and the youth approached the nurse at the counter, the nurse inquired with the youth their name, what medication, and what are the side effects. The nurse pulled the medication from the secured medication cart and checked it against the MAR. The medication was administered, the MAR was updated accordingly, and the youth initialed the MAR in receipt of the medication. The youth opened their mouth to ensure the medication was swallowed, as required.

The center utilizes Destroyer Pharmaceutical Disposal Non-Hazardous Medication Disposal for the disposal of medications. The center maintains a contract with a consulting pharmacy and reviewed documentation supported the consultant pharmacist conducted a pharmacy audit monthly and quarterly. The consultant pharmacist license was observed clear and active in the State of Florida with an expiration date of December 31, 2022. Monthly audit forms documented medications and any applicable identified deficiencies and whether or not the center required any medications disposal. The consultant pharmacist documented comments and recommendations on the last page above their signature and date. The practice is for the consultant pharmacist and the on-site nurse to dispose the medication(s) which cannot be returned to the pharmacy for credit and document it on the Medication Disposal form. Disposal of non-controlled medications is documented on the Drug Disposal form. The consultant pharmacist conducts a quarterly related event summary and discusses the findings with the medical director, superintendent, and the clinical manager. Three of seven interviewed staff indicated they do assist youth in self-administration of medication and four staff indicated they do not provide medication to youth. Informal interviews with staff indicated only the doctor,

nursing staff, and trained JJDO supervisory staff are trained and permitted to give medications to youth. Three of seven interviewed youth indicated the nurse provides medication to youth and four youth indicated not 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. The policy was signed by the superintendent and the designated health authority (DHA) on July 1, 2020. Observations of the medical clinic found the clinic well organized and is secured under lock and key. Medical staff and trained juvenile justice detention officer supervisors (JJDOS) non-licensed 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 under the counter and stores oral prescription and over-the-counter (OTC) medications prescribed for youth. Medication in the cart is separated by each youth. A second locked medication box is in the medication cart is designed to store 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. An interview with the registered nurse indicated inventories are maintained for five years before shredding. 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 three controlled medications on-site during the annual compliance review and the counts were in compliance with the inventories.

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 superintendent and the designated health authority on July 1, 2020. A review of seven youth healthcare records indicated each youth received infection control training within twenty-four hours of admission as part of their orientation to the center's healthcare services. 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 (CCC) were notified of all incidents related to the COVID-19 pandemic. A review of seven 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 maintains a written policy and procedures for the care of pregnant youth to include procedures for medical issues, nutrition, education, and medication. The policy was signed by the superintendent and the designated health authority (DHA) on September 3, 2020. An interview with the nursing staff indicated the center had three pregnant youth since the last annual compliance review. Nursing staff maintained a Pregnant Youth List form documenting the youth's name, Department identification number, admission date, and release date. Three applicable youth healthcare records were reviewed and documentation supported each 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. Three applicable interviewed youth indicated they received gynecological services when needed. A review of seven staff training pre-service and in-service records verified each staff received the Detention Service Women's 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 has a written policy and procedures regarding the supervision of youth. During the annual compliance review week, youth movements were observed for four days. The staff used the radio to call the youth's movement throughout the center and to communicate between the housing unit officers and master control. Staff were observed supervising youth by controlling line movements, positioning themselves appropriately, and giving clear directions throughout the week the annual compliance review team was on-site. During outdoor activities and movement, staff were strategically placed to ensure proper line movement and to ensure there were no physical obstructions of their view of the youth. The center's logbooks were reviewed for the past six months and counts were consistently documented throughout each shift. The center conducts a shift briefing prior to the beginning of each shift. The juvenile justice detention officers (JJDOs) receive their assignments during the shift briefing and copy of the youth alerts. Seven staff were interviewed and each reported they think there have been enough staff at the center to provide for the safety and security of the youth and staff.

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 policy and procedures addressing behavioral management to ensure the safety and security of youth and staff. The behavior management system (BMS) included

rewards for positive behavior and consequences for inappropriate behavior. A review of the center's BMS system indicated a copy is to be given to all the youth entering the center and is also posted throughout the center for the youth to reference. Upon admission into the center, all youth start at level two. The center's level two system provides each youth with all basic rights and some additional activities and incentives, as determined by center administration. The center incentives and activities include playing games, later bedtime, one additional telephone call to parent/guardian, and watch television or movies. The youth can progress to level three with positive behavior. The center's level three system provides youth with all basic rights and will receive additional privileges such as later bedtime, earn extra snacks three days a week, participate in the weekly youth event, receive an additional telephone call, special meal with the superintendent, and participate in work detail.

Seven youth were interviewed and three rated the BMS system as fair, three youth rated as good, and one youth rated as very good. Five of seven interviewed youth thought the consequences received at the center were fair and two youth reported never received consequences. Five youth stated the level can be dropped as a consequence and two youth stated points can be reduced. Seven staff were interviewed and five thought the BMS system was effective and two staff did not believe it was effective. All seven staff reported they discussed consequences being imposed, speak with the youth about alternative behaviors, and give the youth the opportunity to explain their behavior. All staff stated youth will drop a level and/or lose points as a consequence to negative behaviors. All seven staff stated they receive feedback from their supervisor regarding the implementation of the BMS system. All seven staff stated they received monthly, weekly feedback, and 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 in place prohibiting the use of group punishment, corporal punishment, and the use of drugs to control the behavior of the youth. If a youth is non-compliant and staff have exhausted all opportunities to assist the youth in changing their behavior, then the youth's level in the behavior management (BMS) will be dropped to level one in which the youth loses special activities and incentives. Seven interviewed youth reported youth are never allowed to punish other youth. Six of the seven interviewed youth indicated they have never witnessed youth handcuffed or shackled to prevent them from hurting themselves or others. One youth reported witnessed another youth handcuffed during a Protective Action Response (PAR) incident. A follow-up with the center's assistant superintendent stated mechanical restraints are used if a youth is unable to deescalate during PAR. Seven youth indicated they have never been sent to their room for punishment. Seven staff were interviewed

and reported only points and levels can be taken away as a consequence and they have never observed a co-worker do otherwise. The staff stated they have never observed any staff encourage youth to beat up another 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 has a written policy and procedures regarding room checks which states when a youth is confined to a room whether for sleeping, disciplinary, or other reasons, the juvenile justice detention officers (JJDOs) shall conduct, at a minimum, ten-minute checks to ensure safety and security. The center has a total of sixty-four cameras of which sixty-two were operational during the annual compliance review week. Two cameras were reportedly inoperable due to maintenance repair of the area. The digital video recorder (DVR) has a recording capacity and storage for a maximum of thirty days. The center's staff conduct ten-minute checks on all youth using an electronic wand system whereby the staff must physically check each room and press a wand to a sensor button on each door when the youth are in their rooms. Observations of randomly selected surveillance videos from November 2020 through December 7, 2020, during various times on all three shifts revealed JJDOs conducted ten-minute checks, as required. Reviewed documentation of randomly selected ten-minutes checks sheets from July 2020 through December 7, 2020 on all three shifts indicated the checks were recorded in real time. An interview with the center's superintendent confirmed ten-minute surveillance tapes are randomly reviewed by administration and was able to explain the ten-minute check process. Seven staff were interviewed and each stated room checks are conducted every ten-minutes when youth are placed in their room for sleeping or non-punishment reasons.

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 the census, counts, and tracking of all youth under the juvenile justice detention officer (JJDO) staff supervision shall always be maintained. A review of the master control logbooks and unit logbooks for the past six months found population counts were conducted at the beginning and ending of each shift, when a population change occurs, and following any emergency. Youth are accounted for at all times by a physical count and random head counts, when requested by master control. Master control also authorizes all movement of youth prior to and following routine group movements. The JJDOs conduct head counts throughout the day during shifts and documented in the unit logbooks. Documentation revealed all six living modules area counts were documented in the living unit and master control logbooks. Observation of youth count indicated prior to any youth movement, master control is contacted to inform of the number of youth being moved and to what location. Seven staff were interviewed and each stated emergency counts are conducted when youth are believed to be missing, when visibility is hindered, and after a major disturbance.

5.06 Logbook Maintenance	Satisfactory Compliance

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

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

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

The center maintains a policy and procedures for logbook maintenance and requirements. The center requires facility logbooks to contain a record of events and activities and for the logbooks

to be bound with numbered pages. The center maintains a separate logbook for master control, visitors and contracted staff, and one logbook for each living module. A review of the center's master control logbooks and living module logbooks for the past six months confirmed all logbooks are bound with numbered pages, not missing any pages, and were in good working condition. All entries in the logbooks were made in ink, contained the time and date of the event, and documented in a.m. and p.m. time, not military time. Also, all entries in the logbooks included the name of the youth and staff involved, the initials of the staff making the entry along with a brief description of the event, and any entries impacting the safety and security of the center were highlighted. The master control logbooks consistently contained entries documenting emergency situations, incidents, drills, medical and mental health alerts, and the population counts at the beginning and ending of each shift and after emergency situations. Errors were observed to be struck through with a single line with the date and initialed by the person correcting the error. The center's superintendent recorded comments regarding the improper correction of errors during the review of the logbooks, when applicable.

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

The center maintains a written policy and procedures regarding logbook reviews. The superintendent or designee reviews the logbooks on a weekly basis. A review of the master control logbooks and unit logbooks for the past six months found population counts were conducted at the beginning and ending of each shift, when a population change occurs, and following any emergency. Master control staff also authorizes all movement of youth prior to and following routine group movements. All supervisor's entries were documented with different color ink. Supervisory reviews were conducted when staff assumed the center responsibility. The superintendent reviews were weekly, supervisory staff reviewed the master control logbook at the beginning of the shift and throughout the day for each dorm, and juvenile justice detention officer (JJDO) staff reviewed logbooks on their assigned dormitory.

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 has a policy and procedures in place for key control, as outlined in Florida Administrative Code. All keys not in use are stored in a secure key box in the supervisor office. The emergency keys are stored in a locked box in the supervisor office and are accessible only by authorized staff. Reviewed documentation confirmed the center has a key inventory with a list of all keys, each key has an identification number, the capability of each key, and location. Observations found all keys are on a tamper-resistant ring. Facility keys are issued to each staff member by a supervisor at the beginning of each shift and staff returns the key at the end of each shift. There were no reportable incidents of lost keys in the past six months reported to the Department's Central Communications Center (CCC). A random interview with the juvenile justice detention officers indicated they are aware of key control policies. Seven staff were interviewed and each were able to explain the center's daily process for tracking keys. All seven staff reported keys to case management records, mental health records, medical records, youth property, and the kitchen were restricted.

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

The center maintains a written policy and procedures for transportation, operation, and maintenance of each vehicle used to transport youth. The center has one maintenance mechanic who is responsible for the weekly and monthly vehicle inspections. The transportation supervisor has also been designated to complete the vehicle checks daily to ensure all vehicles are equipped and readily available to drive. The center has a total of seven vehicles but only six are used to transport youth. One vehicle was not operational and waiting to be surplus. Each vehicle had an annual safety inspection conducted by a certified automobile mechanic. Observations of seven vehicles verified each was locked when not in use. All seven vehicles had the appropriate number of seat belts, a seat belt cutter, a window punch, up-to-date fire extinguishers, and a first aid kit with approved items by the designated health authority (DHA). The center maintains a binder for each vehicle which contains the vehicle mileage log, mechanical restraint key, gas card, vehicle registration, vehicle policy, and daily check list. Weekly visual vehicle inspection checks are conducted on all vehicles as required and

documented on the preventive maintenance check sheets. The vehicle logbook was reviewed for the past six months and documentation confirmed the vehicle was inspected prior to transport, the destination, number of youth and staff names, and beginning and ending time of the transport. An informal interview with the transportation supervisor verified each vehicle is searched for contraband, vehicles remained locked when not in use, all staff and youth wear seatbelts, and a cellular phone is assigned to the vehicle. Seven youth were interviewed and each indicated staff are driving safely when transporting youth. All the youth indicated never seeing anyone place contraband in a transport vehicle.

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

The center has a policy and procedures in place to address the issuing, inventory, and control of tools. The maintenance staff stores all of the center's tools in a secure location in a shed adjacent to the detention center. The shed is locked at all times with limited access. Only maintenance staff and administration have access to the tool room. A perpetual tool inventory list is maintained by the center and inventoried monthly. Tools are marked with an identification number. Inventory was verified there were no missing tools; however, there was a damage utensil from the kitchen which was replaced. When all tools are in use, a tool tracking form is used indicating the date the tool is being used and the signature of the person using the tool. Tools which need to be disposed of or a replacement is requested by completing a tool disposal/replacement form which the maintenance mechanic signs and request the approval of the assistant superintendent or superintendent. An interview with maintenance mechanic indicated when items are lost or it is assumed to be left in an area youth were in, the shift supervisor and administration is made aware and a searched is initiated. An interview with the maintenance mechanic and assistant superintendent indicated there were no instances of tools being missing within the past six months. A review of the Department's Central Communications Center (CCC) reports found there were no tools lost in the past six months. The center ensures positive identification of service vendors prior to allowing access to the secure area and vendors are never left alone without the presence of detention staff. Youth are removed from the area being serviced and not allowed to re-enter the area until the area has been searched and cleared by staff. The vendor tools are checked to ensure they leave with what they entered with.

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

The center has a written policy and procedures prohibiting the use or access of tools to the youth. The youth are permitted to use mops and brooms under staff supervision. Seven youth were interviewed and each confirmed youth are only allowed to use mops and brooms. All seven youth reported staff spray or pour the cleaning items prior to using mops and brooms as youth used safety gloves to wipe down the areas. Observations of two youth cleaning confirmed no youth sprayed or poured the cleaning liquids during cleaning while under staff supervision. Seven staff were interviewed and each stated youth are not allowed to clean with substances contained toxic, flammable, and/or poisonous.

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

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

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

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

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

The center maintains a written policy and procedures to ensure the proper storage and inventory of flammable, toxic, caustic, and poisonous items. Observation of the storage area indicated all items matched the inventory list and are stored in a locked shed located outside the secure area of the facility. No youth are allowed in the storage area at any time. All materials were found to be properly labeled, stored in a well-ventilated area, and away from youth and staff. All items listed in the Safety Data Sheet (SDS) were present along with a logbook to document all items being used and removed from the area. Only authorized staff have access to this area. All chemicals are inventoried monthly and the inventories were completed consistently for the past six months.

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's policy and procedures forbid youth from handling any hazardous materials. All toxic items are stored in a locked storage portable outside the detention center, which is inaccessible to youth. The access to the locked storage portable is limited to the center's maintenance staff, administrators, and supervisors are permitted access to flammable, toxic, caustic, and poisonous items. A list of authorized staff with access to this area is clearly posted and no youth are listed. Seven staff were interviewed and each reported youth are not allowed to handle and have access to flammable, toxic, and poisonous items. Seven youth were interviewed and each confirmed youth are not allowed to handle or use hazardous chemicals.

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 has a written policy and procedures to address the disposal of all flammable, toxic, caustic, and poisonous items. The center disposes hazardous chemicals in accordance with the manufactures Safety Data Sheet (SDS). All items are secured away from the youth and the staff. Maintenance staff, administrators, and supervisors are the only staff with access to chemicals. The maintenance mechanic at the facility reported there were no chemicals disposed of but florescent light bulbs have been disposed of within the past six months. The facility food director reported the center does not utilize grease or oil for cooking. All kitchen liquid waste is disposed in the kitchen drain. The center utilizes an outside vendor to clean the drain trap and lift station. A review of invoices for the past six months verified the trap is cleaned quarterly. According to the center's administration staff, there has not been an exposure of any such items, nor have there been any instances of chemical spills within the past six months.

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 has a policy and procedures to address confinement of youth under a twenty-four-hour period. The center utilized the youth's room to place youth in confinement when needed. A review of thirty-two confinement reports and visual observations during the annual compliance review week indicated the center's practice is in adherence with their policy with the exception of one incident. There was one incident of a youth placed in confinement whereby the placement extended past the twenty-four hours by twenty-two minutes. The intent of the confinement was to have the duration under twenty-four hours. Once the error was discovered, the supervisor received corrective action in the form of a retraining memorandum dated August 11, 2020 as further demonstration of the intent to have confinement under twenty-four hours. Reviewed documentation for all thirty-two confinement reports confirmed each youth's room was searched and all items were removed prior to youth being placed in their room for confinement. All thirty-two reviewed confinement reports indicated each was completed within one hour and submitted to the juvenile justice detention officer supervisor (JJDOS). The JJDOS reviewed each report within two hours of the initial placement and at least every three hours thereafter. Twenty-eight of the thirty-two logs reflected visual observation was conducted in accordance with policy. Three of the logs had discrepancies in their ten-minute checks. The superintendent and/or designee reviewed all of the thirty-two confinement reports within forty-eight hours. Seven staff were interviewed and each were able to explain the process and what to do when youth are placed in confinement.

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 has a written policy and procedures outlining requirements for confinements over twenty-four hours. A review of the Facility Management System (FMS) found there were no confinements which were applicable to being over twenty-four hours. The superintendent was interviewed and stated confinements are reviewed through the FMS by the superintendent and are reviewed monthly by the regional director.

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 to ensure a plan is in place to manage various emergencies and disaster events. The continuity of operations planning (COOP) drills are required to be conducted twice a year. The evacuation plan is included in the COOP plan. Reviewed documentation verified there were two COOP drills conducted, as required. A hurricane drill was conducted on May 20, 2020 and a chemical spill drill was conducted on December 6, 2020. Reviewed drill forms indicated each form contained written scenarios, staff participation signatures, and critique forms. Seven staff were interviewed on the various type of drills they participated in the past six months. Each staff reported participating in a fire drill. Six staff reported participating in escape, medical, and mental health drills. Four staff reported participating in chemical spill and weather drills. Three staff reported participating in flooding and major disturbances drills. Two staff reported participating in hostage situations and one staff reported participating in terrorism and bomb threat drills. Drills are also reviewed during monthly management meetings and during shift briefings. An interview with the center's superintendent reflected the center has a plan which includes procedures to follow in the event an evacuation is ordered. The center is required to conduct two COOP drills annually, with one conducted at the beginning of the hurricane season. When a drill occurs, the telephone tree is activated and all staff are required to participate in the drills. All drill documentation is uploaded into SharePoint.

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

The center maintains a written policy and procedures to ensure it is prepared to address youth escapes. A review of the prevention plan indicated all required elements outlined in the Department's policy. Provided documentation indicated escape drills are required to be conducted once each quarter. A review of the center's escape drill for the past six months along with corresponding logbook entries verified the center exceeds the requirements and conducts

drills monthly. Additionally, staff sign a roster acknowledging they participated in the drill. A review of seven staff training records verified annual escape training was completed by each reviewed staff. Seven staff were interviewed regarding drill participation within the past six months and each reported they participated in an escape drill.

5.19 Fire Drills	Limited 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 maintains a written policy and procedures for addressing fire prevention and safety. The center's fire prevention and safety plans were reviewed and approved by the state fire marshal on October 27, 2020. The center has evacuation egress plans posted throughout the center. Each egress plan defined primary and secondary exit route and the locations of emergency equipment; such as fire extinguishers and first aid kits. A review of the emergency drill and logbook documentation for the past six months found the center conducted fire drills each month, on each shift, during different times except for the following dates and shifts. On the Alpha-shift, the drill report and sign-in sheet was missing for September 2020. On the Bravo-shift, the sign-in sheet for January 2020 was missing and for C-shift, the drill reports and sign-in sheets were missing for February, April, May, and September 2020. The center's sign-in sheets confirmed a fire drill was conducted for Charlie-shift on June 2020; however, the drill report was missing. Drills are also reviewed during staff meetings and shift briefings. Seven staff were interviewed and each confirmed fire drills were conducted monthly. Seven youth were interviewed and six reported they had been instructed on what to do in the case of a fire. One interviewed youth was recently admitted to the center.