STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Southwest Florida Regional Juvenile Detention Center

Department of Juvenile Justice

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

Review Date(s): July 16-19, 2019

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:

Marissa Stress, Office of Program Accountability, Lead Reviewer (Standard 1)
Rondarrell George, Office of Program Accountability, Regional Monitor (Standard 3)
Douglas Kane, St. Lucie Regional Detention Center, Juvenile Justice Detention Officer Supervisor (Standard 5)
Patrick Morse, Office of Program Accountability, Regional Supervisor (Standard 4)
Joey Nice, DJJ Office of Education, Education Coordinator (Key Indicators 2.13 & 2.14)
Allis Richardson, DJJ Probation, Circuit 19, Senior Juvenile Probation Officer (Standard 2)

Program Name: Southwest Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: Lee County / Circuit 20
Review Date(s): July 16-19, 2019

MQI Program Code: 1046
Contract Number: NA
Number of Beds: 50
Lead Reviewer Code: 178

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.05 Protective Action Response (PAR)	5.14 Confinement Over Twenty-Four Hours
1.07 In-Service Training	
5.13 Confinement Under Twenty-Four Hours	

Standard 1: Management Accountability
Detention Rating Profile

Indicator Ratings

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

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

Standard 2: Youth Management
Detention Rating Profile

Indicator Ratings

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

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

Indicator Ratings

Standard 3 - Mental Health and Substance Abuse Services		
3.01	Designated Mental Health Clinician Authority (DMHCA)	Satisfactory
3.02	Licensed MH/SA Clinical Staff *	Satisfactory
3.03	Non-Licensed MH/SA Clinical Staff	Satisfactory
3.04	MH/SA Admission Screening	Satisfactory
3.05	MH/SA Assessment/Evaluation	Satisfactory
3.06	MH/SA Treatment	Satisfactory
3.07	Treatment and Discharge Planning	Satisfactory
3.08	Psychiatric Services *	Satisfactory
3.09	Suicide Prevention Plan *	Satisfactory
3.10	Suicide Prevention Services *	Satisfactory
3.11	Suicide Precaution Observation Logs *	Satisfactory
3.12	Suicide Prevention Training *	Satisfactory
3.13	Mental Health Crisis Intervention Services *	Satisfactory
3.14	Emergency Care Plan *	Satisfactory
3.15	Crisis Assessments *	Satisfactory
3.16	Baker and Marchman Acts *	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/Exporsure 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	Ten-Minute Checks *	Satisfactory
5.03	Census Counts and Tracking	Satisfactory
5.04	Logbook Maintenance	Satisfactory
5.05	Logbook Reviews	Satisfactory
5.06	Key Control	Satisfactory
5.07	Vehicles and Maintenance	Satisfactory
5.08	Tool Inventory and Management	Satisfactory
5.09	Youth Access & Use of Tools, Cleaning Items *	Satisfactory
5.10	Inventory of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.11	Access to all Flammable, Toxic, Caustic, and Poisonous Items *	Satisfactory
5.12	Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.13	Confinement Under Twenty-Four Hours	Limited
5.14	Confinement Over Twenty-Four Hours	Failed
5.15	Continuity of Operations Planning (COOP) Drills	Satisfactory
5.16	Escape Drills	Satisfactory
5.17	Fire Drills	Satisfactory

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Program Overview

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

Standard 1: Management Accountability

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

The center maintains a written policy and procedures ensuring all Department employees, contractors, and volunteers are background screened prior to hire. Prior to hire, background screenings are conducted on all Department staff, contractors, volunteers, mentors, and interns. The center had eleven newly hired employees, three contractors, and one volunteer staff since the last annual compliance review. A review of eleven staff records and one applicable volunteer record confirmed background screenings were completed, by the Department's Background Screening Unit (BSU)/Clearinghouse, prior to each individual's date of hire and/or contact with youth or access to confidential information. Three contracted employee records were reviewed. Reviewed documentation showed one out of three contracted employee's background screening was not completed by the Department's BSU/Clearinghouse, prior to the staff's date of hire and/or contact with youth or access to confidential information. However, this contracted employee was originally hired at Collier Regional Juvenile Detention Center; and did not begin work at the Southwest Regional Juvenile Detention Center until cleared. None of the newly hired staff required an exemption. Each newly hired staff's Florida Department of Law Enforcement (FDLE), criminal history, Staff Verification System (SVS) module, and Central Communications Center (CCC) Person Involvement Report was reviewed. Each direct care staff is required to complete a pre-employment assessment and receive a passing score. The program had seven direct care staff who required a pre-employment assessment. Reviewed documentation confirmed a pre-employment assessment was completed by each newly hired direct care staff and a copy of the passing score was maintained in each staff's personnel record. The three contracted staff and one volunteer background screenings were processed and maintained in the Clearinghouse database. An Affidavit of Compliance with Level 2 Screenings Standard was submitted to BSU on January 14, 2019 and for school board teachers on December 14, 2018, meeting the annual requirement.

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

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

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

The center maintains a written policy and procedures ensuring all staff adhere to a code of conduct. The center utilizes the Department's employee handbook, which contains a code of conduct. Staff are required to adhere to a code of conduct which prohibits any form of abuse, profanity, threats, harassment, intimidations, or personal relationships with youth. Seven applicable staff personnel records were reviewed, and each contained a signed acknowledgement, receipt, and review of the Department's Code of Conduct and was conducted during their phase one training period. An additional three personnel records were reviewed for disciplinary action to meet the minimum sample size. Documentation found one staff received a five-day suspension, one staff received a written reprimand, and one staff was

terminated for violations of the Department's Code of Conduct. An additional three personnel records were reviewed for commendations to meet the minimum sample size. Documentation confirmed one staff received an Outstanding Service Award, one staff received the South Region Employee of the Quarter, and one staff received the Regional Food Support Worker of the Month award. A review of the internal incidents, Department's Central Communications Center reports, and Protective Action Response reports determined there were no incidents which should have been documented as a violation of a code of conduct but were not. An interview was conducted with the center's superintendent and confirmed the center adheres to a strict code of conduct inclusive of youth confidentiality, prohibiting staff horseplay, verbal or physical abuse, and any personal relationships between staff and youth. Seven staff were interviewed regarding the working conditions of the center. Five of the seven staff reported they have never observed a co-worker use profanity when speaking to a youth. Two of the seven staff reported they occasionally see a co-worker use profanity when speaking to a youth. Three out of seven staff reported the working conditions at the center in the past year have been good. Two out of seven staff reported the working conditions have been very good. Two out of out seven staff reported the working conditions have been fair. Seven youth were interviewed, and six reported staff are respectful when talking with them and other youth. One out of seven youth reported all staff are respectful except one staff. One youth reported this specific staff acts like one of the youth. The youth reported they had a one-on-one talk with the juvenile justice detention officer supervisor and staff member and is hopeful the situation will change. Each interviewed youth reported they have never heard staff use curse words when speaking with youth. Additionally, each interviewed youth confirmed they have never been threatened by a staff or seen a staff member threaten another youth.

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

The center maintains a written policy and procedures ensuring all incidents are reported to the Department's Central Communications Center (CCC). The center shall notify the CCC within two hours of a reportable incident or within two hours of becoming aware of the reportable incident. The center had thirty-five incidents reported to the CCC since the last annual compliance review. The center had forty-two incidents reported to the CCC during the period of July 2017 through June 2018 and thirty-five reportable incidents in the July 2018 through June 2019 period demonstrating a reduction in reported incidents. The center had nineteen incidents reported to the CCC during the last six months, of which five were reviewed. Documentation validated each incident was reported to the CCC within the mandatory two-hour time frame and in accordance with the CCC reporting procedures. The center maintains a master control logbook for documenting reports to the CCC. A review of the logbook validated all reports were documented. A review of internal incidents and grievances for the past six months determined there were no incidents which should have been reported to the CCC but were not. An interview was conducted with the center's superintendent and confirmed all staff must contact the Department's CCC within two hours of a reportable incident occurring. Additionally, all staff are mandated reporters and must contact the Florida Abuse Hotline if any abuse or neglect allegations are made. Seven staff were interviewed, and each confirmed youth are allowed to call the Florida Abuse Hotline and CCC to report suspected abuse. Five out of seven staff reported they notify a juvenile justice detention officer supervisor when an abuse or CCC call needs to be made. Two staff did not respond. Additionally, five out of seven staff reported they

are allowed to call the Florida Abuse Hotline and CCC to make a report. Two staff did not respond. Seven youth were interviewed, and each confirmed they have never been stopped from reporting abuse to the Florida Abuse Hotline. Seven youth were interviewed, and each confirmed they feel safe at the center.

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

The center maintains a written policy and procedures ensuring Protective Action Response (PAR) is in accordance with Florida Administrative Code. All administrators and officers shall be trained in PAR. A PAR report will be generated any time a PAR incident occurs. PAR reports shall include a review by a PAR certified instructor/supervisory staff, post-PAR interview, and a review of the PAR incident report by the superintendent or designee within twenty-four hours of the incident, excluding weekends or holidays. The center had eighty-six PAR reports completed since the last annual compliance review and nine reports were reviewed. Reviewed documentation confirmed each report included statements from all staff involved and completed by the end of the staff member's workday. A review of the PAR incident reports found documentation supported each report contained a review by a PAR-certified instructor and documented a post-PAR interview conducted within thirty minutes of the incidents. None of the reviewed reports required a Mechanical Restraint Supervision Log to be completed. None of the reviewed PAR reports alleged any injuries or required a PAR medical review. Documentation confirmed each report was reviewed and processed within the mandated time frame by a juvenile justice detention officer supervisor and PAR instructor to determine if the use of force was consistent with the center's procedures in each PAR report. Each post-PAR interview was dated, timed, and signed by the individual conducting the interview. Each post-PAR interview was filed in each youth's Individual Healthcare Record. None of the reviewed reports required a Mechanical Restraint Supervision Log to be completed. Reviewed documentation of nine PAR incident reports and comments by the superintendent or designee within seventy-two hours of the incident found five reports had late superintendent/designee reviews completed ranging from three to twenty-four days past due and two reports did not have any superintendent/designee review completed. Two reports reviewed had documentation which validated the superintendent/designee review was completed within the required seventy-two-hour time frame. None of the reviewed reports required a report to the Department's Central Communications Center (CCC), and there was no documentation to support any involved youth made a report to the Florida Abuse Hotline. Logbooks and internal incident/grievance reports were reviewed, and documentation did not reveal any additional PAR incidents occurred. The center's PAR rate during the annual compliance review period was 13.30, which is above the statewide Detention PAR rate of 11.75. The center had 217 PAR incidents during the period of September 2017 through July 2018 and 157 PAR incidents during the period of September 2018 through July 2019 period demonstrating a reduction in PAR incidents. An interview was conducted with the center's superintendent and confirmed PAR reports are entered in the Facility Management System (FMS). All PAR reports are reviewed by juvenile justice detention officer supervisors, the PAR instructor, and an administrator. Additionally, the center reviews logbooks and youth grievances regularly to determine if a reportable incident was not entered into FMS. Seven staff were interviewed, and each confirmed they use verbal techniques prior to using physical or mechanical restraints.

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

The center has a written policy and procedures ensuring all newly hired staff are trained in accordance with Florida Administrative Code within 180 days of hire. Pre-service training is divided into two phases. Phase one consists of instructor-led and web-based courses. Phase two consists of 120 hours of academy instructor-led training. Seven staff training records were reviewed for pre-service training. All reviewed records found two staff completed the certification process within 180 days of hire and five staff have not yet been employed 180 days. All reviewed records found each staff completed the required trainings inclusive of Protective Action Response (PAR), first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), mental health services, substance abuse services, suicide prevention, safety and security emergency plans, human trafficking, Department detention facility operations, supervision, active shooter, and Prison Rape Elimination ACT (PREA) prior to having any contact with youth. A review of seven training records found documentation to support each staff completed phase one training. Two out of seven staff completed phase two training and five staff are currently attending the academy and will complete phase two training prior to their 180 days of hire. All training was conducted by qualified trainers and documented in the Department's Learning Management System (SkillPro).

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

The center has a written policy and procedures ensuring all staff complete at least twenty-four hours of in-service training annually, including mandatory topics specified in Florida Administrative Code. The program has a written in-service training plan which was submitted to the Department's Office of Staff Development and Training on January 7, 2019 and approved on January 14, 2019. Seven applicable staff training records, which included three juvenile justice detention officer supervisors (JJDOS) training records, were reviewed for in-service training. Each staff training record documented the staff exceeded the twenty-four hours of in-service training requirements. Each staff had current certifications in first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), and Protective Action Response (PAR). Each staff also completed training in professionalism and ethics. Two out of seven staff did not complete one hour of the required six hours of suicide prevention training. One out of seven staff did not complete the annual active shooter training requirement. Three JJDOS training records were reviewed for completion of the eight hours of management and supervisory training inclusive of management, leadership, personal accountability, employee relations, communications skills, and fiscal. Reviewed documentation validated one out of three JJDOS did not complete any of the required supervisory training hours. All trainings were delivered by qualified trainers and documented in the Department's Learning System (SkillPro). An interview with the center's superintendent confirmed staff are required to attend suicide

prevention, PAR, CPR, and first aid training annually. The center maintains an annual training calendar which is updated to reflect any changes. The calendar was last approved by the Department's Office of Staff Development and Training on January 14, 2019.

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

Superintendents shall ensure Critical and Special Alerts are reviewed and responded to appropriately.

Upon completion of the Admission Wizard, the officer shall ensure all Critical and Special Alerts are listed in JJIS.

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

If the electronic system is inoperable, for any reason, the JJDO Supervisor shall ensure the last hard copy of the alerts shall have a written notification or update of the recent admissions or changes to existing alerts on the alert sheet and distribute to all staff within the center immediately.

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

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

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

The center maintains a written policy and procedures ensuring alerts are entered into the Department's Juvenile Justice Information System (JJIS) and the use of an internal alert system. Critical and special alerts are reviewed, updated, and responded to appropriately. Staff shall always keep a copy of the detailed alert list with them. An interview with the center's superintendent was conducted and confirmed medical alerts are entered at the time of admission and updated when necessary. Additionally, the JJIS alert reports and internal alerts are distributed and reviewed daily by the juvenile justice detention officer supervisors and administration. A current alert list is also maintained in the medical clinic and kitchen. During the annual compliance review week, an observation of a shift briefing was conducted which validated this practice. Seven staff were interviewed, and each confirmed they are made aware of alerts through alert forms and shift debriefings. Each staff confirmed management informs staff about issues throughout the center through staff debriefings. Five out of seven staff reported issues and information from management is distributed through all-staff meetings. Two out of seven staff reported communication of issues occurs through email. A review of seven youth records found each was applicable to have an alert entered into the program's internal alert system and the JJIS alert system. A review of the seven youth records found a total of twenty-two alerts which were required to be entered in the in internal alert system and the JJIS alert system. Reviewed documentation supported each youth had the appropriate alert entered into the internal alert system; however, four youth were classified as Vulnerable to Victimization and/or Sexually Aggressive and three out of four youth did not have the required Single Room

Only (SRO) alert entered into the JJIS alert system. However, each of the four-identified youth were placed appropriately in a SRO. The superintendent confirmed only medical staff can remove or downgrade a medical alert, only mental health staff are able to remove or downgrade a mental health alert, and only administrative staff can remove or downgrade safety and security alerts. Alerts are announced at shift briefings and hard copies are distributed to all direct care staff.

Standard 2: Assessment and Performance Plan

2.01 Admission	Satisfactory Compliance

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

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

The center maintains a written policy and procedures ensuring all youth are admitted into the center in accordance with Florida Administrative Code. The juvenile justice detention officer (JJDO) shall review all required paperwork and screenings at the time of admission. A JJDO of the same gender shall conduct an electronic, frisk, and strip search of the youth. The admitting officer is required to search and document all items in the youth's possession. All youth shall be allowed to place a telephone call to their parent/guardian and given another opportunity if their call is not successful. Seven youth case management records were reviewed. Six out of seven youth case management records had documentation to support an arrest affidavit was in the record. One youth case management record did not have an arrest affidavit in the record because the youth was transported to the center from another detention center. A detention/custody order was in the record. Six out of seven reviewed case management records contained a Detention Risk Assessment Instrument (DRAI). One out of seven records did not have a DRAI in the record as the youth was transported to the center from another detention center and did not require to have one completed for the youth's admission. Each reviewed youth record contained the Suicide Risk Screening Instrument (SRSI). Each reviewed record included documentation which validated each youth was searched by a staff member of the same gender, the youth were provided a meal, and received a medical, mental health, and substance abuse screening. Six out of the seven records reviewed had documentation to support the youth were offered telephone calls to their parents/guardians, which were completed. One record had documentation to support an attempt to notify the parent/guardian was made by the JJDO staff, but in the Admission Phone Call section, the option "no" was selected with no note of a refusal or attempt in this field. An observation of an admission process was conducted during the annual compliance review week. The JJDO reviewed the arrest affidavit, DRAI, and custody order. The youth was searched by a same gender JJDO staff member. The youth viewed the Prison Rape Elimination Act (PREA) video and was given the opportunity to ask any questions in which the youth did not have any. The JJDO offered the youth to make a telephone call to their parent/guardian in which it was conducted. The JJDO verified the parent's/guardian's information about what was documented on their Juvenile Justice Information System (JJIS) Face Sheet and contacted the youth's parent/guardian. The JJDO inquired of the youth's mental health and medical history with the youth's parent/guardian and provided an opportunity for the parent/guardian to relay any pertinent information to the JJDO. The youth was then given the opportunity to converse with their parent/guardian and was appropriately timed and monitored. The SRSI was preliminarily started by the juvenile probation

officer screener and the JJDO completed the required detention section on the form. The youth was screened to identify medical, mental health, and substance abuse requirements. The youth was provided a shower, standard detention clothing and shoes, and provided a meal. The youth was placed on standard observation, given the opportunity to brush their teeth in the Boys Module, and promptly transported to the classroom to follow the daily activity schedule. The youth was observed respectful and cooperative throughout the process. An informal interview was conducted with the youth. The youth advised the admission process was well paced and the staff provided all the information they felt they required for their stay.

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

The center maintains a written policy and procedures ensuring youth are advised of the center's rules and regulations, expectations of behavior and related consequences for failing to meet those expectations and youth rights within twenty-four hours of being admitted into the center. Seven youth case management records were reviewed, and each record included an orientation packet which was completed within twenty-four hours of admission. Each reviewed record had documentation to validate the orientation was explained verbally and in writing by the juvenile justice detention officer (JJDO). Each youth signed the orientation packet acknowledging they received the packet. Each orientation packet included information on rules and regulations, youth rights, visitation, telephone calls, grievance procedures, access to medical, mental health, and substance abuse services, access to the Florida Abuse Hotline, Department's Central Communications Center, and the behavior expectations and consequences. The packet further reviews the possible behavior related consequences as level drops, privilege restrictions, confinement, and possible new law violations for property damage, and assault/battery. The orientation packet also includes information for positive reinforcement such as level increases and privileges which entail telephone calls, additional snacks, and later bed times. Seven youth were interviewed regarding the orientation process, and each youth confirmed they were provided information regard the center's rules and regulations, daily schedule, education services, medical and mental health availability, visitation days and times, process of abuse report, filing a grievance, and behavior management system. There was no orientation video available at the center to observe. A youth admission was observed during the annual compliance review, but an orientation was not observed. The youth was interviewed and reported receiving orientation prior to admission paperwork.

2.03 Classification	Satisfactory Compliance

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

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

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

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

The center maintains a written policy and procedures ensuring all you admitted into the center are classified to ensure the highest level of safety and security. The center considers several factors prior to placing youth into a room inclusive of height, weight, age, gender, level of aggression, mental illness, development disabilities, physical disabilities, history of violence, gang affiliation, criminal history, history of sexual offenses, vulnerability to victimization, suicide risk identified or suspected, medical, and security and escape risk. A review of seven youth case management records were reviewed for classification. Each reviewed record contained a copy of the Department's Juvenile Justice Information System (JJIS) Admission Wizard documentation, which included the classification results and the Screening for Vulnerability for Victimization and Sexually Aggressive Behavior (VSAB) form. Each reviewed classification form had documentation with the results which showed considerations for the youth's gender, height, weight, age, level of aggressiveness, mental illness, intellectual abilities, physical abilities, history of violent behavior, gang affiliation, criminal behavior, history of sexual offenses, medical status, suspected suicide risk or identified risk, and security and escape risk. Seven youth case management records contained the VSAB form. Each reviewed record was assessed for classification using the VSAB, Secure Detention Admission Wizard, the youth's offenses/charges, active and closed alerts, and the Suicide Risk Screening Instrument. Two out of the seven youth were placed on standard supervision. One out of the seven youth was placed on constant supervision and subsequently stepped down to standard supervision upon evaluation from the psychiatrist. Four out of the seven youth were placed in single occupancy rooms due to sexually aggressive behavior, vulnerability to victimization, or history of sexual offenses. Three out of the four youth classified were placed in single occupancy rooms and did not have the Single Room Occupancy (SRO) alert place in JJIS. An informal interview was conducted with the center's superintendent. The superintendent stated if a youth is a documented gang member verified by law enforcement, an alert will be entered by either the

superintendent or assistant superintendent. The on-duty juvenile justice detention officers are briefed of all alerts and pertinent information during the shift briefing and provided a list of active alerts for the youth currently in their population. An updated alert list is provided for all staff on active duty, along with any updated changes as needed.

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

The center maintains a written policy and procedures ensuring all information regarding suspected gang involved youth admitted into the center shall be shared with the circuit gang representative by email. The center has designated one of the assistant superintendents to serve as the gang representative for the center, to share information regarding suspected gang activity. The assistant superintendent notifies the juvenile probation officer (JPO) representative, superintendent, the juvenile probation officer supervisor (JPOS), and a liaison for Lee County's Sheriff's Office on any gang activity by electronic mail. The center is required to enter the "other suspected gang affiliation" alert into the Juvenile Justice Information System (JJIS) if there is a youth suspected to have gang affiliation. Alerts are shared with staff daily at shift briefings. Seven youth case management records were reviewed, and none were applicable for gang involvement. Additional records were requested from the center to meet the minimum sample size. Two youth case management records were identified as gang involvement in the last twelve months. Each reviewed record contained a corresponding email to a liaison from the Lee County Sheriff's Office, the assigned JPO, and JPOS. The email included a description of the incident and a copy and/or picture of the depiction of the gang affiliated event.

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

The center maintains a written policy and procedures ensuring youth personal property is maintained securely and returned to them in a timely manner upon their release. The youth's property is itemized and documented in the personal property receipt form Juvenile Justice Information System (JJIS) module. The form is printed and verified by the youth for accuracy. Any personal valuable items, such as money, cellular phones, and/or jewelry are placed in a clear, tamper proof bag. The tamper proof bag includes the date, name of the youth, Department of Juvenile Justice Identification Number (DJJID), and a list of the items written on the bag. The date, youth's name, time, DJJID, and name of the juvenile justice detention officer (JJDO) which secured the property is written in the center's drop safe logbook. The youth's clothing and shoes were placed in a garment bag and identified with the youth's name, DJJID, and list of included items. The garment bag is placed in a secure garment room located in the intake processing unit. Seven youth records were reviewed. Five out of the seven records

contained an itemized personal property receipt forms signed by the youth and staff member and two did not. Six out seven records had a letter of acknowledgement regarding unclaimed property which was signed by the youth and one did not. Two out of seven records were applicable for valuable property taken during admission. The property was documented on their itemized personal property receipt form and was signed by the youth and staff member. The personal property was logged into the logbook and the items were placed in a tamper proof clear bag. All items were labeled appropriately with the youth's name, DJJID, name of the staff securing the property, staff's initials, date and a listing of the items in the bag. The tamper proof bags were stored in a secure lockbox in master control in which only the superintendent, assistant superintendent, and juvenile justice detention officer supervisors (JJDOS) have access to and the valuable property receipt was placed in the youth case management record. None of the youth refused to sign property receipt forms. An admission process was observed during the annual compliance review week. Observations revealed the JJDO searched and frisked the youth and took custody of any valuable property, inclusive of a belt and wrist watch. The items were already placed in a clear tamper proof bag during their screening process at the juvenile assessment center (JAC) earlier. The JJDO verified the items in the bag with the youth and prepared another clear tamper proof bag for transfer. The JJDO documented the date, time, youth's name, DJJID, and valuable items onto the bag. The items were transferred from one bag to another, securely closed, and the JJDO had the youth verify the information written on the bag and sign. The JJDO then documented the date, youth's name, DJJID, time and their initials in the logbook. The property was then securely stored in a safe for secure transport by a superintendent to master control. The JJDO then proceeded to inventory the clothing and other property in which the youth came into the center with to include a shirt, pants, socks, underwear, shoes. The information was documented on the Property Receipt form in the Juvenile Justice Information System (JJIS). The form was printed and the JJDO had the youth verify the list to be correct and upon verification, the youth signed and dated the form. The JJDO then signed and dated the form. The JJDO escorted the youth to a bathroom in which the youth unclothed, was searched once again, and provided a shower. The youth was then given standard detention center clothing and shoes, and the JJDO then took custody of the youth's personal clothing. The youth's personal clothing was then placed in a garment bag, zipped, and labeled with the youth's name, DJJID, and a list of items in the garment bag. The bag was then placed in a secure room located in the intake processing unit. The door was monitored by camera surveillance. The storage room is securely locked, and all staff have keys for access. Seven youth were interviewed regarding the admission process, and each reported staff checked their personal property upon admission, and youth signed a form stating their personal property is inventoried. An informal interview was conducted with the superintendent regarding the admission process. The superintendent reported all youth have their personal property inventoried upon admission, items are stored in a tamper-proof bag, and both staff and youth must sign, date, and acknowledge all items are listed in the bag.

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

The center maintains a written policy and procedures ensuring youth's personal property is secure and returned to them in a timely manner upon their release. Observation of the center's storage area during the annual compliance review week found all applicable personal valuable property secured in a locked safe box under video surveillance in a clear tamper proof bag with the name, date, Department of Juvenile Justice Identification Number (DJJID), and itemized inventory list documented on the bag. The youth's clothing and shoes were placed in a garment

bag and secured in a locked room under video surveillance. Access to the youth's garment property is available by all pertinent staff for a timely distribution upon release. The youth's personal valuable property, which are initially stored in a locked safe box, is accessible by only the superintendent and assistant superintendent. Items are removed daily, logged and stored in a locked cabinet in master control until the youth is released, or the youth's parent/guardian reports to the center to take custody of the property. The property is relocated to a safe box in master control in which the juvenile justice detention officer supervisors have access to if the superintendent or assistant superintendent will not be available during a scheduled release. A review of the Department's Central Communications Central (CCC) reports for the past six months found no incidents regarding youth property. An interview with the center's superintendent was completed. The superintendent validated the center's property storage practice.

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 ensuring all releases from the center occur promptly and accurately. The juvenile justice detention officer (JJDO) completing the release shall verify the courts authorization to release the youth. The JJDO shall review all paperwork with the juvenile justice detention center supervisor (JJDOS) before releasing the youth. The JJDOS is responsible for verifying there are no holds, court orders, or other legal reasons not to release the youth from the center. Parents/guardians are confirmed, and a photo-identification is placed in the youth case management record prior to release. A review of three closed youth case management records validated the center's practice. Each reviewed record contained documentation to support the on-duty JJDOS reviewed all paperwork related to release inclusive of court paperwork prior to the youth's release. Each record contained documentation to support the youth was released to their parent/guardian; and a copy of the parent/guardian's driver's license and/or identification card was taken and placed in the record. Each record contained documentation to support the youth's identification was verified before the release process was started, youth and parent/guardian were reminded of any future court dates, and all parties signed required release forms. Each reviewed record had documentation which confirmed the admission date and termination date in the case record correlated with the Department's Juvenile Justice Information System. An observation of a youth release was conducted during the annual compliance review week. The youth's identification was verified by the JJDO and the JJDOS. The parent/guardian's identification was verified, and a copy of their

driver's license was taken. The JJDOS called the medical staff and verified if the youth was to be released with medication. The medical staff secured the youth's medication in a clear plastic storage bag and prepared written aftercare instructions. The medical staff released and verified the medication with the parent/guardian and verbally instructed the parent/guardian with the aftercare instructions. The instructions were also given in written form. The youth was processed for release and presented with their personal and valuable property. The youth verified receipt of all documented property listed on the property receipt form and youth and parent/guardian signed the form. The Release Wizard was completed and signed by the youth and parent/guardian. The youth and parent/guardian were notified of any future court dates and/or instructions given by the courts as documented by their court order. A copy of the court order was presented to the youth and parent/guardian to ensure proper service of future court dates and instructions. A review of the Department's Central Communications Center (CCC) reports from the past six months found there were no documented unauthorized releases at the center.

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

The center maintains a written policy and procedures ensuring youth's property is maintained securely and released from detention promptly and accurately. Staff, youth, and the parent/guardian review and sign the property release form at the time of release. Three closed youth case management records were reviewed. Each record contained documentation validating the youth and parent/guardian signed the property receipt acknowledging receipt of each youth's personal property. An interview with the center's 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. Additionally, the superintendent explained the practice regarding unclaimed property. Youth sign a Property Letter of Acknowledgement form upon admission making them aware of the process. A letter is mailed to the youth, parent/guardian, and the assigned juvenile probation officer (JPO) regarding any property not claimed after thirty days of release. The center makes every effort to return property. Personal property not claimed is inventoried and can be disposed of to a local non-profit charity. A review of inventoried property which was not claimed by the youth and parent/guardian was reviewed during the annual compliance review week. Documentation reviewed supported a notice was mailed to the youth and parent/guardian with a copy of the signed property receipt form. An observation of a youth release was conducted during the annual compliance review week. The youth's identification was verified by the JJDO and the JJDOS. The parent/guardian's identification was verified, and a copy of their driver's license was taken. The JJDOS called the medical staff and verified if the youth was to be released with medication. The medical staff secured the youth's medication in a clear plastic storage bag and prepared written aftercare instructions. The medical staff released and verified the medication with the parent/guardian and verbally instructed the parent/guardian with the aftercare instructions. The instructions were also given in written form. The youth was processed for release and presented with their personal and valuable property. The youth verified receipt of all documented property listed on the property receipt form and youth and parent/guardian signed the form. The Release Wizard was completed and signed by the youth and parent/guardian. The youth and parent/guardian were notified of any future court dates and/or instructions given by the courts as documented by their court order. A copy of the court order was presented to the youth and parent/guardian to ensure proper service of future court dates and instructions.

Examples of logs and receipts were reviewed, and an observation of a release process was observed 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 ensuring prescribed medication, along with medical instructions accompany detained youth upon release. The center utilizes the Department's Medication Receipt for youth being release with medication. Three closed youth case management records were reviewed. Each reviewed record contained a receipt of medication, signed by the parent/guardian or receiving Department staff, the type of medication, strength, dosage, quantity, any health or welfare issues regarding the medication, and any pending medical appointments. An observation of a release during the annual compliance review confirmed the center's practice.

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

The center maintains a written policy and procedures ensuring detention reviews are conducted weekly for youth securely detained, placed on home detention, or electronic monitoring, to ensure proper management of youth and the sharing of information. A review of the detention review census report confirmed the center has had weekly detention reviews for the past six months. Throughout the review cycle period, the Department confirmed the center is no longer responsible to maintain notes on the detention review form and it is the Office of Probation and Community Intervention's responsibility to ensure the notes are updated in the Department's Juvenile Justice Information System (JJIS). An interview with the center's superintendent was conducted. The superintendent reported the detention review officer coordinates case reviews of all youths in the center's care and on home detention. Medical, mental health, commitment placement staff, as well as probation personnel all attend weekly meetings.

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

The center maintains a written policy and procedures ensuring youth are constructively involved in activities and adhere to a daily schedule. The center's superintendent develops a daily schedule, which is posted in each living area and outlines the days and times for each activity. Wake up time starts at 6:45 a.m. every day and bedtime begins at 8:00 p.m., depending on the youth's level. Posted schedules included personal hygiene, meal times, visitation times, education, recreation and physical activities, indoor activities, shift changes, bed times, groups shift changes, and open program times. Every activity was appropriately documented with the type of activity and the time frame of each activity. Visitation times are twice a week. Indoor activities promote education and problem-solving skills. Observations during the annual

compliance review week revealed schedules are posted throughout the center in each living module. A review of the center's logbook and observations confirmed the center adheres to the daily activity schedule. Seven youth were interviewed regarding the daily activity schedule, and each reported there is a daily activity schedule in the center. Six out of seven youth reported the staff follow the daily schedule each day. One youth reported the schedule sometimes is not followed by the Bravo-shift. Seven staff members were interviewed regarding the daily activity schedule, and each stated the daily schedule is followed. Six out of seven staff members stated there are restorative justice activities. Four out of seven staff members reported the facility offers gender-specific programming. Three out of seven staff members reported there were no gender-specific programming activities. However, the reviewed daily schedule provides for gender-specific programming.

2.12 Adherence to Daily Schedule	Satisfactory Compliance

Center staff shall adhere to the daily activity schedules. Documentation of all activities shall be made in all applicable logs.

The on-duty supervisor must approve any significant changes in the activity schedule and shall document the reason for the change(s) in the shift report.

Any cancellation of visitation shall be approved by the superintendent.

The center maintains a written policy and procedures ensuring the staff follow a daily activity schedule. Changes to the schedule require approval from administration. The daily activity schedule, logbooks, and movements were observed during the annual compliance review week. Reviewed logbooks and daily movements validated the center is adhering to the daily activity schedule. Seven staff were interviewed regarding the daily activity schedule. Each staff reported the daily activity schedule is followed every day. Seven youth were interviewed regarding the daily activity schedule. Six out of seven youth confirmed the daily activity schedule is followed each day. One out of seven youth reported the schedule is not followed on Bravo-shift.

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 integrates career and academic education instruction into the daily schedule to ensure the integrity of required instructional time. The center ensures daily education for qualified youth through Lee County Public School system. The Lee County Department of Juvenile Justice school schedule for the detention center, as well as the center's daily schedule support the required 250 days (with ten days used at teacher training and/or planning) days of instruction for the year and twenty-five hours of instruction weekly. Educational instruction is scheduled Monday through Friday in the on-site portable classrooms. 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. There were no on-site observations during the annual compliance review week to suggest the educational experience was unduly interrupted or suspended for any length of time. Seven staff were interviewed regarding educational interference, and each

staff reported there is minimal interference during educational instruction time. Seven youth were interviewed regarding educational classes, and each reported the center offers educational classes. Six out of seven youth reported they attend classes Monday through Friday. One youth reported to have completed a General Education Diploma (GED). Six youth reported taking math and reading classes. Five youth reported taking science class. Three youth reported taking computer class. Two youth reported taking social studies and history. One youth reported taking life skills, career choices, and English classes.

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

The center maintains a written policy and procedures ensuring the development and implementation of a career competency program. The center collaborates with the Lee County Public School system to ensure implementation of Type 1 career education competency programming. Career education programming is based on the age, assessed educational abilities, the goals of the youth and the typical length of stay to which each youth is assigned. Career education programming in the center integrates communication, interpersonal, decision-making and personal accountability skills and behaviors leading to development of work habits which lead to maintaining employment and living standard.

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

The center maintains a written policy and procedures ensuring there is a uniform behavior management system (BMS) offering a predictable set of rewards, privileges and consequences for behavior. The center has a system of rewards, privileges, and consequences to motivate youth to meet the center's expectations. Observations conducted during the annual compliance review week revealed the center has the BMS system posted in both living modules. The postings specify appropriate behaviors and rewards for such behavior, and inappropriate behavior and consequences for such behavior. The postings also reflect the rules, norms, and expectations of the center. Youth are informed of the BMS during the admission process through an orientation. The BMS is a three-level system. Each youth enter at level two when admitted, and their level moves up or down, depending on their behavior in the center. Youth on level three can earn extra privileges such as pizza and ice cream. The assistant superintendent also rewards level-three youth by selecting a Youth of the Week. Youth levels are updated daily on their level sheets. Youth can view their status and are able to ask questions, if needed. Inappropriate behavior is also documented in the center's logbooks. A review of the level sheets and logbooks confirmed the center's practice. Seven youth were interviewed regarding the BMS. Four youth stated the BMS is very good. Three youth stated the BMS is good. Three youth reported the consequences they received in the center were fair. One youth reported the

consequence they received was not fair. Three youth reports they have never received a consequence during their admission into the facility. Seven staff members were interviewed regarding the BMS. Six staff members reported they feel the BMS is effective. One staff member reported they do not feel it is effective as most of the youth are repeat offenders and are familiar with the system. The staff member reported “it does not mean a lot to them.” Seven staff stated they speak to the youth to discuss the consequences being imposed and alternative acceptable behavior. Each interviewed staff stated the youth are provided an opportunity to explain their behavior. Five staff reported points can be taken away as a consequence. Seven staff stated the loss of a level can be taken away as a consequence. Seven staff members stated the juvenile justice detention officer supervisor provides feedback to the staff regarding their implementation of the BMS as needed.

2.16 Unauthorized Use of Punishment (Critical)	Satisfactory Compliance

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

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

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

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

The center maintains a written policy and procedure ensuring group and corporal punishment is prohibited. Youth are not allowed to discipline other youth at the center. All allegations of corporal punishment on any youth by detention center staff shall be reported to the Florida Abuse Hotline and the Department’s Central Communications Center (CCC). Seven staff were interviewed, and each reported meals, snacks, sleep, or school cannot be taken away as a consequence for inappropriate behavior. Each interviewed staff reported they have never seen another co-worker deny meals, snacks, sleep, or school from a youth as a consequence for inappropriate behavior. Each interviewed staff denied ever seeing another staff member encourage another youth to beat up another youth. Seven youth were interviewed regarding consequences in the center. Three youth stated levels are downgraded. Two youth stated points are taken away. One youth stated there were no consequences. Three youth reported they have never received any consequences at the center. Each interviewed youth stated they are not allowed to punish other youth. Four youth stated they have been sent to their room for punishment and three stated they have never been sent to their room. Two out of the four youth who reported being sent to their room stated their door was shut. Two out of four youth reported their door was shut and locked. Seven youth denied the use of handcuffs and leg irons in the center when a youth is out of control. An interview with the superintendent confirmed the center utilizes a three-level reward system to encourage positive behavior.

2.17 Grievances	Satisfactory Compliance

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

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

The center maintains a written policy and procedures ensuring all youth are treated fairly, respectfully, and without discrimination. The center ensures all youth have the right to file a grievance. The grievance process is posted in each module and explained to each youth during the admission and orientation process. An interview with the superintendent was conducted. The superintendent explained the grievance process in detail. The grievance process consists of three phases. The first step in the process is the informal phase which is completed by detention staff whereby the youth and staff attempt to resolve the youth's issue. A written grievance will be submitted to the juvenile justice detention officer supervisor (JJDOS) if the staff is unable to resolve the issue which begins the formal grievance process. Next, the appeal phase requires a response from the superintendent or designee. Grievance forms are electronically kept in the Facility Management System (FMS) for at least one year. Observations conducted during the facility tour during the annual compliance review week found grievance forms were in the B-module; however, in the G-module the forms were empty. The administration staff was made aware and the forms were replaced. Observations throughout the rest of the annual compliance review week found grievances forms in both living modules. Two grievances were filed in the last twelve months and both were reviewed. One out of two grievances were resolved at the informal phase. One grievance was forwarded to the on-duty JJDOS within the required time frame, through the FMS, and the youth was informed of the findings by the end of the shift. An interview with the superintendent explained all youth have the right to file a grievance if they feel their rights have been violated. Seven youth were interviewed regarding the grievance process. Six youth stated they have never submitted a grievance. One youth reported filing grievance during his stay in the center and rated the process as fair. Seven staff were interviewed, and each were able to describe the grievance process.

2.18 Trauma-Informed Care	Satisfactory Compliance

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

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

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

The center maintains a written policy and procedures ensuring trauma-informed care is incorporated into current operations and services with youth in custody. Center staff receive training in trauma-informed care as part of their pre-service and in-service requirements. 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 center has a functioning garden on the property which includes a tortoise, fish pond, fountains, flowers, and plants which are designed to help support youth who have experienced trauma. The center currently provides individual and group sessions with the youth in the center during their stay. The center is also piloting a new Transitional Intensive Mental Health (TIMH) program for qualified youth. The program is intended for youth who are pending placement to a commitment program. The youth receive three individual counseling sessions and five group counseling sessions each week. The center also started therapeutic drum circles, art therapy, and games to supplement the provided services. An interview with the center's superintendent was conducted. The superintendent confirmed the success of the center's newly started TIMH program.

Standard 3: Mental Health and Substance Abuse Services

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

The center maintains a written policy and procedures ensuring there is a single licensed mental health professional identified as the designated mental health clinician authority (DMHCA), who is responsible for the coordination and implementation of mental health and substance abuse services. The center has a licensed mental health counselor (LMHC) assigned to serve as the designated mental health clinician authority (DMHCA) who is responsible for the coordination and implementation of mental health and substance abuse services. The DMHCA is on-site forty hours a week, Monday through Friday, from 8:30 a.m. to 4:30 p.m., and on-call on weekends. The DMHCA has a clear and active license to practice in the State of Florida, verified on the Florida Department of Health website with an expiration date of March 31, 2021. An interview with the DMHCA confirmed they are responsible for ensuring the clinical quality and integrity of the therapeutic program as required by all applicable standards, regulations, and policies. The DMHCA has management and administrative oversight over mental health and substance abuse services throughout the center. The center has a contract with Maxim Healthcare Services, Inc. which subcontracts with Camelot Community Care, Inc., to provide comprehensive mental health and substance abuse services.

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 clinical staff are working under direct supervision and are providing services they are qualified based on education, training, and experience. The center's contract with Maxim Healthcare Services, Inc. provides for a regional mental and substance abuse clinical director for the south region, one full-time DMHCA, and a psychiatrist for approximately three hours each week. The psychiatrist is an osteopathic physician (DO) and is subcontracted with Camelot Community Care, Inc. Reviewed licenses for all licensed professionals found each maintained a clear and active license to practice in the State of Florida. The center's DMHCA is a licensed mental health counselor (LMHC). The reviewed LMHC license was free and clear in the State of Florida and expires March 31, 2021. A review of the psychiatrist's license confirmed a licensed DO with a specialty in child and adolescent psychiatry. The psychiatrist's license is free and clear in the State of Florida with an expiration date of March 31, 2020.

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

The center maintains a written policy and procedures to ensure services are provided by individuals with appropriate qualifications. The designated mental health clinician authority (DMHCA) ensures the center's non-licensed clinical staff are working under direct supervision and are providing services they are qualified based on education, training, and experience. The center employs a licensed DMHCA providing direct supervision to the center's two non-licensed master's-level registered mental health counselor interns who both are employed by Camelot Community Care, Inc. A review of the contract with Maxim Healthcare Services indicates the non-license mental health clinical staff shall have either a master's-level degree with a major in psychology, social work, or counseling and the non-license substance clinical staff shall have at least a minimum of a bachelor's-level degree with a major in psychology, social work, counseling, or a related human services field and work under the direct supervision of a licensed qualified professional. Reviewed records found the non-licensed clinicians are qualified to provide services based on their education, training, and experience. A review of training records supported both non-licensed therapists completing the center's Assessment of Suicide Risk form completed twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. The DMHCA provides weekly face-to-face clinical supervision, which includes directions, instructions, and recommendations to non-licensed staff. A review of the past six months of weekly direct supervision logs documented both non-licensed staff received weekly supervision. Each reviewed direct supervision note was documented on the Department's Licensed Mental Health Professionals and Licensed/Certified Substance Professionals Direct Supervision Log form and contained all required elements.

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

The center maintains a written policy and procedures ensuring mental health and substance abuse needs of youth are identified through a comprehensive screening process. The center utilizes a standardized screening process which includes review of the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) and the Suicide Risk Screening Instrument (SRSI). A review of seven youth records found documentation which validated each youth record had documentation to support the juvenile probation officer (JPO) administered the MAYSI-2 and the SRSI upon the youth's intake at the juvenile assessment center (JAC). All seven reviewed records documented the SRSI and MAYSI-2 detention section was completed by a juvenile justice detention officer (JJDO) in the Department's Juvenile Justice Information System (JJIS). The nursing and/or mental health staff completed the required sections of the SRSI in each of the seven reviewed records. Six out of the seven reviewed youth records were

identified as applicable for a need for further assessment based on the admission assessments. Each reviewed record had the summary and recommendations completed in full in the screening results section. Six out of the seven reviewed records were identified with an elevated suicide risk factor. Reviewed documentation validated each applicable youth was placed on precautionary observation (PO); and a mental health referral and notification to the superintendent was completed for each youth. Documentation reviewed validated each of the six applicable youth had an Assessment of Suicide Risk completed by the licensed or non-licensed trained clinical staff. An interview with the superintendent was conducted. The superintendent reported staff at the JAC screen the youth using the SRSI.

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

The center maintains a written policy and procedures ensuring the mental health and substance abuse evaluations identified through preliminary screening as having mental health and substance abuse issues receive in-depth mental health and substance abuse assessment shortly after intake. The mental health staff makes a request for the comprehensive assessment to the juvenile probation officer supervisor (JPOS) at the weekly detention review meetings held at the center. The center is responsible for establishing procedures to track the receipt of comprehensive assessments at the center. A review of seven youth mental health and substance abuse records found three out of the seven youth were referred by staff for a mental health and substance abuse evaluation. Reviewed documentation confirmed each of the three applicable records had completed evaluations by outside agencies completed within fourteen days of admission to the center.

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

The center maintains a written policy and procedures in place to ensure mental health and substance abuse treatment planning focuses on providing mental health or substance abuse which reduce or alleviate the youth's symptoms of mental disorder or substance abuse impairment and enable the youth to function adequately. Youth determined to have a serious mental disorder or substance abuse impairment and are receiving mental health and/or substance abuse treatment at the center must have an initial or individualized mental health or substance abuse treatment plan based off findings in the Comprehensive Mental Health and/or Substance Abuse Assessment/Evaluation, or Psychiatric Evaluation/Diagnostic Interview. Each youth determined to need mental health treatment, including treatment with psychotropic medications or substance abuse treatment while in the center, must be assigned to a mini-

treatment team. The mini-treatment team meets bi-weekly to discuss each youth receiving services. Reviewed mini-treatment team documentation supported each applicable youth was assigned to a mini-treatment team which consists of the designated mental health clinician authority (DMHCA), the center's administration, mental health and substance abuse staff, nursing staff, and juvenile justice detention officer staff. Observation of a mini-treatment team meeting during the annual compliance review week and an interview with the DMHCA validated the center's practice. A review of seven youth mental health and substance abuse records indicated six youth were applicable for mental health treatment services. Each of the six reviewed records were applicable for the youth receiving individual, group, or family mental health and/or substance abuse counseling. Each reviewed record showed the youth participated in treatment planning and treatment team meetings. Each of the reviewed records documented the service to be received and outlined the frequency of counseling services. Each of the six reviewed records contained a properly executed Authority for Evaluation and Treatment (AET) form and an additional consent for mental health, substance abuse, and/or psychiatric medications as required. A review of treatment notes showed all were documented on the Department's Counseling/Therapy Progress Notes form and maintained within the youth's electronic medical record. A review of the center's group therapy sign-in sheets for the past six months showed groups were being held at least bi-weekly. Sign-in sheets reflected the center was holding both mental health and substance abuse groups. Sign-in sheets supported all groups were limited to ten or fewer youth with mental health diagnoses for mental health treatment groups and fifteen or fewer youth with substance abuse diagnoses for substance abuse treatment groups. An interview with the DMHCA reported the center is a pilot site and has a new contract for a Transitional Intensive Mental Health Program. The program is intended for youth who are pending placement to a commitment program. The youth receive three individual counseling sessions and five group counseling sessions each week. The center also started therapeutic drum circles, art therapy, and games to supplement the provided services. Services are reviewed consistently by the DMHCA during the weekly supervision meetings to ensure fidelity and they are being delivered in a manner consistent with contractual requirements. Seven youth were interviewed regarding mental health and substance abuse services. Three youth reported receiving mental health and substance abuse services. One youth rated the services as good and two youth rated the services as very good. Four youth reported they have never received mental health or substance abuse services while at the center.

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

The center maintains a written policy and procedures ensuring mental health and substance abuse treatment planning focus on providing mental health treatment and/or substance abuse services which will reduce or alleviate the youth's symptoms of mental disorder or substance abuse impairment and enable the youth to function adequately. The center's superintendent and designated mental health clinician authority (DMHCA) or mental health and substance clinical

staff are responsible for ensuring the development and review of an initial and individualized mental health/substance health treatment plan of each youth receiving mental health/substance abuse treatment in the center. All youth receiving mental health and substance abuse treatment shall have a discharge summary completed documenting the focus and course of the youth's treatment and recommendations for mental health and/or substance abuse services upon the youth's release. A review of seven youth mental health and substance abuse records found six youth were applicable for requiring an initial treatment plan completed within seven days of initiation of treatment. Each reviewed record documented an initial treatment plan was documented on the Department's Initial Mental Health/Substance Abuse Treatment Plan form and contained all required elements. Each reviewed initial plan documented the reason for treatment, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, initial treatment methods, and initial treatment goals. Five out six reviewed records were applicable for psychiatric services. Each of the six reviewed records documented signatures by the mental health staff, youth, and team members involved in the development of the plan. There was no documentation in any of the records to confirm any of the youth were alleged victims of a Prison Rape Elimination Act (PREA) event. A review of seven youth mental health and substance abuse found six youth were applicable for individual treatment plans. Each reviewed plan supported each plan was developed by the thirty-first day of the youth's admission and was signed by the licensed mental health clinician within the ten-day required time frame. Each was signed the same day the plan was developed. Each reviewed individual plan identified the youth's DSM-5 diagnosis, symptoms which are treatment focused, treatment goals, strengths, and abilities. Five out of the six reviewed plans were applicable for psychiatric services and/or psychotropic medication monitoring and pharmacological interventions. A review of five youth which were applicable for psychiatric treatment found documentation to support psychiatric treatment and services are provided by a licensed psychiatrist. Documentation supported each reviewed record had progress notes which validated youth were receiving treatment services as outlined on the treatment plan. Each reviewed treatment plan had documentation which validated each plan was signed and dated by the youth, mental health staff, treatment team members, and parent/guardian. During visitation, clinical staff meet with the parent/guardian to discuss the treatment plan and obtain their signatures. When parents/guardians do not visit, attempts are made when the youth is released, and the parent/guardian picks up the youth. Clinical staff mail a copy of the plan for youth participating in the Transitional Intensive Mental Health Program requesting their review and provide a signature. The center conducts mini-treatment team meetings bi-weekly for applicable youth receiving mental health and substance services. Treatment teams consist of the DMHCA, the center's administration, mental health and substance abuse staff, nursing staff, and juvenile justice detention officer staff. A mini-treatment team was observed during the annual compliance review week which confirmed the center's participants and practice.

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

The center maintains a written policy and procedures ensuring psychiatric services are provided to youth in need. The center provides psychiatric services which include psychiatric evaluations, psychiatric consultations, medication management, and medical supportive counseling. The center maintains a contract with Maxim Healthcare Services, Inc. to provide mental health and substance abuse services. Maxim Healthcare Services, Inc., subcontracts with Camelot

Community Care, Inc., who subcontracts with a State of Florida licensed psychiatrist. Additionally, Maxim Healthcare Services, Inc. subcontracts with Camelot Community Care, Inc., to provide comprehensive mental health and substance abuse services and psychiatric services. The center's psychiatrist is a licensed medical doctor with a specialty in child and adolescent psychiatry. The psychiatrist's license was free and clear in the State of Florida with an expiration date of March 31, 2020. The psychiatrist contract requires on-site services three hours a week and each applicable youth is evaluated within fourteen days of admission. A review of the sign-in and sign-out logs validated the psychiatrist was on-site providing services as required. Seven youth records were reviewed. Five out of seven youth records were applicable for psychiatric services. Each of the five reviewed records were applicable for arriving with psychotropic medication prescribed and received a psychiatric evaluation within fourteen days of admission as required. The center completed an in-depth psychiatric evaluation for all youth. Each reviewed psychiatric interview documented the reason for referral, history, mental status examination, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, treatment recommendations, applicable prescribed medication, explanation of the need of psychotropic medication, and frequency of medication monitoring. Each reviewed psychiatric evaluation also included developmental history, psychiatric history, individual, contributing family or environmental factors, and the signature of the practitioner. The center completed an in-depth psychiatric evaluation which contained all the required elements on each of the five-applicable youth. None of the youth were applicable for a newly prescribed medication or change to an existing prescription; however, the third page of the Clinical Psychotropic Progress Note (CPPN) form was completed for all the youth. Each of the five records were applicable for the continuation of a prescription of psychotropic medication and documented the medication's identifying data, medication target symptoms, evaluation and description of effect of prescribed medication on target symptoms, prescribed medication, side effects, youth's adherence to the medication regime, youth's height/weight, laboratory findings, applicable parent/guardian contact, and the signature and date of the psychiatrist. Each of the five reviewed records contained documentation to support the monthly monitoring of Tardive Dyskinesia. Each reviewed record contained an active Authority for Evaluation and Treatment form. None of the reviewed records were applicable for youth in foster care or reaching eighteen while at the center and requiring additional consents. The center had no applicable youth for significant changes in dosage of the prescription of medications after admission. An interview with the center's registered nurse and psychiatrist explained the conservative practices were due to the extremely short-term care of the youth at the center. An interview with the center's psychiatrist during the annual compliance review confirmed twenty-four hour a day on-call availability, active communication with the center's mental health and medical staff, as well as fulfilling the role and responsibilities for the oversight of psychiatric care at the center. The center's designated mental health clinician authority (DMHCA) also reported the psychiatrist sees all youth admitted on psychotropic medication within two weeks of admission, and is responsible for monitoring concerns, side effects, and medication management.

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

The center maintains a written policy and procedures ensuring there is a suicide prevention plan is in place to safely assess and protect youth with elevated risk suicide in the least restrictive means possible, in accordance with Department's Rule 63N-1, Florida Administrative Code. The center's suicide prevention plan includes identification and assessment of youth at risk of

suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and review process. The plan was revised and approved by the center's superintendent and designated mental health clinician authority (DMHCA) on March 1, 2019. The plan is located in the mental health office, superintendent office, and is accessible to all staff on the center's K-drive.

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

The center maintains a written policy and procedures ensuring a suicide prevention plan is in place to safety screen, refer, assess, monitor, and protect youth with an elevated risk of suicide in the least restrictive means possible. All youth identified as having suicide risk factors by screening, information obtained from the youth, or staff observations must be placed on suicide precautions and receive an Assessment of Suicide Risk (ASR). Reviewed training records confirmed the center's mental health staff met the required training hours. A review of seven youth records showed six were applicable for a youth being placed on suicide precaution status upon admission as a result of the completed admission screenings. Each of the six records documented the completion of an ASR by the non-licensed master's-level clinician. Each record documented the immediate notification to the center's superintendent and/or designee and the completion of a Suicide Precaution Observation Log. No records were applicable for the youth being released from the center on precautionary observation (PO) status. Each record documented a referral was made to a mental health professional, an alert was entered into the Department's Juvenile Justice Information System (JJIS) and the youth was maintained on precautionary observation until assessed. Each of the records documented the youth was transitioned to standard supervision after the completion of an ASR, consultation with the designated mental health clinician authority (DMHCA), and the consultation with the center's superintendent and/or designee as outlined in the center's suicide prevention plan. None of the reviewed records were applicable for disciplinary confinement. A review of the center's master control logbook showed beginning and end times were documented for youth placed on precautions. The center did not have any instances of a youth attempting suicide or self-inflicting injury since the last annual compliance review; however, there is an established review process in place. Seven staff were interviewed regarding suicide prevention in the center. Each of the seven-staff stated they would contact mental health staff. Six staff reported they would maintain constant sight and sound supervision. Two staff reported they would document supervision. Four reported they would notify their supervisor. Two staff also reported they would search the youth and the youth's room for sharp objects. An interview with the center's superintendent was conducted. The superintendent reported the center only utilizes secure observation for potentially suicidal youth showing active aggression towards staff. The superintendent confirmed the center's practice is to have staff stand at the door maintaining constant monitoring of youth placed in secure observation. The superintendent stated the center

only utilizes secure observation for potentially suicidal youth showing active aggression towards staff. None of the reviewed records were applicable for youth being placed on secure observation status during this annual review period. According the DMHCA, the center had no applicable youth placed on secure observation since the last annual compliance review. An interview with the center's DMHCA explained the reporting procedures for youth placed on PO at the center. The DMHCA explained assigned juvenile probation officers and parents/guardians are notified of PO status and the mental health practitioner notes the contact in the chronological log. Additionally, it was reported the superintendent and/or designee are notified of any youth requiring PO status through face to face contact or by email. Seven youth were interviewed, and each reported never being placed on suicide precautions while at the center. Each interviewed youth reported never being left alone while on PO status.

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

The center maintains a written policy and procedures ensuring youth placed on suicide precautions must be maintained on one-to-one or constant supervision. 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. Seven youth records were reviewed and six were applicable for being placed on suicide precaution status upon admission. Each reviewed applicable record contained the Department's Suicide Precaution Observation Log with documentation of the youth's behavior in real time. Each reviewed log documented all observations at or below thirty-minute intervals. None of the reviewed records were applicable for warning signs which required notification to administration and/or mental health consultation. Each reviewed applicable record had logs which were reviewed and signed by the juvenile justice detention officer supervisor and mental health clinical staff daily. Informal interviews were conducted with the three youth, and each stated staff never left them alone while they were on suicide precaution status.

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

The center maintains a written policy and procedures ensuring all staff who work with youth must be trained to recognize verbal and behavioral cues indicating suicide risk, suicide prevention, and implementation of suicide precautions. All staff who work with youth must receive a minimum of six hours of annual training on suicide prevention and implementation of suicide precautions. A review of seven in-service staff training records found five out of seven staff received the required four hours of instructor-led and two hours of computer-based training of suicide prevention and implementation of suicide precautions training, in the Department's Learning Management System (SkillPro). The center is required to conduct mock suicide drills on each shift at least quarterly. All staff with direct youth contact must participate in at least one mock suicide drill semi-annually. A review of staff training records found each staff completed the required mock suicide drill and emergency response training as required. Staff members who are not present during a quarterly mock drill must have the opportunity to review each mock drill scenario and procedures during shift meetings. A review of the quarterly mock suicide drills since the last annual compliance review found drills were conducted quarterly on each shift

except for Charlie-shift. Charlie shift was missing a first quarter drill from July through September 2018. Documented use of life saving techniques such as cardiopulmonary resuscitation (CPR) was noted on the mock emergency drills conducted on Alpha-shift two times, Bravo-shift one time, and none for Charlie-shift. Each reviewed drill documented action by staff, provisions of contacting center staff and 9-1-1 when applicable, and provisions for life saving measures. The center's practice is to review all completed drills during monthly all-staff meetings. An informal interview with the designated mental health clinician authority (DMHCA) confirmed there were four suicide response kits at the center located in master control, medical clinic, and in both sub-control offices. Seven staff were interviewed regarding the suicide response kit, and each confirmed the locations of each kit.

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

The center maintains a written policy and procedures ensuring all staff must respond to youth in crisis in the least restrictive means possible to protect the safety of the youth and others while maintaining control and safety of the center. The program must be able to differentiate a youth who has an acute emotional problem or serious psychological distress from one who requires emergency services. The center's crisis intervention plan was inclusive of a notification and alert system, means of referrals including self-referral, crisis assessment and follow-up mental health status examination, communication, supervision, mental health supportive services, documentation, and review. The center's combined emergency services plan was reviewed and approved by the superintendent on March 04, 2019, and then by the designated mental health clinician authority (DMHCA) on March 05, 2019. The plan is maintained in the center's mental health office, master control, and juvenile justice detention officer supervisors' office.

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

The center maintains a written policy and procedure ensuring there is an emergency care plan outlining the mental health and substance abuse emergency procedures. The center is required to ensure youth who are believed to be an imminent danger to themselves or others, due to mental illness or substance abuse impairment, receive emergency mental health or substance abuse services. The center's emergency care plan was approved and updated on March 1, 2019 by the superintendent. The designated mental health clinician authority (DMHCA) approved the plan on March 5, 2019. The emergency care plan outlines the procedures for immediate staff response, notification and communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment under Chapter 394 Florida Statute (Baker Act),

transportation for emergency mental health evaluation and treatment under Chapter 397 Florida Statute (Marchman Act), return from emergency mental health or substance abuse services, documentation, training, and review. The center utilizes Salus Care, Colonial Campus in Fort Myers, Florida, for Baker Act crisis stabilization and for Marchman Act. The plan is maintained in the center's mental health office, master control, and the juvenile justice detention officer supervisors' offices. Seven staff training records were reviewed and confirmed seven staff received emergency care plan training.

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 maintains control and safety of the center. An interview was conducted with the designated mental health authority clinician authority (DMHCA) who confirmed the center has not had any applicable youth requiring a crisis assessment since the last annual compliance review. Seven staff training records were reviewed and confirmed staff received mental health crisis training as required.

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 staff immediately respond to youth who are believed to be an imminent danger to themselves or others as a result of mental illness or substance abuse impairment require emergency mental health or substance abuse services, to protect the youth and others from harm. An interview conducted with the designated mental health authority clinician authority (DMHCA) indicated the center had one applicable youth requiring Baker Act procedures since the last annual compliance review. A review of one applicable youth record found staff ensured youth safety and supervision pending Backer Act. A review of the record found the DMHCA completed the required forms for the Baker Act proceedings. The mental health staff, juvenile probation officer (JPO), and parent/guardian were notified of the emergency. The youth was placed on precautionary observation (PO) upon re-admission from Baker Act. A Mental Status Examination was also competed. The Department's Juvenile Justice Information System (JJIS) was updated, as required with the appropriate alerts. The youth remained on PO until released from the center. The center had no applicable Marchman Act procedures since the last annual compliance review.

Standard 4: Health Services

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

The center maintains a written policy and procedures ensuring there is a contract agreement with a licensed physician. The center maintains a contract with Maxim Healthcare Services who subcontracts with an osteopathic physician (DO) who holds an unrestricted license and meets all requirements for independent and unsupervised practice in the State of Florida. The DO has specialty training in internal medicine. The DO serves as the center's designated health authority (DHA) and is clinically responsible for the medical care of all youth. A review of the contract with Maxim Healthcare Services, Exhibit One, indicates the DHA shall provide two on-site hours each week conducting periodic evaluations, Comprehensive Physical Assessments, sick call referrals, and administrative duties. Interview with the DHA supported this practice. The DHA is on-site on Fridays from 10:00 a.m. to 12:00 p.m. and is available twenty-four hours a day, seven days a week for consultation. In addition, the contract provides for an advance registered nurse practitioner (ARNP) to provide six on-site hours each week. The ARNP is on-site on Tuesdays, from 8:00 a.m. to 4:00 p.m. On-site nursing coverage is provided Monday through Friday from 7:00 a.m. to 7:00 p.m. and on weekends from 8:00 a.m. to 8:00 p.m. The ARNP has Collaborative Practice Protocols in place with the DO. Reviewed attendance logs found the DHA was on-site weekly with no more than nine days between visits with the exception of March 22, 2019 through April 5, 2019. There was no documentation in the logs to support the DHA was on-site during this period; however, a review of timesheets indicated the DHA was on-site during this period. The DHA is responsible for communication with center staff regarding youth medical needs and participates in weekly DHA meetings with the center's administration. Reviewed attendance logs supported nursing staff also participated in the meetings. Interview with the DHA indicated Maxim Healthcare Services provides for back-up coverage when the DHA is on scheduled leave.

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

The center maintains Facility Operating Procedures (FOPs) for all utilized health-related procedures and protocols. Reviewed documentation supported the designated health authority (DHA) reviewed, signed, and dated the FOPs, nursing protocols, and non-healthcare protocols on July 27, 2018. The center's contracted psychiatrist documented a review with signature and date for applicable FOPs. Maxim Healthcare Services 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. Reviewed documentation supported the registered nurse, two licensed practical nurses, DHA, and superintendent documented their review of the center's healthcare FOPs and protocols on a cover page in July 2018 and August 2018.

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 parents/guardians are afforded the right to give or withhold consent with regard to the healthcare provided to the youth. A review of seven youth Individual Healthcare Records (IHCR) supported five contained a signed Authority for Evaluation and Treatment (AET) and two contained a Limited Consent for Evaluation and Treatment (LCET). One youth IHCR contained the original and six contained copies; however, three of the six did not clearly document “Copy” on the form. Each AET or LCET was obtained prior to providing medical services.

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

The center maintains a written policy and procedures outlining requirements for parental notification and written consent from the parent/guardian. The center notifies the parent/guardian of significant changes in the youth’s condition and to obtain consent when new medications and treatments are prescribed. A review of seven youth Individual Healthcare Records (IHCR) found six had significant changes to existing medications and/or changes in chronic conditions. There were no applicable over-the-counter medications not covered by the Authority for Evaluation and Treatment prescribed. None of the reviewed IHCRs required vaccinations/immunizations. Interview with nursing staff indicated there were no Religious Exemption from Immunization forms submitted since the last annual compliance review. A review of three additional youth IHCRs applicable for off-site emergency care supported nursing staff notified the parents/guardians by telephone and, subsequently, in writing. Five reviewed records were applicable for newly prescribed medication and the chronological notes and the Parental Notification of Health-Related Care form documented the parent/guardian was notified as required. Written parental notices were sent regardless of telephone notifications. Three youth were admitted on prescribed psychotropic medications and the medications continued; therefore, parental notification was not required.

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

The center maintains a written policy and procedures ensuring at the time of admission, each youth will receive a healthcare admission screening utilizing the Department’s Medical and Mental Health Admission Screening form. A review of seven youth Individual Healthcare Records (IHCR) found each contained a Medical and Mental Health Admission Screening form completed on the date of admission by a juvenile justice detention officer and five indicated the screening was reviewed by a licensed practical nurse (LPN) on the same day and two were reviewed within twenty-four hours. Each screening form was completed in the Department’s

Juvenile Justice Information System (JJIS) Admission Wizard. Interview with nursing staff validated this practice. None of the reviewed records were applicable for a change in physical custody since the youth's admission date. A review of three applicable records supported the center completed a new healthcare admission screening each time custody changed and reviewed by nursing staff within twenty-four hours of readmission. One applicable record supported the youth received a qualitative urine pregnancy screening test, with the youth's verbal consent, at the time of admission. The results were documented in the laboratory section of the IHCR.

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

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

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

The center maintains a written policy and procedures ensuring the designated health authority (DHA) is notified when youth admitted required emergency care or routine notification in accordance with Department requirements. A review of seven youth Individual Healthcare Records (IHCR) supported the DHA was notified within twelve hours of admission of any youth with a chronic medical condition, psychotropic medication, or medical concern. Notification was documented on the nursing admission chronological notes for five of the seven reviewed records. Two youth records left the DHA notification blank. Interview with nursing staff and reviewed documentation supported the two youth were documented on the Chronic Conditions Log of DHA Notification and placed in the Physicians Referral Log for follow-up. 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 of the youth being admitted either through a telephone call or email.

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 of the center.	

The center maintains a written policy and procedures detailing the process for conducting or reviewing admission history. The center utilizes and completes the standard Department Health-Related History (HRH) form for all youth admitted into the physical custody. A review of seven youth Individual Healthcare Records (IHCR) found each contained a HRH form completed electronically by a licensed nurse within seven days of the youth's admission to the center. Each HRH was reviewed by the designated health authority (DHA) or advanced registered nurse practitioner (ARNP) and was maintained in the youth IHCR. The HRH was completed before or at the same time as the Comprehensive Physical Assessment (CPA) for each youth.

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

The center maintains a written policy and procedures ensuring a Comprehensive Physical Assessment (CPA) form will be completed for all applicable youth admitted determining the health and wellbeing of the youth. The center also maintains a written policy and procedures ensuring an alert system is in place to alert staff when medical, mental health, or security issues exist which may affect the security and safety of the youth. The center's policy and procedures for tuberculosis (TB) control and screening addresses the routine screening of all youth for latent and active TB, as well as environmental controls in the case of a youth with active TB. Interview with nursing staff indicated all youth are screened for TB by placing a Tuberculosis Skin Test (TST) in the left forearm once yearly. The test is ready by nursing staff within forty-eight to seventy-two hours after placement. A review of seven youth Individual Healthcare Records (IHCR) validated two youth had a current CPA on file at admission and five youth required the completion of a new CPA. Reviewed documentation supported one of the two current CPAs did not document a review by the designated health authority (DHA) and/or advanced registered nurse practitioner (ARNP). However, the center was able to provide a Refusal of Treatment form whereby the DHA attempted to conduct a new CPA and the youth refused. Reviewed CPAs indicated three were completed by the DHA and four were completed by the ARNP. Each CPA was completed in full to include the medical grade, Tanner Stage, cardiovascular, body mass index, visual acuity field, and most recent TST. There were no applicable refusals of the examination; therefore, no signed refusal forms were required. Reviewed practice supported when the CPA was completed, the Department's Problem List was also updated. There were no applicable youth with any symptoms of active TB in the center at the time of the annual compliance review. The center's internal alert system coincides with the Department's Juvenile Justice Information System (JJIS) and each applicable alert was updated as required.

4.10 Sexually Transmitted Infection/HIV Screening [Contract Provider]	Satisfactory Compliance
The center shall ensure all youth are evaluated and treated (if indicated) for sexually transmitted infections (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 STIs. After the screening, youth will be referred to the designated health authority (DHA) or advanced registered nurse practitioner (ARNP) to determine if further testing is indicated. A review of seven youth Individual Healthcare Records (IHCR) indicated each youth was screened for STIs and six required further evaluation. Interview with nursing staff indicated orders are obtained from the DHA for STI testing and a urine sample is collected to be sent to LabCorp for testing. The center maintains a written policy and procedures ensuring each youth is provided the opportunity to receive counseling, testing, and treatment for human immunodeficiency virus (HIV). All seven reviewed youth records supported each youth was offered testing and three consented and four did not consent as documented on the Department's Human Immunodeficiency Virus Antibody Test Youth Consent Form. Seven interviewed youth each indicated they could request testing for HIV. One of the center's nursing staff is a certified counselor and provides pre-test and post-test counseling. The nursing staff swabs the youth's mouth and sends to LabCorp. If the results are positive, a blood sample is also tested, and the results are given to the Lee County Health Department. The HIV test results are placed in a sealed envelope marked "Confidential" and filed in the IHCR.

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

The center maintains a written policy and procedures ensuring all youth will be able to make sick call requests and have their complaints treated through the sick call system. The sick call process responds to a youth's compliant of illness or injury of a non-emergent nature, but which requires a professional nursing assessment and possibly, a nursing intervention. The center provides sick call seven days a week, two times daily, from 9:00 a.m. to 10:00 a.m. and 4:00 p.m. to 5:00 p.m. A review of seven youth Individual Healthcare Records (IHCR) indicated two youth submitted sick call requests. An additional applicable record was reviewed. Sick calls are documented by staff electronically and communicated to medical staff. All three youth were seen by the licensed practical nurse (LPN) for the sick call within twenty-four hours. Two of the three sick calls were reviewed on the same day by the registered nurse and one was reviewed the next day within the twenty-four-hour time frame. Interview with nursing staff indicated sick calls are also reviewed with the advanced registered nurse practitioner (ARNP) daily. None of the sick calls required treatment or referral off-site. There were no instances in which a youth presented a similar sick call compliant three or more times in a two-week period or of a youth complaining of any severe pain with which staff were unfamiliar. The center maintains treatment protocols appropriate to the level of the provider conducting sick call approved by the designated health authority (DHA) on July 27, 2018. According to nursing interviews, the DHA does not conduct sick calls while at the center. All three applicable sick call events were documented on the Sick Call Index and Sick Call Referral Log. Sick Call forms documented the nature of the complaint, assessment, and plan to include subjective, objective, assessment, and plan format (SOAP). An interview with the RN indicated when there is not a licensed nurse on-

site, the juvenile justice detention officer supervisor (JJDOS) will review the sick calls no longer than four hours after the sick call is submitted, to determine the need for intervention. The JJDOS are trained to contact the DHA. There were no sick call requests submitted during the annual compliance review week; therefore, there were no sick calls to observe. Seven interviewed staff indicated sick call is conducted by nursing staff. Seven interviewed youth found one indicated they can be seen immediately should they submit a sick call request, five indicated within one day, and one indicated within three days. One youth indicated the doctor and/or the nurse conducts sick call, and all the other six youth indicated the nurse conducts sick call. Four youth rated the sick call process as very good, one rated the process as good, and two rated the process as fair.

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

The center maintains a written policy and procedures ensuring a comprehensive process of episodic care, first aid treatment, and emergency care. The center utilizes an episodic care log to document episodic care and first aid treatment. The log contains information to include the date, name of youth, the youth's Department of Juvenile Justice Identification Number, nature of illness or injury, treatment rendered, staff initials, nurse initials, verification of who provided episodic care, and whether the youth was recommended for off-site care. A review of seven youth Individual Healthcare Records (IHCR) found two youth received episodic care conducted by nursing staff. Two additional youth IHCRs were reviewed for episodic care conducted by nursing staff. All four applicable IHCRs documented problem-oriented elements which were used to chart 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. The center had one applicable episodic care event conducted by non-healthcare staff whereby the youth received episodic care and was also transported to the emergency room for a laceration and the services received were documented on the Department's Report of Off-Site Healthcare by Non-Healthcare Staff form. A random review of three first aid kits found each contained the required items identified on the designated health authority (DHA) inventory list. The center has thirteen first aid kits which are located throughout the program in master control, the four classrooms, two sub-controls, kitchen, four vehicles, and the medical clinic. Nursing staff conducts monthly reviews of the first aid kits and items are replenished upon use. Nursing staff seal and date the first aid kits after replenishment and review. The center has two automated external defibrillators (AED) located in the medical clinic and in the entrance to administration. The AED procedures were located in the AED box as well as audio instructions. Nursing staff check the AED batteries and pads daily to ensure the AED is operational and document their review on a tracking sheet. The AED was self-tested in front of the annual compliance review team to ensure it was operational. The batteries in both AEDs expire on August 31, 2023 and the pads expire on March 28, 2021. Both AEDs were recently purchased, and each contained the original batteries and pads. A review of seven staff training records found all staff were trained in cardiopulmonary resuscitation (CPR), first aid, and AED. All non-healthcare staff and nursing staff are required to maintain certifications. Reviewed documentation supported the DHA and the advanced registered nurse practitioner (ARNP) both maintained current certifications in CPR and AED. Emergency contact numbers were observed posted in the medical clinic and in master control to include the number for the statewide Poison Information Center. Interview with the assistant superintendent indicated the emergency contact numbers are also located in administration and in the juvenile justice detention officer supervisor's office. Nursing interviews indicated the emergency numbers are located in master

control and in the clinic contact book. Only healthcare and trained supervisory non-healthcare staff can administer the epinephrine auto injector for youth requiring administration, when indicated. A review of seven training records supported each staff received the required training on the center's Emergency Care Plan and the supervisory staff received training on epinephrine auto injector. At the time of the annual compliance review, there was one youth prescribed an epinephrine auto injector and there were two in bulk supply. The center's policy and procedures indicated emergency drills are conducted for each shift on a quarterly basis at minimum. Not all drills must include CPR, but those techniques must be practice on a regular basis and at least once a quarter or once a shift each year. A review of quarterly mock emergency drills since the last annual compliance review found drills were conducted at least once a quarter on each shift. Documented use of life saving techniques such as CPR was noted on the mock emergency drills conducted on Alpha shift two times, Bravo shift one time, and none for Charlie shift. All documented drills included the type of medical event, time the drill/event occurred, time 9-1-1 was called, name of the juvenile justice detention officer supervisor, healthcare provider in charge, healthcare provider response time, type of medical care rendered, time the event concluded, clinical manager/medical staff review, and critique. Seven staff were interviewed to determine if they can call 9-1-1 if necessary and each reported they can call when needed.

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

The center maintains a written policy and procedures to provide for timely referrals and coordination of medical services to ensure youth have timely access to off-site care services. A review of seven youth Individual Healthcare Records (IHCRs) found none were applicable for off-site medical care. The center provided six additional youth records for review and all were applicable for off-site medical emergency care. Four youth were taken off-site for emergency care and two youth were take off-site for routine follow-up care. The designated health authority (DHA) was notified for each emergency event. Each youth record contained a Summary of Off-site Care form, discharge documentation, and instructions. The DHA and/or advanced registered nurse practitioner (ARNP) did not document a review of the off-site care findings, instructions, and information. None of the youth required additional referrals for follow-up testing or appointments.

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

The center has a policy and procedures to ensure youth identified with chronic conditions receive regularly scheduled evaluations and necessary follow-up care. The frequency of the periodic evaluation is determined by the youth's condition, clinical needs, and clinically appropriate medical standards. Youth are screened during the intake process for medical conditions warranting periodic evaluations and follow-up care. A review of seven youth Individual Healthcare Records (IHCRs) found six youth were applicable for the existence of chronic conditions and each was taking medication. Each youth was classified with a medical grade between two and five. None of the youth were classified with a body mass index (BMI) greater than thirty. Three youth were undergoing treatment for a physical health condition while the remaining three applicable youth had a mental health diagnosis. 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 or missed periodic evaluations. All six youth were placed on the chronic conditions roster. Reviewed records supported each Department Problem List was updated as required.

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

The center has a policy and procedures ensuring all medication and pharmaceutical products are procured, dispensed, administered, and stored safely, accurately and in accordance with state, federal, and industry standards. The center's practice is for nursing staff to verify all medications will have a current, valid order and are given according to a current prescription or practitioner's order. Nursing staff verify medication with the parent/guardian when they deliver the medication to the center. The Medication Receipt, Transfer, and Disposition Form is used to document medication received in the original packaging from a licensed pharmacy with a current legible patient-specific label affixed. A review of seven youth Individual Healthcare Records (IHCRs) identified four youth were taking prescribed medication upon admission and were applicable for medication management. Each applicable youth record documented verification of prescription medication by the nurse. In each applicable record, the licensed nurse obtained an order from the designated health authority (DHA) to resume the applicable medication. All orders were signed by the practitioner. There were no applicable over-the-counter (OTC) medications not listed on the Authority for Evaluation and Treatment (AET) form administered. The center maintains a contract with Diamond Pharmacy Services for procurement of medications with an expiration date of August 31, 2019 and a Modified Class II Type B Pharmacy Permit with an expiration date of February 28, 2021. All medication is delivered to the center in blister packs. The center utilizes a local Publix Pharmacy for emergency medications. The center maintains a current Drug Enforcement Administration (DEA) Controlled Substance Registration Certificate with an expiration date of June 30, 2022 and a Clinical Laboratory Improvement Amendments Certificate of Waiver with an expiration date of January 28, 2021. The center utilizes the standard Department Medication Administration Record (MAR) for each youth receiving either prescription medications on a routine basis or OTC medications. Reviewed documentation supported the staff initialed each administered medication entry and five applicable youth documented their initials on the MAR. When the youth refused the medication administration, the refusal was clearly documented on the MAR and the Department's Refusal of Treatment Form was completed. The center maintains a written policy and procedures to ensure the usage of the MAR by licensed healthcare staff and non-licensed staff. Each reviewed MAR clearly documented the youth's name, Department of Juvenile Justice Identification Number, date of birth, youth allergies, precautions, medical grade, medical alerts, and current picture of the youth. The MAR clearly indicated medication start and stop dates and nursing staff documented weekly side-effect monitoring. There were no lapses or errors noted. No youth required parenteral medication. The center has a secure refrigerator in the medical clinic which contained Tuberculin vaccinations during the annual compliance review. Nursing staff track daily temperatures of the refrigerator. The center has authorized and trained the superintendent, two assistant superintendents, seven juvenile justice detention officer supervisors (JJDOS), and the training coordinator to assist youth with self-administration of medication. The center's practice is to have licensed nursing staff on-site until 7:00 p.m. on weekdays and 8:00 p.m. on weekends, thereby having only nursing staff to administer medication. Trained non-licensed staff are permitted to provide OTC

medications when nursing staff are not on-site. A review of three applicable JJDOS training records supported each received training on the MAR. The center did not have any standing orders for psychotropic medications, no pro re nata (PRN) orders for psychotropic medications, or emergency treatment orders for psychotropic medications. Five of the seven reviewed youth records documented the youth was admitted on prescribed medications of which three were prescribed psychotropic medications. The DHA and the designated mental health clinician authority (DMHCA) was notified for each admission. The psychiatrist was notified when the medication was received to obtain an order for continuation. Reviewed documentation supported all three youth received an initial diagnostic psychiatric interview conducted well within the required fourteen days of admission. Youth receiving psychotropic medications are reviewed weekly each time the psychiatrist is on-site. There was one youth with psychotropic medications prescribed subsequent to admission and received the same medication monitoring from the psychiatrist. Observations of two medication administration validated the JJDOS escorted the youth to the medical clinic. The nurse had the medication cart pulled up to the door and each youth approached the nurse one at a time and the nurse pulled the medication from the secured medication cart and checked it against the MAR. The medication was administered, and the MAR was updated accordingly. Observations also included the nursing staff reading the results from the Tuberculosis Skin Test (TST). The center utilizes RX Destroyer for the disposal of medications. The center maintains a contract with Consulting Pharmacist, Inc. and reviewed documentation supported the consultant pharmacist conducted a pharmacy audit monthly. Monthly audit forms documented whether or not the center required any controlled medications disposal. The practice is for the consultant pharmacist and the on-site nurse to dispose the medication(s) which cannot be returned to Diamond Pharmacy for credit and document it on the Medication Disposal Form. Disposal of non-controlled medications is documented on the Drug Disposal Form. Seven interviewed staff indicated none provided medication to youth. Informal interviews with staff indicated only the doctor, nursing staff, and trained juvenile justice detention officer supervisory staff are able to give medications to youth. Seven interviewed youth found three youth indicated the nurse provides medication to youth and four youth indicated they do not take medication.

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

The center maintains a written policy and procedures ensuring medications and any medical equipment classified as sharps will be secured and inventoried. The dose-by-dose daily administration and documentation of a medication is documented utilizing a perpetual inventory process for the daily distribution of non-controlled prescription medication and over-the-counter (OTC) medication. Documentation of each individual dosage of medication administered to youth is maintained on the Medication Administration Record (MAR) to demonstrate the distribution of medications. Any medical equipment classified as sharps is secured and inventoried utilizing a routine perpetual inventory descending count as each sharp is utilized and disposed. A review of the medical clinic found the clinic is secured under lock and key. Medical staff and trained juvenile justice detention officer supervisors (JJDOS) non-healthcare staff have access to the clinic. The JJDOS non-healthcare staff are trained by the nurse to assist youth with self-administration of OTC medication. A locked medication cart is located in the medical clinic and stores oral prescription and over-the-counter (OTC) medications prescribed for youth as well as sharps. Medication in the cart is separated by each module and each youth. A

second locked medication box is in the medication cart and stores controlled medication. The center maintains an inventory of all sharps and medical equipment classified as sharps to include syringes, butterflies, scissors, needles, and suture removal kits. Items designated as sharps are stored in a designated locked cabinet in the medical clinic and are inaccessible to youth. A review of the perpetual inventory for the past six months found sharps inventory counts to be accurate. A review of three random prescriptions and three OTC medications found the counts were accurate. A review of the running daily inventory of all prescription and OTC medications matched the random count. The center had two controlled medications on-site securely stored in the locked box within the locked medication cart. A review of three random sharps found the counts were accurate.

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 (CDC) guidelines. The comprehensive education plan shall include pre-service and in-service training for all staff. Education for youth infection control shall also be provided at the time of intake and subsequently when the need is identified.	

The 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 also maintains a separate Exposure Control Plan/Infection Control Plan approved by the designated health authority on July 4, 2019. A review of seven youth Individual Healthcare Records supported each youth received infection control training within twenty-four hours of admission. The infection control training included hand-washing techniques, universal/standard precautions, prevention/transmission of communicable diseases, vaccinations, and the Center 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 also 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. There were no reportable incidents for which the local county health department, Centers for Disease Control and Prevention (CDC), and the Department's Central Communications Center (CCC) should have been notified of an infectious disease since the last annual compliance review. A review of seven staff training records supported each staff received pre-service and in-service training on the center's Exposure Control Plan/Infection Control Plan.

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

The center has a written policy and procedures for the care of pregnant youth to include procedures for medical issues, nutrition, education, and medication. An interview with the nursing staff indicated the center had two pregnant youth since the last annual compliance review and each was documented on the Pregnant Log. The youth Individual Healthcare Records were not available for review due to the youth being placed in a residential program. The electronic medical records (EMR) supported each youth was admitted in the center with a positive confirmation of pregnancy and prenatal care protocols were implemented. Prenatal care was delivered at recommended intervals, including off-site medical prenatal, obstetrical, or gynecological appointments. Reviewed documentation supported the designated health authority (DHA) and/or advanced registered nurse practitioner (ARNP) conducted a focused medical evaluation at least once every thirty days. Reviewed chronological notes supported there was daily monitoring of danger signs of pregnancy complications. Reviewed healthcare education records 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 each youth for weight and nutritional status. A pregnancy alert was entered into the Department's Juvenile Justice Information System (JJIS) for each youth. A review of seven staff training records verified six staff received Girls Health training specific to working with pregnant youth. There was no documentation of one staff receiving the Girls Health education. Staff training was provided by the registered nurse (RN) at the time of hire and annually, thereafter.

Standard 5: Safety and Security

5.01 Active Supervision of Youth (Critical)	Satisfactory Compliance

Staff are aware of the location of youth assigned to their supervision at all times. Staff monitor the movement of youth in their direct care from one location to another.

Youth are in sight of at least one juvenile justice detention officer (JJDO) at all times (with the exception of sleeping hours or time secured in rooms).

Officers are responsible for the care of youth at all times. At no time shall another youth be allowed to exercise control over or provide discipline or care of any type to another youth.

When a youth leaves the group or program area of the center for any reason, all staff assigned to supervise the youth are informed.

Master Control authorizes all movement of youth prior to the actual movement, and no movement occurs until cleared by Master Control.

Staff moves youth from one area of the center to another in accordance with Florida Administrative Code.

The center maintains a written policy and procedures ensuring youth are actively supervised by staff. Staff communicate by way of two-way radio with master control any issues pertaining to the center and youth supervision. The center utilizes a roster generated in the Department's Juvenile Justice Information System (JJIS) to track the daily census of the youth. During the annual compliance review week, daily observations of youth were conducted which confirmed the active supervision of youth by detention staff. Staff were observed supervising youth during transport, school, lunch, line movement, and in the modules. Each observation indicated staff were positioned in a manner providing them full view of youth in the area, were aware of the number of youth being supervised, were in sight and sound of youth, and requested permission from master control prior to any youth movement. No inappropriate interactions were observed between youth and staff. Staff was observed to have positive interaction with youth. A review of the master control logbooks for the past six months prior to the annual compliance review validated youth headcounts have been completed consistently on the beginning and end of each shift, and prior to each youth movement. Seven staff were interviewed, and five confirmed they believe there is enough staff at the center to provide for the safety and security of the youth and staff. Two out of seven staff reported there are not enough staff to provide for the safety and security of the youth and staff, indicating the center is short staffed. Each interviewed staff reported youth counts are completed at the beginning of each shift, the end of each shift, before/after school, and before/after meals. Seven staff were interviewed regarding steps taken to reconcile incorrect counts. Each interviewed staff reported a recount is completed immediately if counts are off. One out of seven staff additionally reported, staff notifies master control in addition to a recount, if a count is off.

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

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

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

The center maintains a written policy and procedures ensuring ten-minute checks are conducted when youth are in their rooms for sleeping or other reasons. The center has a total of forty-six operable cameras with a recording capacity of thirty-seven days. The center utilizes Guard One Plus which is an electronic system to document ten-minute checks. Staff utilize the electronic Guard One Plus want by tapping the wand on the check point sensor located on the outside of each youth's room door. Each day, data from the wand is downloaded to ensure no data is lost. The juvenile justice detention officer (JJDO) is responsible to pause at the door and look into the room to observe the youth behind the closed door, before the check point sensor is activated with the wand to ensure there are no issues with the youth. The superintendent was interviewed and confirmed this practice. Observations of youth living modules and rooms validated there were no obstructions over windows and areas where direct line of sight is needed. Observation of ten-minute room checks on two different modules, from three different shifts, and six different days and times along with corresponding ten-minute log indicated checks were being conducted every ten-minutes, or less, and in real time. Seven staff were interviewed, and each staff confirmed room checks are completed every ten-minutes.

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

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

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

The center maintains a written policy and procedure ensuring logbooks are maintained at master control and in each living area in accordance with Florida Administrative Code. The center maintains separate logbooks in master control and for each living module, as well as one for visitors, and one for contracted staff. Logbooks are also maintained to document emergencies and emergency drills. Observations of each logbook found they were bound together with numbered pages. A review of logbooks for the past six months for each living module and master control verified all entries were legible and written in ink, with no erasures or whiteout areas. Each entry included the date and time of the event or incident, name of the staff and youth involved, brief description of the incident. However, a review of two of twenty logbook pages did not have the a.m. or p.m. denoted for the time of the incident. A review of logbooks for the past six months confirmed each logbook was bound with numbered pages, all entries included the date and time of the event or incident with the name of the staff and youth involved, and a brief description of the event and the initials of the staff making the entry. However, several entries observed did not include a.m. or p.m. following the time entry. All entries for the last six months revealed safety and security of the center, including medical, special needs, and mental health alerts were highlighted. Reviewed logbooks reflected all errors are struck through with a single line and dated and initialed by the person correcting the error. Reviewed master control logbooks included emergency situations, incidents, fire and escape drills, population counts at the beginning and end of each shift, group movements, admissions and releases, presence of law enforcement, and name of youth placed in confinement, including the time confinement began and the time confinement ended, name of youth placed on precautionary/secure observation, including the time precautionary/secure observation began and the time precautionary/secure observation was discontinued.

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

The center maintains a policy and procedure ensuring logbook reviews are conducted. The superintendent or designee reviews the logbooks on a weekly basis and documents any discrepancies and/or issues. A review of the center's logbooks for the past six months validated this practice. The master control and living unit logbooks for the past six months were reviewed and confirmed the juvenile justice detention officer supervisor (JJDOS) from each shift documented a review of the master control logbook prior to accepting the shift. A review of the living module logbooks for the past six months validated the JJDOS coming on-duty documents a review of the logbook as well.

5.06 Key Control	Satisfactory Compliance
Each center is responsible for maintaining inventory and control of all facility keys. *All keys shall be placed on a tamper-resistant key ring designed to inhibit the removal of keys.* *Emergency key rings shall be maintained separately from other facility keys, in master control, in a secure location designated by the Superintendent. These keys shall be notched or otherwise identifiable by touch.* *The key(s) on these rings shall provide egress through facility exterior doors providing access to evacuation areas.* *A key inventory shall be maintained by the Superintendent or designee at all times.* *(For the entire indicator statement, please reference the Monitoring and Quality Improvement FY 2019-2020 Detention indicators.)*	

The center maintains a written policy and procedures ensuring the inventory and control of all center keys, as well as replacing lost or damaged keys. Center keys are maintained on a tamper-resistant ring with a brass tag identifying the ring number and the number of keys on the ring. Center keys, including restricted keys, are stored in master control in a locked key box accessible by the master control operator, juvenile justice detention officer supervisors (JJDOS), and administrative staff. Emergency keys providing egress through exterior doors are stored in master control and the module sub control rooms which staff can access. All keys are inventoried in the Facility Management System (FMS). The center maintains a master key inventory which accounts for all key rings by ring number, the number of keys on each ring, the capability of each key, and the staff assigned to the keys. When staff enter the center, personal keys are placed in a locked key box located in the lobby prior to entering the secure area of the center. The JJDOS are issued keys through the master control operator at the beginning of their

shift. A review of the master control logbook and observation of distribution and collection of keys validated the issuance of keys/key rings were documented in the master control logbook on each shift with the date time, staff name, and initials of staff issuing the keys. juvenile justice detention officers (JJDO) are issued keys through the JJDOS during shift briefings. Each JJDO is required to sign and enter the date and time on the key control log when issued their keys. When keys are returned, each JJDO turns their keys back into the JJDOS and must sign, date and enter the time again on the key log. The JJDOS return all keys back to master control at the end of their shift and sign, date, and enter the time into the master control key log. Observations conducted during the annual review validated this practice. A review of the master key control inventory during the annual compliance review confirmed the inventory report matched the actual keys in use. Observations were made of staff carrying their assigned keys on their person at all times and youth did not have access to keys. All center keys were accounted for during the review. There were no reported incidents during the review period of lost keys. An informal interview was conducted with the superintendent. The superintendent confirmed there was one incident in which a staff member left the center with their keys; however, the keys were returned to the center within two hours of discovering the keys were taken home. Visitor keys are stored in visitor lockers or in master control in the non-secure area of the center. A review of seven staff training records confirmed each staff received key control training during detention services phase on training plan. Seven staff were interviewed regarding restricted key access. Six staff reported restricted keys included access to mental health records. Five staff reported restricted keys included access to medical records. Four staff reported administration and JJDOS office keys were restricted. Three reported case management keys were restricted. Two staff reported kitchen keys were restricted. One staff reported training keys were restricted access. Seven staff were interviewed regarding the center's daily process for tracking keys. All interviewed staff reported the center tracks keys daily and center keys are assigned to staff. Four staff reported inventory of keys are conducted. Three staff reported youth do not have access to keys, the center is searched for missing keys, master control is notified of missing keys, and youth are search for missing keys. Two staff reported staff keys are given to master control upon entry into the center. One staff reported a key is replaced when damaged.

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

The center maintains a written policy and procedures ensuring vehicles to transport youth are properly maintained, inspected annually, and in good repair. The maintenance mechanic is responsible for weekly and monthly vehicle inspections. The center has a total of seven vehicles used to transport you. Reviewed documentation confirmed each vehicle had an annual safety inspection conducted by a certified automobile mechanic. Observations of the seven vehicles verified each was locked when not in use. Inspections of the seven vehicles validated each vehicle had the appropriate number of seat belts, seat belt cutter, a window punch, up-to-date-fire extinguisher, a first aid kit with approved and up-to-date items. Each vehicle was observed to have a binder which contained the vehicle mileage log, mechanical restraint key, gas card, vehicle policy, and vehicle registration. Each vehicle is inspected prior to transporting youth using the Department's approved checklist. Reviewed documentation validated this practice. Weekly visual vehicle inspection checks are also conducted on each vehicle as required and

documented on the maintenance check sheets to inspect water coolant, lights, oil, emergency equipment, brakes, horn, interior/exterior, and cleanliness of the vehicle. Monthly vehicle checks are also conducted on the tires, battery, windshield, wipers, windows, mirrors, and other visual damage and documented on the mandatory maintenance form. Reviewed documentation supported a pre-trip inspection is completed on each vehicle by two staff. Each vehicle is inspected prior to transporting youth using the Department's approved checklist. During the annual compliance review, an observation of pre-transport activities was conducted. The vehicle was searched by staff prior to transport and inspected for contraband. Staff ensured vehicle had sufficient gasoline. The security screen was tested. Staff searched the youth prior to placing the youth in the vehicle. Staff assisted the youth in securing the seatbelt and secured staff's seatbelt as well. The staff was in possession of the assigned cell phone, vehicle logbook, transportation procedures, and binder inclusive of the Vehicle Log which validated the center's practice.

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

The center maintains a written policy and procedures ensuring all tools and equipment are properly maintained, stored, and inventoried. The center's maintenance tools are maintained in a secure, locked portable building, within the secure fenced perimeter. Tools are maintained on a shadow board and marked with an identification number. A perpetual tool inventory list of tools and maintained by the center to document what tools are being used by the maintenance staff including the times the tools were checked-out, the location of the tools, and times the tools were returned. An interview with the maintenance mechanic reported inventory is conducted monthly by the maintenance staff and reviewed by the superintendent and/or designee. The center's kitchen tools inclusive of knives and scissors are securely stored in a locked storage cart, with an inventory sheet, located in the food service manager's office. A perpetual inventory of kitchen tools is maintained, and counts are documented three times per day. Any maintenance or kitchen tool in need of disposal or replacement is requested by completing a tool disposal/replacement report which the maintenance or food service manager signs and gives to the superintendent for approval. Additionally, when tools are lost or suspicion a youth may be in possession of a tool, the juvenile justice detention officer supervisor (JJDOS) is notified immediately, and a search is initiated. A review of the monthly inventory sheets confirmed there were no missing maintenance or kitchen tools. An interview with the superintendent confirmed there have been no missing tools in the past six months. Seven staff were interviewed regarding the center's practice for damaged or missing tools. Three staff reported a work order is completed for damaged or missing tools. Two staff reported administration and JJDOS are notified. Two staff reported there have been no missing tools. One staff reported they get rid of the damaged tools and there have been no missing tools.

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

The center maintains a written policy and procedures ensuring youth do not have access to any tools, including kitchen or medical equipment. The center only allows youth to use cleaning items such as mops, brooms, buckets, and other common household items for general cleaning.

Youth are under constant supervision when utilizing these items. Observation during the annual compliance review supported this practice. Seven staff were interviewed, and five indicated youth can use mops and brooms. Two staff stated youth do not have access to any tools. Seven youth were interviewed, and six youth indicated they can use mops and brooms. One youth stated they do not use any tools.

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

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

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

The center maintains a written policy and procedure ensuring limited access to flammable, toxic, caustic, and poisonous items. The center's policy prohibits youth from accessing any materials which are flammable, toxic, caustic, and/or poisonous. The center maintains a list of authorized staff who are allowed access to the chemical storage. All toxic items are stored in a locked storage portable building within the secure perimeter. Observations conducted during the annual compliance review found there no toxic materials stored in any place accessible to youth. An interview with the superintendent confirmed flammable, toxic, and caustic materials

are securely stored in the storage unit within the secure perimeter and are only accessible to administrators and maintenance staff. Seven staff were interviewed; and each confirmed youth are not allowed to use substances which are toxic, flammable, or poisonous. Seven youth were interviewed, and each reported they are not allowed to use any type of cleaning agents such as bleach, laundry soap, window, or toilet cleaner.

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

The center maintains a written policy and procedure ensuring the proper disposal of toxic, caustic, and poisonous items. The center has a safety plan in place to address any chemic spills or leaks. The kitchen has an outdoor container outside to store grease for which a contractor is maintained with A-1 Gator for disposal. The plan addressed what procedures to follow in the event of a chemical leak, or spill. The maintenance mechanic confirmed materials are disposed of by evaporation, compaction or taken to Lee County's Topaz Solid Waste Annex. The kitchen has a container outside to store grease and this is disposed of through a contractor. The detention center superintendent stated there has been no chemical spills or leaks within the annual compliance review period. If a chemical spill occurs, procedures indicate a staff will notify master control of the location of the spill, a juvenile justice detention officer supervisor and/or master control shall direct the shutdown of all air handlers, ventilation system, and close all windows and doors. The center will then obtain assistance from outside the center by contacting the necessary emergency contacts. Biohazardous waste disposal is the responsibility of the medical staff. An informal interview with the maintenance mechanic confirmed materials are disposed of by evaporation, compaction, compaction disposal service, or taken to Lee County's Topaz Solid Waste Annex. The maintenance mechanic also confirmed the large quantity of old paint was disposed of by evaporation in November 2018. An informal interview with the center's superintendent confirmed there have been no chemical spills or leaks since the last annual compliance review.

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

The center maintains a written policy and procedures ensuring confinements under twenty–four hours are used as an immediate, short term response strategy during volatile situations with a youth's sudden or unforeseen onset of behavior imminently and substantially threatens the physical safety of self or others. The center has four designated confinement rooms. If a youth's behavior escalates, a youth will be placed in one of designated confinement rooms. Observations during the annual compliance review indicated the confinement rooms were free from obstruction and each room contained no non-fixed items. Youth who are in confinement have no contact with the general population; however, are afforded living conditions approximating those available to the general population. The center documents confinements under twenty-four hours in the Facility Management System (FMS). A review of seven confinement reports documented rooms were searched prior to youth being placed in confinement. Each report confirmed visual observation was conducted in accordance with policy

and procedures. Five out of seven reports were not completed by the juvenile justice detention officer (JJDO) within one hour of the incident. A review of seven confinement reports found documentation which confirmed the juvenile justice detention office supervisor (JJDOS) reviewed the report and indicated the reason for confinement. Five out of seven reviewed confinements did not have a three-hour review completed by the JJDOS. Three out of seven confinement reports had a late superintendent or designee review completed. Each superintendent or designee review completed had documentation to support the need for continued confinement based on the severity of rule infraction, past disciplinary history, or behavior confinement. Each reviewed confined report showed documentation of the report being communicated to school personnel. Seven staff were interviewed regarding confinements, and each staff reported they must search the confinement room prior to placing a youth in confinement. Five out of seven staff also indicated a confinement report must be completed each time. Four staff indicated ten-minute checks must be completed. Two staff reported the youth must be searched prior to confinement.

5.14 Confinement Over Twenty-Four Hours	Failed Compliance

Confinement beyond twenty-four hours must be approved by the Superintendent or designee.

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

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

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

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

The center maintains a written policy and procedures ensuring confinement over twenty–four hours are approved by the superintendent or designee as well as the regional director or designee. An interview with the superintendent was conducted. The superintendent confirmed confinements are reviewed after two hours, and every three hours after. The superintendent must review any request to exceed twenty-four hours of confinement. All confinements are tracked in the Facility Management System (FMS). Additionally, regional detention management reviews the use of confinement, lockdown, and restraints through FMS reporting, video surveillance review, and logbook reviews as needed. The center had three confinements over twenty-four hours during the annual compliance review period. Each confinement report reviewed confirmed the juvenile justice detention officer supervisor (JJDOS) completed reviews, evaluating youth every three hours, and documented the need for confinement based on the severity of the rule, violations, past disciplinary history, or behavior while in confinement. Each confinement report showed documentation which indicated the superintendent or designee reviewed and approved the confinement. Two of the three reports reviewed did not include a

review by the mental health professional. Two of the three reports reviewed did not indicate the regional director approved the confinement beyond twenty-four hours. None of the confinements extended beyond three days; therefore, no confinement hearing was required.

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

The center maintains a written policy and procedures ensuring the management of various emergencies and disaster events. The center's Continuity of Operations Plan (COOP) was approved by the regional director on March 21, 2018. Documentation confirmed there were two COOP drills conducted as required. Hurricane drills were conducted in January and May 2019 which was prior to the June 1, 2019 start of hurricane season. In each instance there was documentation to support there were written scenarios and drill forms, critique forms, and emails used to document the drills. Seven staff were interviewed and asked what drill they have participated in within the last six months. Each staff responded they have participated in an escape drill and fire drill. One staff report they have participated in flooding drill. One staff reported they have participated in a major disturbance drill. Drills are also reviewed during staff meetings and shift briefings. An informal interview with the superintendent reflected the center conducts various safety, emergency, and medical drills monthly. All drills are documented on drill forms and in the logbook. Additionally, staff signs a roster acknowledging they have participated in the drill.

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

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

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

The center has a written policy and procedures ensuring fire prevention and safety of the center. The center contracts with Cintas Fire Protection to conduct annual inspections of the fire

detectors, fire alarms, and sprinkler systems. The center's disaster plan, fire prevention plan, and evacuation plan were reviewed and approved by the local fire marshal on September 7, 2018. A review of the emergency drills and logbook documentation for the past six months validated the center conducts fire drills every month, on each shift, during different times. Staff sign a roster acknowledging they have participated in the fire drills as well. Drills are also reviewed during staff meetings and shift briefings. Seven staff were interviewed, and each staff confirmed they have participated in fire drills monthly. Seven youth were interviewed, and each reported they have been instructed on what to do in the case of a fire. A review of seven staff training records showed six out of seven staff received the annual fire prevention training.