STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

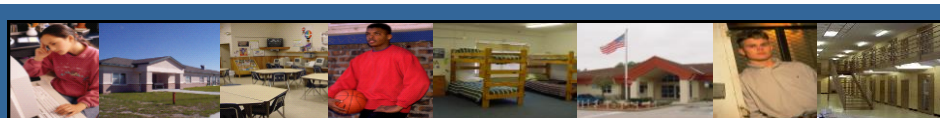
Annual Compliance Report

Alachua Regional Juvenile Detention Center

Department of Juvenile Justice

(State-Operated)
3440 NE 39th Avenue
Gainesville, Florida 32609

Review Date(s): December 8-11, 2020



Promoting Continuous Improvement and Accountability
in Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Mike Marino, Office of Accountability and Program Support, Lead Reviewer (Standard 1)
Jeff Campbell, Office of Education, Education Specialist (Standard 2)
LeAnn Gruentzel, Office of Accountability and Program Support, Regional Monitor (Interviews)
Forrest Hallam, Marion Regional Juvenile Detention Center, Superintendent (Standard 5)
Kristine Harshaw, Office of Accountability and Program Support, Regional Monitor (Standard 4)
Gwen Nelson, Office of Accountability and Program Support, Regional Monitor (Standard 3)
Devon Whitten, DJJ Probation, Circuit 7, Juvenile Probation Officer (Standard 2)

Program Name: Alachua Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: Alachua County / Circuit 8
Review Date(s): December 8-11, 2020

MQI Program Code: 89
Contract Number: NA
Number of Beds: 42
Lead Reviewer Code: 37

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.05 Protective Action Response (PAR)	
2.08 Release of Youth Personal Property	

Standard 1: Management Accountability
Detention Rating Profile

Indicator Ratings

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

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

Standard 2: Youth Management
Detention Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Detention Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Detention Rating Profile

Indicator Ratings

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

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Program Overview

Alachua Regional Juvenile Detention Center is a state-owned detention facility, operated by the Department, located in Gainesville, Florida. The center serves youth in Alachua, Baker, Bradford, Columbia, Dixie, Gilchrist, Hamilton, Lafayette, Levy, Putnam, Suwannee, and Union Counties, over three judicial circuits. Male and female youth who are detained pending adjudication, disposition, or placement in a residential commitment program are housed in the forty-two-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 Sequel Youth and Family Services through a contract with the Alachua County School Board. The center's management team includes the superintendent, two assistant superintendents, one administrative assistant, seven juvenile justice detention officer (JJDO) supervisors, and forty JJDOs. Mental health and healthcare services are provided through the contracted provider, Camelot Community Care. Mental health services are provided by a licensed mental health professional, who serves as the designated mental health clinician authority (DMHCA), a registered mental health counselor intern, and a psychiatrist. 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. Medical services are provided by a medical doctor (MD) who serves as the designated health authority (DHA), an advanced practice registered nurse (APRN) who is on-site twice a week, a full-time registered nurse (RN) who serves as the clinical manager, a full-time licensed practical nurse (LPN), a pro-re-nata (PRN) LPN, and a medical records clerk. At the time of the review, a part-time RN and a part-time LPN were out on medical leave.

The medical clinic maintains nursing coverage Monday through Friday from 8:00 a.m. to 7:30 p.m. and on weekends from 8:00 a.m. to 4:30 p.m. Nursing coverage hours can be adjusted based on youth need. 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 four living modules which are divided by male and female. There are seventy-eight security cameras at the center of which all were operational. The center was clean and free of any noticeable graffiti, odors, or pests. At the time of the annual compliance review, the center had eleven vacancies, which included one JJDO supervisor and ten JJDOs. In addition, there were three newly hired JJDOs in training.

Standard 1: Management Accountability

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

The center has a written policy and procedures requiring compliance with the Department's background screening requirements. An initial background screening for eight newly hired employees and four contracted medical staff found the center received background screening from the Department's Background Screening Unit (BSU) prior to each newly hired staff, as required. The center did not have any volunteers since the last annual compliance review A pre-assessment tool was administered to the six direct-care staff, and all received a passing score. The Clearinghouse employment roster for the contracted provider for medical and mental health services included all medical and mental health staff working at the center. The Annual Affidavit of Compliance with Level 2 Screening Standards was not submitted to the BSU by January 31. The superintendent upon becoming aware of the requirement, completed and submitted the annual affidavit on July 1, 2020. The superintendent entered an Outlook calendar reminder for the completion of the annual affidavit. The education provider submitted their Annual Affidavit of Compliance with Level 2 Screening Standards to the BSU on December 4, 2019. The contracted provider for medical and mental health services submitted their Annual Affidavit of Compliance with Level 2 Screening Standards to the BSU on January 29, 2020.

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

The center maintains a written policy and procedures to ensure all employees, contracted providers, and volunteers with access to youth undergo a criminal history background check every five years. Four staff were applicable for a five-year background rescreening. A background rescreening was completed for each staff prior and within a year of their anniversary hire date, as required. There were no volunteers or contracted staff applicable for a five-year background rescreening.

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

The center has a written policy and procedures addressing the staff code of conduct. All staff acknowledged the code of conduct by signature or through the Department's onboarding process upon hire. A review of the Central Communications Center (CCC) reports found there were no substantiated incidents of abuse during the annual compliance review period. The center took disciplinary action on four staff for violations of the code of conduct during the annual compliance review period in which all were oral reprimands. In addition, two staff resigned pending investigation for violation of the code of conduct. Three staff were awarded the Regional Employee of the Month award for Detention Services.

Five youth were interviewed and each reported they felt safe at the center. None of the youth stated exchanging emails, telephone numbers, or social media contact information with staff. Four youth reported they have not been stopped from reporting abuse. The remaining youth stated never having to report abuse. Four youth stated staff are respectful when speaking to them or other youth. All youth reported they have never heard staff threaten them or other youth. When questioned if they heard staff use profanity when speaking with youth; two youth stated never, one stated once, one stated occasionally, and one stated often.

Five staff were interviewed and each were familiar with the process for reporting suspected abuse to the Florida Abuse Hotline or Central Communications Center (CCC). Four staff reported they have never observed a co-worker use threats, humiliation, or intimidation when interacting with youth. The remaining staff stated having observed this when they first started with the center in 2017 but have not observed since then. When questioned if staff have observed a co-worker use profanity when speaking with youth; one staff stated once, three stated occasionally, and one stated often. When questioned about the working conditions at the center in the past year; four staff rated working conditions as fair and one stated very poor.

An interview with the superintendent referenced the facility operating procedures related to the code of conduct, which state staff must adhere to a code of conduct prohibiting any form of abuse, profanity, threats, harassment, intimidation or personal relationships with the youth. The superintendent also identified the requirements for reporting alleged abuse to the Florida Abuse Hotline and the CCC.

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

The center maintains a written policy and procedures regarding response to incidents. During the past six months, the center reported forty-nine incidents to the Central Communications Center (CCC). Five CCC incidents were reviewed and each were reported within a two-hour time frame and documented in the master control logbook, as required. There were no indication of any reportable incidents not being reported to the CCC. The superintendent stated when a reportable incident occurs, the center's highest ranking staff on duty shall notify the CCC within two hours of the incident or within two hours of becoming aware of the incident.

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 to be completed and filed in accordance with the Florida Administrative Code.	

The center maintains a written policy and procedures to ensure all detention staff use physical intervention techniques in accordance with Florida Administrative Code. The center had eighty-seven Protective Action Response (PAR) incidents in the past six months. Eight PAR reports were reviewed. All eight reports including statements from all staff involved, were completed by the end of the staff members' workday. None of the PAR incidents included use of mechanical restraints or resulted in serious injury to a youth. One PAR incident resulted in a staff member seeking outside medical attention for an injury, and the Central Communications Center (CCC) was contacted within two hours. None of the youth alleged abuse during these PAR incidents.

The PAR reports were reviewed by a supervisor and PAR instructor; however, five of the eight supervisor and PAR instructor reviews were documented prior to statements being completed by staff involved in the PAR incident. In another PAR report, the supervisor and PAR instructor review is documented prior to one of the four staff statements being completed. Four of the eight reports documented a post-PAR interview conducted with the youth by an administrator or designee within thirty minutes after the incident occurred. In the remaining reports, the post-PAR interview was documented an hour to six hours after the incident. Five of the eight PAR reports were reviewed by the superintendent or designee within seventy-two hours of the incident, as required. In the remaining three reports, the superintendent or designee reviews were documented four, six, and eleven days after the incident. The superintendent interview indicated video reviews are completed for all PAR incidents but this was not consistently documented on the PAR reports. None of the PAR reports indicated a medical review was necessary, the center takes youth to the medical clinic after PAR incidents, which was documented in medical records. The center's PAR rate during the annual compliance review period was 15.14, which is below the statewide Detention PAR rate of 16.56.

Five staff were interviewed and each reported they try to talk to youth prior to using physical restraints. An interview with the superintendent indicated all PAR incidents are reviewed to ensure the use of force was reasonable and justified. All documentation was included.

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

The center maintains a written policy and procedures regarding a pre-service training plan for all new staff. Five staff training records were reviewed for pre-service training. Each reviewed staff completed the essential skills training prior to contact with youth to include Protective Action Response (PAR), cardiopulmonary resuscitation (CPR)/automated external defibrillator (AED), first aid, mental health and substance abuse services, suicide recognition and intervention, safety and security, Prison Rape Elimination Act (PREA), human trafficking, and detention operations. All five staff completed all Phase One training to include orientation, information security awareness, legal, gang awareness, interpersonal and communication skills, active shooter, and youth management. Three staff completed the academy (Phase Two Training) and were certified within 180-days of hire. The remaining two staff were hired within the past 180-days and are pending certification. All training was documented in the Department's Learning Management System (SkillPro) within thirty days of training completion.

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

The center maintains a written policy and procedures regarding in-service training for all staff. Five staff training records were reviewed for in-service training, including three supervisors. All five staff exceeded the annual requirement for twenty-four hours of training, completing between fifty to seventy-seven hours of training. All five staff had current cardiopulmonary resuscitation (CPR), first aid, and automated external defibrillators (AED) certifications. All five staff had an eight-hour Protective Action Response (PAR) update. All five staff completed training on professionalism and ethics, human trafficking, and suicide prevention. Four of the five staff completed active shooter training. Two of the three supervisors received at least eight hours of training in management related topics. The remaining supervisor received two hours of training in management during the previous calendar year. The center has an annual in-service training calendar, which is updated as changes occur. All in-service training was documented in the Department's Learning Management System (SkillPro) within thirty days of training completion. An interview with the superintendent identified the training required for staff and management training completed during the past year.

1.08 Grievances	Satisfactory Compliance

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

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

The center has policy and procedures for a youth grievance process. The process includes an informal phase which the youth speaks with staff, a formal phase which the youth files a grievance and is reviewed by the supervisor, and an appeal phase in which the grievance is forwarded to administration. Grievance forms are available to youth in the modules and youth are instructed to request a pencil from staff in order to complete the grievance form. Five grievances were filed by youth during the annual compliance review period. Each grievance was entered in the Facility Management System (FMS) on behalf of the youth by staff. Supervisors responded to the grievances within the required time frame in four of the five cases. In the remaining case, the supervisor response was a day late. Youth acknowledged the supervisor response in each case and three accepted the supervisor's explanation or proposed resolution. Two youth requested their grievance to be forward to the appeal phase. Both appealed grievances were addressed by administration within the required time frame.

Five youth were interviewed and each was able to explain part if not all of the grievance process to include talking with staff, availability of grievance forms, and filling out a grievance. When questioned how they would rate the grievance process; two youth rated it as good, one youth rated it as very good, and two youth reported they have never filed a grievance. All five interviewed staff were able to explain the grievance process. The superintendent interview clearly outlined the grievance process. The superintendent indicated grievances are entered into and maintained in the FMS.

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

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

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

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

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

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

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

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

The center enters an alert into the Department’s Juvenile Justice Information System (JJIS) for youth who require an alert which may not have been previously identified prior to the youth’s admission. Five youth case management, individual healthcare, mental health records, and JJIS were reviewed for alerts. Alerts identified in youth records and those listed in JJIS matched. The center verifies all youth alerts, contacting parent/guardians if necessary. All youth reviewed had a medical grade of two to five and had a corresponding alert(s) in JJIS created by nursing staff. Four reviewed youth had a mental health alert created by mental health staff. The remaining youth did not have any type of mental health alert. Medical alerts were discontinued only by nursing staff and mental health alerts were discontinued only by mental health staff. Two youth had security alerts as “single room only” which were entered by center administration or designees. Security alerts can only be discontinued by center administration or designees.

Five staff were interviewed and each reported they are informed of youth alerts during shift briefings. Staff also reported they receive alert information through alert forms, JJIS, and emails or training. The superintendent indicated staff maintains a copy of alerts while on duty and alerts are reviewed weekly to ensure they are current.

Standard 2: Assessment and Performance Plan

2.01 Admission	Satisfactory Compliance

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

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

The center has a written policy and procedures for admissions. Five youth case management records were reviewed for admission. Four records contained an arrest affidavit/custody order, a Detention Risk Assessment Instrument (DRAI), and Suicide Risk Screening Instrument (SRSI). The remaining record was a courtesy hold for Duval Detention and contained the arrest affidavit/custody order, courtesy hold order, and DRAI. All five records had the admission wizard printed and placed in the record. Each Admission Wizard documented youth were allowed to make a telephone call, to be frisked, electronically searched, stripped searched, and screenings to identify medical, mental health, and substance abuse needs. All five of the Admission Wizards documented youth were offered a snack or meal. An admission was unable to be observed during the week of the annual compliance review.

2.02 Orientation	Satisfactory Compliance

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

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

The center maintains a written policy and procedures to advise youth of center rules and regulations, expectations for behavior and related consequences for failing to meet those expectations, and youth rights within twenty-four hours of a youth being admitted into the center. Five youth case management records were reviewed for orientation. Documentation revealed orientation was completed within twenty-four hours of admission for each youth, with youth acknowledging the orientation by signature. The orientation process included identification of key personnel, the daily activity schedule, the center's 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 and Central Communications Center, behavior expectations and related consequences, and possible new law violations for destruction of property. Four of five the interviewed youth reported staff provided them with information about the center's rules and regulations, daily schedule, education services, visitation, abuse reporting, and the behavior management system.

2.03 Classification	**Satisfactory Compliance**

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

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

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

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

The center has written classification procedures to ensure all youth admitted to the center are classified to provide the highest level of safety and security. Five youth case management records were reviewed. Admission Wizards were completed in each record which included a review of each youth's history, sex, height, weight, age, level of aggressiveness, identified special needs, history of sexual offenses, the Victimization and Sexually Aggressive Behavior (VSAB) form, medical, suicide risk identified or suspected, escape, gang affiliation, and security. Youth were assigned to rooms based on classification procedures. Alerts were entered in the Department's Juvenile Justice Information System (JJIS), as applicable.

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

The center has a screening process for youth newly admitted into the center to determine if the youth is a gang member or gang affiliated. A review of three applicable youth case management records, one from the initial sample and two additional records, indicated all youth were screened for gang affiliation during intake. Each youth was identified as a gang member or having suspected gang affiliation in the Department's Juvenile Justice Information System (JJIS), which was reflected on the intake paperwork. The alleged gang affiliation identified at intake was passed on to the shift supervisor and subsequently forwarded to the center's gang representative which is currently the center's superintendent). All JJIS alerts are provided to staff during shift briefings; therefore, all staff were informed of the gang alerts.

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

The center maintains a written policy and procedures to ensure a youth's personal property is maintained securely. Five youth case management records were reviewed and each record documented the youth's property was inventoried by the admitting juvenile justice detention officer (JJDO) and entered into the Department's Juvenile Justice Information System (JJIS). A Property Receipt Form was printed and signed by the youth and JJDO in each record. Youth property is placed in a bag with a copy of the Property Receipt Form, a photo of the youth, and the bag is placed in a secured room. Money and other valuable items are placed in a clear tamper-proof bag and placed in a drop safe, which is under camera surveillance. The tamper-proof bags are labeled with the youth's name, Department identification number, a listing of the items in the bag, and both youth and staff signatures. A log is maintained to document items placed in the drop safe. All records contained a signed letter of acknowledgement regarding unclaimed property. Three of the five interviewed youth reported staff checked their personal property and the youth signed a property receipt upon admission to the center. The remaining two youth stated they did not have any personal property. An interview with the superintendent confirmed the process for the receipt of youth property.

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

The center maintains a written policy and procedures to ensure a youth's personal property is maintained securely and returned to the youth in a timely manner upon their release. Upon entering the center, youth personal property is stored within two separate areas in the center. Youth clothing is stored in a property room with access restricted to supervisors and intake personnel. Valuable property is turned over to the shift supervisor. Valuable property items are secured in a tamper-proof bag and secured in the drop safe, which is under closed-circuit television (CCTV) surveillance. Currently, only administration and the staff assistant have access to the drop safe. Valuable property is removed daily and stored into the main safe area, which is also under CCTV surveillance. Property bags are listed in a binder by date order. Property is purged by the staff assistant after a youth departs the center and a notice of thirty-day disposal is sent to the parent/guardian. A review of Central Communications Center (CCC) reports for the past six months indicated there were no incidents related to youth property reported. The superintendent was interviewed and clearly explained all procedures related to the storage of youth personal property.

2.07 Release	**Satisfactory Compliance**
When releasing youth from the center, the releasing officer shall verify the court's authorization to release the youth. Care must be taken to ensure all case file information is reviewed to prevent the negligent release of a youth. *All releases from the center are court-ordered, with the exception of deaths, escapes, and expirations of detention time period. In the absence of a written order, documentation of a verbal order in open court may be used for release.* *The on-duty JJDO Supervisor reviews all paperwork prior to a youth's release. The JJDO Supervisor is responsible for ensuring there are no holds, court orders, or other legal reasons not to release the youth.* *Questions concerning release are presented and addressed by the superintendent, or designee, prior to release.* *The releasing officer shall verify the identification of the youth.*	

The center maintains a written policy and procedures to ensure all releases from the center occur promptly and accurately. Four closed youth case management records were reviewed for release documentation. All records confirmed the center was consistent in photocopying the identification (ID) cards of the responsible adult to whom youth were released. Each of the four records documented court orders and other paperwork related to the release were reviewed by the supervisor. Each record documented the youth's identity was confirmed prior to release. In all four records, the youth and responsible adult to who the youth was being released to were reminded of future court dates. All four records confirmed all required parties signed all applicable release forms. A review of Central Communications Center (CCC) reports for the past six months indicated there were no unauthorized releases. A release was unable to be observed during the week of the annual compliance review.

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

The center maintains a written policy and procedures to ensure a youth's personal property is maintained securely and returned to the youth in a timely manner upon their release. Four closed youth case management records were reviewed for release of youth personal property. In all four records, there was a copy of the property receipt on file. In all four records, the property receipt was signed by the youth. In three of the four records, the property receipt was not signed by the parent/guardian. There is a process in place to purge property and send a letter to the parent/guardian informing them of the intent to dispose of the property if the property is not picked up after thirty days. The superintendent interview indicated property not picked up after thirty days is either donated to a local charitable organization or discarded. Unclaimed currency is forwarded to the Bureau of Unclaimed Property.

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

The center maintains a written policy and procedures regarding release of youth with prescription medications. Three youth case management records of youth released from the center with medication, one from the initial sample and two additional records, were reviewed. A medication receipt form was completed in each record. All forms were signed and dated by all required parties. A review of reports found the supervisor advised medical staff if a youth was being released from the center, checking to see if the youth had any medication upon their release. Medical staff will bring the medication to the lobby area and complete a review and count of the medication with the parent/guardian. The parent/guardian, medical staff, and a witness signed the medication receipt.

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

The center maintains a written policy and procedures ensuring detention reviews are conducted weekly for youth securely detained to ensure proper management of youth and the sharing of information. The superintendent reported the center has designated a juvenile justice detention officer II (JJDO II) to serve as the detention review specialist to coordinate detention reviews weekly on Wednesdays. The superintendent advised the weekly reviews include representatives from administration, mental health, medical, and education services at the center along with probation staff from the circuit. The superintendent indicated the meetings address youth alerts, confinements/behavior issues, current court status, any issues relative to youth's placement if committed, education, and medical or mental health concerns. Documentation of detention reviews occurring during the past six months was reviewed and a detention review was observed. All youth on detention status were reviewed, which included any follow-up information needed from previous reviews, pending court dates, commitment status, release dates, and other pertinent information. The reviews were attended either in person or by telephone, by circuit probation staff and all departments within the center.

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

The center maintains a written policy and procedures to address the daily activity schedule. The daily activity schedule is posted in each living area and outlines the days and times for each youth activity. A review of logbooks, five youth and five staff interviews, and observations during the annual compliance review indicated the center follows the daily activity schedule. The schedule includes times for personal hygiene, meals, visitation, education, indoor and outdoor recreation, shift change, faith-based services, groups, shower time, bedtime, and down time for youth.

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

The center maintains a written policy and procedures which outlines adherence to a daily schedule. Observations during the week of the annual compliance review confirmed youth moved to and from class, meals, and other activities as scheduled. Logbooks documented the schedule was followed unless an emergency event or disturbance occurred. Any changes to the schedule must be approved by the shift supervisor or administration. Five staff and five youth were interviewed and each but one youth reported the activity schedule is followed. The one youth was unable to provide an explanation to their response.

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 program has a policy and procedures to provide for educational access. The center provides education services through Sequel Youth and Family Services. The center integrates education into the daily schedule to ensure the youth are receiving the required minimum instruction time distributed over a twelve-month period. The district and daily school calendars were reviewed and incorporated the required 250-days of instruction with ten days used for teacher planning. The provided schedule indicated three block educational instructional periods. Block One is one hour and fifty minutes and Blocks Two and Three are one hour and thirty-five minutes. This fulfills the weekly requirement of twenty-five hours of instructional time. Youth receive credit for course completions, as appropriate. During the COVID-19 pandemic, youth were receiving educational services through a virtual platform utilized Zoom. The center returned to face-to-face instruction. An interview with the lead educator verified youth are attending school according to the daily schedule. A review of the logbook confirmed there were no interruptions to the daily school schedule.

Five youth were interviewed and each confirmed they attend school Monday through Friday, with minimal interreference of educational instruction. Three youth indicated the center was preparing them well educationally. The remaining two youth responded not well, with one youth indicating the school was not helping the youth, and the remaining one youth indicated being bored because the youth has graduated.

Five staff were interviewed and indicated school is taking place Monday through Friday, as scheduled with minimal interference. One staff report feeling the kids did not want to learn at no fault of the teachers and stated it is difficult to teach at grade level when there is a diverse grade level of youth. During an interview with the superintendent, it was reported there is minimal interference of educational instruction. The superintendent indicated if a student is needed by a counselor, attorney, or medical; they are escorted to them and returned directly back to the class.

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

The center has a policy and procedures to provide for career education. An interview with the lead teacher revealed the center provides Type 1 career education development through their Personal Career School Development class. This class includes Career Learning Strategies such as interviewing skills and techniques, career interest, inventories, budgeting, résumé writing, as well as completing employment applications. The center also provides Character Education through Life Skills including lessons in citizenship, integrity, and good moral character traits.

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

The center maintains a written policy and procedures which addresses trauma-informed care. The superintendent interview indicated staff receive training annually on trauma-Informed care. Staff not only address any negative behavior but look at the triggers in what is causing the trauma. Staff work with the youth to help them identify the triggers and try to find a different approach to their negative behavior. The center uses brighter colors in the building in an effort to keep the center from looking like an institutional setting. Observations and a review of ten staff training records confirmed the information provided in the superintendent interview.

Standard 3: Mental Health and Substance Abuse Services

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

The center has a written policy and procedures for a single licensed mental health professional to serve as the designated mental health clinician authority (DMHCA). The DMHCA is responsible for coordinating and implementing all mental health and substance abuse services. The center's DMHCA is a licensed mental health counselor (LMHC). The DMHCA has a clear and active license in the State of Florida, which expires on March 31, 2021. The DMHCA's written interview confirmed the DMHCA is responsible for the administrative oversight and management of mental health and substance abuse services at the center. The DMHCA is on-site forty hours a week, Monday through Thursday ten hours each day. Sign-in logs confirmed the DMHCA was on-site weekly for the past six months. The DMHCA is on-call to provide services twenty-four hours a day, seven days a week. The DMHCA position description outlines the duties and responsibilities of the DMHCA.

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 has a written policy and procedures ensuring services are provided by individuals with appropriate qualifications. The designated mental health clinician authority (DMHCA), psychiatrist, and one as needed licensed therapist are qualified professionals licensed in accordance with the contract and Rule 63N-1, F.A.C. The licenses of all clinical staff are clear and active. The psychiatrist's license expires on January31, 2022, the DMHCA and as needed therapist's licenses expires on March 31, 2021. There were no discipline or complaints associated with the licenses.

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 has a written policy and procedures to address non-licensed mental health and substance abuse clinical staff. The center has one contracted non-licensed clinical staff. The non-licensed mental health and substance abuse clinical staff has a master's-level degree in psychology. The non-licensed clinical staff provides substance abuse services under Chapter

397, F.S. working under the direct supervision of the designated mental health clinician authority (DMHCA). The non-licensed clinical staff completed twenty-four hours of training in assessing suicide risk, mental health crisis interventions, and emergency mental health services. The non-licensed clinical staff completed five assessments of suicide risk in the presence of the DMHCA. The non-licensed clinical staff receives one hour per week face-to-face direct supervision from the DMHCA, who is responsible for reviewing and signing off on the non-licensed clinical staff work.

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

The center has a written policy and procedures to ensure the mental health and substance abuse needs of youth are identified in the course of the comprehensive screening process. Five youth mental health and substance abuse records were reviewed and each record had an admission screening. Each record had a Community Assessment Tool (CAT), Suicide Risk Screening Instrument (SRSI), Massachusetts Youth Screening Inventory – Second Version (MAYSI-2), and Victimization and Sexually Aggressive Behavior (VSAB) completed by the probation screening staff. Each youth's admission information was documented in the Department's Juvenile Justice Information System (JJIS). Three of the five reviewed records indicated youth were placed on precautionary observation due to screening instruments identifying risks for suicide. Documentation demonstrated the referral process was initiated and a mental health professional was notified in the three reviewed records. The CAT indicated a need for a comprehensive assessment to be completed for three of the five youth reviewed. Appropriate referrals were made.

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

The center has a policy and procedures to address mental health and substance abuse evaluations. A review of five youth mental health and substance abuse records found three youth were identified during admission as requiring a comprehensive evaluation. Two youth were in the center long enough to receive an evaluation. One evaluation was completed by clinical staff at the detention center and the remaining evaluation by a community provider. Each evaluation was uploaded into the electronic medical record by mental health staff within thirty days of the referral. Mental health staff track youth who are referred for comprehensive evaluations and ensure the evaluations are received or completed within required time frames.

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

The center has a policy and procedures to determine if mental health treatment services are required. Five youth mental health and substance abuse records were reviewed for mental health treatment services. Three youth required treatment services. Three youth were receiving psychiatric services. One youth was discharged prior to the treatment plan due date. Two youth had treatment plans completed. The youth receiving treatment services were assigned to the mini-treatment team and treatment plans were signed by all team members. Each of the five records contained a signed Authority for Evaluation and Treatment (AET) form. All treatment notes were completed on the Department's Mental Health/Substance Abuse form. The center's policy and procedures prohibited mental health groups to contain more than ten youth. According to the designated mental health clinician authority (DMHCA), due to the COVID-19 pandemic all mental health groups were discontinued since March 2020. The center currently does not provide an alternative virtual platform for the delivery of treatment services. The DMHCA written interview indicated services prior to the COVID-19 pandemic include mental health overlay services, substance abuse overlay services, and psychiatric services. The one record documented a discharge summary was completed on the Department's Mental Health and Substance Abuse Treatment Discharge Summary form, which was provided to the youth and parent/guardian upon release. Documentation supported the discharge summary was sent to the youth's assigned juvenile probation officer (JPO).

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

The center has a written policy and procedures designed by the designated mental health clinician authority (DMHCA) and management staff for developing and reviewing mental health and substance abuse treatment plans. Five youth mental health records were reviewed. Three youth were determined to need mental health treatment, including treatment with psychotropic medication while in the center, and each was assigned to a mini-treatment team. One youth taking psychotropic medication was discharged prior to thirty days being admitted in the center. The youth refused to continue the use of psychotropic medication while in the center. An initial treatment plan was developed for the two youth in the center for more than thirty days. The youth's assigned mini-treatment team members were involved in the development of the initial treatment plan. The plans were developed for the two youth within five days of treatment and by the thirty-first day of admission. The two youth plans were completed on the proper form and signed by the appropriate parties within the proper time frame. Two youth were receiving psychotropic medication. Each of the two youth received an initial diagnostic psychiatric interview within five days. The frequency of medication monitoring by the psychiatrist was documented on the proper form. One of five reviewed records were applicable for a mental health and substance abuse treatment discharge summary.

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 has a policy and procedures to provide psychiatric services. The center utilizes a psychiatrist licensed pursuant to Chapter 458, F.S., who is board certified in Child and Adolescent Psychiatry. Five youth mental health and substance abuse records were reviewed. Three youth were applicable for psychiatric services. Two of three records had documentation of services provided by the psychiatrist. The remaining youth refused psychiatric services. The two applicable records noted a diagnostic psychiatric interview within fourteen days of the youth's admission to the center. The psychiatric written interviews included all required elements. All psychiatric evaluations were conducted within thirty days of intake using the Department's Clinical Psychotropic Progress Note (CPPN). Each record had a consent for psychotropic medication, which was witnessed by another staff member. Each youth had documentation of monitoring for Tardive Dyskinesia, as indicated by the psychiatrist. The designated mental health clinician authority (DMHCA) reported the psychiatrist sees all youth admitted on psychotropic medication within two weeks of admission. The psychiatrist is responsible for medication management for youth on psychotropic medications. All youth receiving treatment services have a current Authority for Evaluation and Treatment form (AET) and a consent for psychotropic medications signed by the youth's parent/guardian. None of the reviewed records were applicable for youth in foster care or reaching eighteen years of age while at the center and requiring additional consents. All services provided by the psychiatrist are face-to-face. No tele-psychiatry services were provided. Psychiatry back-up services are provided from the contract provider's pool of psychiatrists.

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's suicide plan outlines how to safely assess and protect youth by using the least restrictive means. The plan includes all the required elements including identification and assessment, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response a and review process. The plan is in accordance with Rule 63N-1., Florida Administrative Code. The plan was reviewed and approved by the center's superintendent and designated mental health clinician authority (DMHCA) on July 23, 2020 and July 24, 2020.

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

The center has suicide prevention services to assess and protect youth at risk for suicide in the least restrictive means and in accordance with Rule 63N-1, Florida Administrative Code. Five youth mental health and substance abuse records were reviewed. Three of the five reviewed youth were placed on suicide precaution status upon admission due to the youth's admission screenings and the center's policy. Each record documented the completion of an Assessment of Suicide Risk (ASR) by the designated mental health clinician authority (DMHCA). Each record documented the immediate notification to the center's superintendent and/or designee and the completion of a suicide precaution observation log. None of the records indicated a 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 PO until assessed. Each record had documentation of the youth transitioning 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. A review of the center's master control logbook indicated beginning and end times were documented for youth placed on PO.

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 has a written policy and procedures for staff assigned to monitor youth on suicide precautions. Five youth mental health and substance abuse records were reviewed. Three youth were applicable for a suicide precaution observation log. Each record contained the Department's Suicide Precautions Observation Log form. Each record contained documentation of the youth's behavioral observations documented in real time. Staff observations were completed at or below thirty-minute intervals with two exceptions. Staff initialed their observations with few exceptions in which six of the 436 observations were not initialed by staff. None of the reviewed records were applicable for observed warning signs requiring supervisory and/or mental health notification and/or consultation. Each record documented the signatures of each shift supervisor, the center's mental health clinical staff, and documentation of safe housing requirements. Logs were reviewed and signed by the mental health clinical staff and the shift supervisor daily. Five additional youth who had been on suicide precautions were interviewed. Each youth reported staff were always with them 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 has a written policy and procedures requiring staff to complete at least six hours of suicide prevention and implementation of suicide precautions training annually. A review of ten staff training records supported each staff received two hours of suicide prevention training in the Department's Learning Management System (SkillPro) and eight direct care staff completed four hours of instructor-led suicide prevention and suicide precaution training, as required. Mock suicide drills were held for each shift and each quarter. The mock suicide drills contained all the required elements and all reviewed staff participated in quarterly drills, as required. Five staff were interviewed and each stated they participated in a mock suicide drill. When question about the location of the suicide response kits, all five staff stated the kits were located in master control and a closet outside the dorms. Four staff stated a kit is located in sub-control in the girls' module and one staff stated a knife-for-life kit is in the medical office.

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

The center has a written policy and procedures for providing mental health crisis intervention services. The center utilizes this plan to respond to youth in crisis in the least restrictive means possible. A review of the mental health crisis intervention plan determined the plan includes notification and alert system, means of referral, including youth self-referral, communication, supervision, and documentation and review. The emergency services plan was reviewed and signed by the designated mental health clinician authority (DMHCA) and superintendent on July 23, 2020 and July 24, 2020.

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

The center's emergency care plan is in accordance with the Department's Rule 63N-1.011 and Rule 63N-1.0112, Florida Administrative Code. The plan includes training, review, documentation, transport, response, communication, supervision, notifications, and authorization to transport for emergency mental health or substance abuse services for Baker Act and Marchman Act. The plan was reviewed by the center's superintendent and designated mental health clinician authority (DMHCA) on July 23, 2020 and July 24, 2020. A copy of the emergency plan is located in the supervisor office, mental health office, training office, and on the center's K drive.

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 did not have any youth requiring a Crisis Assessment during the annual compliance review period. The center has a written policy and procedures to respond to youth in crisis. A Crisis Assessment is to be completed in accordance with the center's policy and procedures when a youth is identified as being in crisis. The center's Crisis Assessment contained all the appropriate requirements to include the reason for assessment, mental status examination and interview, determination of danger to self and others, initial clinical impression, supervision recommendations, treatment recommendations, recommendations for follow-up or further evaluation, and notification to parent/guardian of follow-up treatment. The assessments are to be documented on the Department's Crisis Assessment form. The assessments are completed by a licensed mental health professional and a mental health alert is completed and entered in the Department's Juvenile Justice Information System (JJIS).

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 has a policy and procedures for youth requiring Baker and Marchman Act services. The center had two youth requiring a Baker Act during the annual compliance review period. Mental health staff initiated the Baker Acts. Documentation included notifications to the youth's parent/guardian and assigned juvenile probation officer (JPO). The youth were maintained on one-to-one supervision prior to being transported for the Baker Act services. Upon returning to the center, each youth was placed on constant supervision. A Mental Status Examination (MSE) was conducted by the licensed mental health staff. A suicide risk alert was completed in the Department's Juvenile Justice Information System (JJIS). The level of supervision was not lowered until follow-up Assessments of Suicide Risk were completed and mental health staff consulted with the superintendent or designee. There were no Marchman Acts during the annual compliance review period.

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 Department contracts with Camelot Community Care, Inc., to provide medical, mental health, substance abuse, and psychiatric services for youth in the Department's twenty-one regional juvenile detention centers. Camelot Community Care subcontracts with a medical doctor (MD) to serve as the designated health authority (DHA) at the center. The MD has a clear and active license to practice in the state of Florida, which expires on January 31, 2021. The DHA is available twenty-four hours a day, seven days a week by telephone to address any medical concerns at the center. Sign-in logs for the past six months were reviewed and confirmed the DHA was on-site for at least one hour each week. Another MD has been identified to provide back-up coverage if the DHA is on scheduled leave. Camelot Community Care also employs an advanced practice registered nurse (APRN). The APRN holds a clear and active license to practice in Florida, which expires on July 31, 2022. The APRN provides services on-site ten to fifteen hours a week. The APRN works in collaboration with the DHA and there is a signed Collaborative Practice Protocol between the APRN and DHA. The DHA and APRN perform Comprehensive Physical Assessments or focused evaluations on each youth, evaluate youth with chronic conditions, conduct sick call and episodic care when on-site, and make referrals for testing and/or off-site care. A check of all licensed medical staff confirmed all had current State of Florida medical licenses, verified by the Department of Health.

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 has facility operating procedures (FOPs) and treatment protocols for all healthcare-related services provided at the center. All healthcare FOP and treatment protocols were reviewed and signed by the designated health authority (DHA) and the superintendent in August 2020. The psychiatrist reviewed and signed the FOP related to psychiatric services in November 2020. All nursing staff signed a cover page acknowledging all healthcare FOP and treatment protocols. The center did not have new nursing staff since the last compliance review. The FOP state newly hired nursing staff will receive a comprehensive clinical orientation to the Department's healthcare policies and procedures, provided by a registered nurse.

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.	

Five youth individual healthcare records (IHCR) were reviewed for the completion of an Authority for Evaluation and Treatment (AET).Three additional youth records were reviewed for the completion of the Limited Consent for Evaluation and Treatment and court order for youth in the custody of the Department of Children and Families (DCF). The five records for youth requiring an AET contained an AET signed by a parent/guardian. A Limited Consent for

Evaluation and Treatment and court order authorizing medical treatment were present for the three DCF youth. The AETs and Limited Consents for Evaluation and Treatment were obtained prior to medical services being provided at the center. The nurse completing the interview was familiar with procedures for the completion of an AET.

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.	

Five youth individual healthcare records (IHCR) were reviewed for parental notifications, with an additional two youth records utilized to review notifications for off-site care. The five youth requiring parental notifications included four notifications for over-the-counter medications not covered by the Authority for Evaluation and Treatment (AET), two notifications for off-site care, and two notifications for psychotropic medications. Verbal notifications to the parent/guardian were documented in each case. A witness was documented for each notification for psychotropic medication. Written notifications were completed in each case. For psychotropic medications, the notifications included page three of the Clinical Psychotropic Progress Note (CPPN). The nurse completing the interview were knowledgeable of the process for parental notification and consent requirements.

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.	

A review of five youth individual healthcare records (IHCR) found each youth received a medical and mental health admission screening upon admission. Each screening was completed on the day of admission. Each youth was screened by a juvenile justice detention officer (JJDO) or JJDO supervisor. There was documentation of each screening being reviewed by a licensed nurse within twenty-four hours. Three additional youth IHCR for female youth were reviewed. Each female youth consented to and received a qualitative urine pregnancy test. There were no instances of youth with a change in physical custody requiring a healthcare admission rescreening. The superintendent interview revealed medical and mental health admission screenings are completed by the admitting JJDO and reviewed by nursing staff within twenty-four hours. The nurse completing the interview was knowledgeable of the process for initial screenings and re-screenings for youth with a change in custody.

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

Five youth individual healthcare records (IHCR) were reviewed. Each record documented nursing staff provided a general orientation to healthcare services within twenty-four hours of admission to the center. The healthcare topics reviewed during orientation included access to medical services, sick call, what constitutes an emergency and who to notify, medication process and side effects monitoring, the right to refuse care and how it is documented, what to do in the case of a sexual assault or attempted sexual assault, and the non-disciplinary role of the healthcare providers.

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.	

A review of five youth individual healthcare records (IHCR) found three were applicable for notification to the designated health authority (DHA). The DHA was notified when youth were confirmed as possessing a medical concern or chronic condition. The psychiatrist was notified when youth had prescriptions for psychotropic medication. The notifications were documented in each youth's IHCR. The nurse reported the DHA is immediately notified when youth are admitted with serious or chronic conditions.

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

A review of five youth individual healthcare records (IHCR) found each had a Health-Related History (HRH) form completed within seven days of admission. Three of the HRH forms were new and the remaining two were updated. All HRH forms were completed by a licensed nurse and reviewed by the designated health authority (DHA) or the advanced practice registered nurse (APRN). Each of the HRH forms were completed before the Comprehensive Physical Assessment (CPA). In addition, HRH forms were updated as new medical information became available, such as the youth being placed on medication. The nurse interview indicated medical staff completed the HRH within twenty-four hours of admission.

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

A review of five youth individual healthcare records (IHCR) found each contained a current Comprehensive Physical Assessment (CPA). Three of the reviewed records had a current CPA at the time of the youth's admission. In each of the three records, the designated health authority (DHA) or advance practice registered nurse (APRN) documented a review of the CPA and completed a focused evaluation within seven days of admission. The remaining two records documented a new CPA was completed within seven days of admission. If a youth refused any part of the exam, the clinician documented "Youth Refused" and the youth signed a refusal of care form. The Department's Problem List was updated for each youth. Each youth had at least one verified Tuberculin Skin Test (TST) documented in the IHCR on the CPA and Infectious and Communicable Diseases form. The Tier 1 Tuberculosis screening was completed within seventy-two hours for each youth. None of the youth had a positive TST or symptoms of Tuberculosis requiring them to be transported to the nearest hospital for further evaluation. The nurse interview was able to explain the process for completion of CPAs and TSTs.

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

Five youth individual healthcare records (IHCR) were reviewed for youth evaluated and treated, if necessary, for sexually transmitted infections (STI). Each youth was screened and evaluated for STI and each screening was reviewed by the advanced practice registered nurse (APRN). Each youth was offered human immunodeficiency virus (HIV) testing; three youth declined testing. The ARNP ordered STI testing for two youth; however, one youth refused at the time of the testing. Results of the STI testing for the one youth were documented on the Infectious and Communicable Disease (ICD) form. The Department of Health conducts HIV testing at the center. Pre-test and post-test counseling were documented on the Health Education Record for the youth and test results were documented in a confidential manner. The nurse completing the interview described the screening and testing processes for STIs and HIV. Five youth were interviewed and four stated they could request a HIV test and the remaining youth stated they could not request a HIV test.

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

The center has a policy and procedures in place for the completion of sick calls. Three instances of sick call care were reviewed. All Sick Call Request forms and narrative progress notes conformed to the professional standards to include all elements of the subjective, objective, assessment, and plan (SOAP) format. Each sick call was conducted within twenty-four hours of the sick call request being completed by the youth. One sick call was conducted by a licensed practical nurse (LPN) and was reviewed by a registered nurse (RN) within twenty-four hours. Sick calls were found to be documented on the youth's Sick Call Index and the center's sick call log. None of the youth presented a similar sick call complaint three or more times within a two-week period. There were no youth complaints regarding any severe pain with which medical staff were unfamiliar. Sick calls are conducted in the medical clinic by licensed medical staff at the center. When there is not a licensed nurse on-site, the center has procedures in place for the shift supervisors to review Sick Call Requests no longer than four hours after a request is submitted. Sick call is scheduled Monday to Friday from 9:00 a.m. to 10:00 a.m. and from 5:00 p.m. to 6:00 p.m. and on Saturdays and Sundays from 9:00 a.m. to 10:00 a.m.; although, sick calls are conducted throughout the day as needed. During the week of the annual compliance review, one sick call was observed with the youth's permission. The youth was escorted to the medical clinic by a Protective Action Response (PAR) trained supervisor. The youth was examined by a licensed medical staff. The youth was seen in a private area with no other youth present to hear or see the examination.

The nurse completing the interview reported sick call is provided daily by nursing staff. The nurse explained sick calls conducted by licensed practical nurses (LPN) must be conducted under the direction of a RN or higher level medical professional. The nurse further explained youth presenting with a similar complaint three or more times in a two-week period require a referral to the designated health authority (DHA) or advanced practice registered nurse (APRN). Five direct-care staff were interviewed and each stated nursing staff provide sick call care. One staff replied sick call can be conducted by the supervisor if medical staff is not on-site. Three of the five interviewed youth reported they had never submitted a sick call request. The remaining two youth stated they were seen within one day of making a sick call request. Three youth reported a nurse conducts sick call and two reported they had never made a sick call request.

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

The center has a policy and procedures for first aid care, episodic care, and emergency care. A review of five youth individual healthcare records (IHCR) found none of the youth received episodic/first aid care from a non-healthcare staff. Medical staff reported there have not been any instances of non-healthcare staff providing episodic care. Two additional records with four instances of episodic care provided by medical staff were reviewed. The episodic care was documented in the subjective, objective, assessment, and plan (SOAP) format. All instances of episodic care were documented in the Episodic Care Log.

First aid kits were located in each master control including the kits for each vehicle. The designated health authority (DHA) approved the contents of each first aid kit and a list of approved items signed by the DHA was in each observed first aid kit. First aid kits in the building were checked monthly by nursing staff, which was documented on a log attached to each first aid kit. The first aid kits in the building had all required contents.

The program has three automated external defibrillators (AED) with one located outside of the medical clinic in the hallway, one outside of B1 dorm, and one in the training portable. All three AEDs were tested during the week of the annual compliance review and appeared ready for use. Documentation confirmed the AEDs were checked monthly by medical staff. The AED pads expire on March 28, 2021 and the AED batteries expire on September 27, 2022.

A review of the center's medical drills confirmed the center conducts emergency medical drills monthly on each shift. The emergency drills included a cardiopulmonary resuscitation (CPR)/AED demonstration at least once each quarter. All direct-care staff participated in emergency drills. All of the licensed healthcare staff have a current CPR/AED certification. A review of five pre-service and five in-service training records found all had current CPR/AED and first aid certification. The center has a list of emergency telephone numbers and cell phone numbers posted in master control, which is accessible to all staff.

The nurse interview was knowledgeable of the location of all first aid kits and AEDs. The nurse explained the requirements for conducting medical emergency drills and documentation requirements for episodic care. All five direct-care staff interviewed stated they are able to call 9-1-1, if they feel necessary.

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

The center has a policy and procedures in place for off-site care. Two youth had a total of four instances of off-site care were reviewed. A Summary of Off-Site Care form was completed and filed in each of the youth's individual healthcare record, along with discharge instruction documents. The designated health authority (DHA) and advanced practice registered nurse (APRN) reviewed the discharge instructions. Both youth required a follow-up appointment which was tracked by nursing staff. The nurse completing the interview stated orders from off-site care providers are obtained and reviewed by the APRN and DHA. Any follow-up care is tracked and scheduled by nursing staff.

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 written policy and procedures for the delivery of treatment to youth identified as having a chronic medical condition. A review of five youth individual healthcare records (IHCR) found three youth were identified with a chronic medical condition and/or taking prescribed medications. Each youth was classified with a medical grade two through five. Each applicable IHCR documented an initial assessment of the youth was conducted by the designated health authority (DHA) and the youth's chronic condition was monitored. The Department's Problem List was updated in each of the IHCR to identify the youth's chronic condition, as required. None of the three youth required a reevaluation, as none of the youth were in the center for ninety days. The nurse completing the interview was knowledgeable of the requirement for periodic evaluations for youth with chronic conditions, stating the frequency of the evaluations would be based on the youth's condition and in no case the time between evaluations exceed three months.

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

The center has a written policy and procedures to ensure medication is received, verified, and administered in a safe and effective manner. Five youth individual healthcare records (IHCR) for youth taking medication were reviewed. Three youth were admitted with medication. Nursing staff verified the youth's medication upon arrival at the center. The designated health authority (DHA) and/or psychiatrist was notified in each case and ordered the medication be continued as prescribed.

The center uses the standard Department's Medication Administration Record (MAR) to document administration of medications. Each MAR included the youth's name, DJJID, date of birth, youth allergies, medical alerts, medication precautions, and a picture of the youth. Three of the five MARs had the correct medical grade listed. In one instance, the youth's medical grade was missing on the MAR. This was corrected when nursing staff were informed. The remaining youth's MAR had two different medication grades listed. There were no lapses or errors in medication administration. The medical staff documented weekly side effect monitoring on the MARs. Refusals were documented clearly on the MAR and Refusal of Care Form. The center did not have any youth who required parenteral medication during the annual compliance review period.

Two of the five youth reviewed were taking psychotropic mediation and two youth had a history of taking psychotropic medication. The psychiatrist was notified when youth were identified as being prescribed psychotropic medication. The initial diagnostic psychiatric interview was conducted with fourteen days of admission for the four youth. None of the youth required a thirty-day monitoring for psychotropic medication, as none of the youth had been in the center for thirty days after the initial psychiatric interview. The center's policy and procedures required psychotropic medication monitoring every thirty days.

A medication pass completed by a nurse was observed during the week of the annual compliance review. The nurse followed the six rights of medication administration; right youth, right medication, right dose, right route, right time, and right documentation. After the nurse administered the youth their medication, the nurse verified the youth consumed the medication by checking their mouth. The center has trained non-healthcare staff to assist in the delivery of medications when licensed staff are not on-site.

The nurse interviewed was able to explain all aspects of medication management to include receipt and verification, storage, administration, and disposal of medication. Five youth were interviewed. One youth reported nursing staff provides the medication and the remaining youth stated they do not take medications; although, the one youth who reported they did not take medication, was observed during medication pass taking their medications.

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

The center has a written policy and procedures ensuring medications and sharps are secured and inventoried. Medications and sharps were found stored and locked in designated areas, inaccessible to youth. Medications storage areas include a locked medication cart, locked cabinets, and a locked refrigerator in the medical clinic. Active medications are stored in the medication cart. Sharps and stock medication are stored in cabinets. All controlled medications are stored in a lockbox within the locked medication cart. The center had no youth on controlled medication at the time of the annual compliance review. Three youth individual healthcare records for youth who had been on controlled medication while at the center were provided and reviewed. A shift-to-shift inventory count of the controlled medication was documented on each youth's individualized Controlled Medication Inventory Record.

The center has a policy and procedures for sharps and medication inventories, which includes procedures to identify and report discrepancies in sharps and medication inventories. Sharps and medication inventories were found to be out of compliance during the month of October 2020. The issue was corrected and perpetual inventories have been in compliance since November 1, 2020. Three sharps inventories were randomly selected to review for accuracy. All three of the inventories had accurate counts. Three over-the-counter (OTC) medications inventories were randomly selected to review for accuracy. Inventories were documented weekly for all OTC medication and perpetual inventories recorded when OTC medications were transferred from the stock supply in cabinets to the active supply in the medication care. The inventories for all three OTC medications were accurate.

The center has a policy and procedures in place for the disposal of medication. The contracted pharmacy consultant is responsible for the disposal of medication. Documentation confirmed the pharmacy consultant properly disposed of expired or discontinued medication with medical staff at the center witnessing the disposal.

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

The center has a written policy and procedures and an Exposure Control Plan addressing infection control, which includes staff training and education for youth on infection control. The Exposure Control Plan is written in accordance with Occupational Safety and Health Administration (OSHA) standards. The Exposure Control Plan was signed by the designated health authority (DHA) and superintendent. The Central Communications Center (CCC) has been notified when a youth or staff was tested for COVID-19. The local health department was notified on youth placed in quarantine at the center.

A review of five youth individual healthcare records (IHCR) found each youth received infection control training within seven days of admission. Training included guidelines for hand-washing techniques, universal/precautions, prevention/transmission of communicable diseases, prevention of blood borne pathogens, and guidelines for infection control. A copy of the Health Education Record form was maintained in each reviewed IHCR. A review of ten staff training records confirmed all staff received infection control training. All training and education were provided in accordance with the Centers for Disease Control and Prevention guidelines. The nurse completing the interview was knowledgeable of the location of the exposure control plan and requirements for infection control training for youth and staff.

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 in place for prenatal care for pregnant youth. The policy and procedures also address health education for youth and training for staff on healthcare issues for female youth. A review of ten training records found all staff received training on girls' healthcare. A review of medical alerts for the center found no pregnant youth were admitted to the center during the annual compliance review period. The nurse interview fully explained the center's procedures and practices for pregnant youth, including testing for youth who may be pregnant, dietary and other provisions of care for pregnant youth, off-site services available, and training for staff on girls' healthcare.

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.

Active supervision of youth was observed throughout the week of the annual compliance review. Staff were always present and aware of the youth in their supervision. Youth were never observed outside the sight and sound supervision of a juvenile justice detention officer (JJDO). During youth movement, staff were observed positioning themselves in order to best observe the youth. Staff were overheard calling in movements of youth by radio to master control prior to moving youth from one location to another and awaiting master control authorization. Logbook reviews confirmed count changes when youth left an area and when youth were released or admitted. Master control maintains a perpetual count of all youth who enter and exit the facility in the logbook, on a daily movement sheet, in the Department's Juvenile Justice Information System (JJIS), and on a white board within the control room. All five interviewed staff indicated they believe there are enough staff to provide for the safety and security of youth and staff and ratio is being met.

5.02 Behavior Management System	Satisfactory Compliance

The center provides a system of rewards, privileges, and consequences to encourage youth to fulfill the center's expectations.

Each center shall implement and maintain a behavior management system to meet the needs of the youth and the center. The system shall include rewards for positive behavior and consequences for inappropriate behavior.

The behavioral norms and expectations for youth shall be posted in all living areas and shall clearly specify appropriate and inappropriate behaviors.

The center utilizes a point and level system and has a written policy and procedures to explain the level system in detail. The system provides incentives and consequences appropriately based on the youth's behavior. Posters were visible on all mods explaining the behavior management system (BMS). Logbook reviews confirmed incentives such as a later bedtime and game room access, are provided for positive behavior.

The interview completed by the superintendent detailed the BMS Five staff were interviewed and each were able to explain the BMS and stated the BMS is effective. All staff stated they speak to youth to discuss the consequences prior to being imposed, youth are given the opportunity to explain their behavior, and staff speak to youth about alternative acceptable behaviors. Four of the five staff indicated items are not taken from youth as a consequence for their behavior. The remaining staff explained items youth earn as an incentive can be taken if a youth acted out. All staff stated they receive feedback from supervisors on the implementation of the BMS.

Five youth were interviewed and each were able to explain the BMS to some degree. Four of the five interviewed youth rated the BMS between fair to very good. The remaining youth rated the BMS as poor. Four of five youth reported consequences were fair. The youth identified examples of rewards for positive behavior to include pizza parties, later bedtimes, ice-cream, and access to the treasure box/canteen.

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

The center's behavior management policy clearly states group punishment, corporal punishment, and chemical controls are prohibited. All five interviewed youth indicated youth are not allowed to punish other youth. When questioned to identify what could be taken away when consequences were given, each youth reported only points and levels were taken and not any type of right. All five interviewed staff indicated the only items youth can have taken from them due to their behavior are points and their levels. None of the staff reported ever observing a youth being deprived of their rights because of behavior. None of the staff reported ever observing any staff encouraging youth to beat up other youth.

5.04 Ten-Minute Checks (Critical)	Satisfactory Compliance

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

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

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

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

The center has a policy and procedures to address supervision levels of youth. The center utilizes the SilverGuard system to complete ten-minute checks with an electronic wand. Ten-minute checks were observed over the previous month across all three shifts and on both the male and female sleeping units. There were four exceptions over a six-hour period of checks completed one to two minutes late while the remaining of the checks were consistently completed at the required ten-minute interval. Observation of sleeping units found all youth rooms appeared free from any visual obstructions in the windows. All five interviewed staff were knowledgeable of the requirement for checking youth every ten minutes while in their rooms for sleeping or non-punishment reasons. The superintendent interview detailed the use of the electronic wand to record checks and indicated supervisors download wand data daily.

5.05 Census, Counts, and Tracking	Satisfactory Compliance

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

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

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

The center has policy to govern the tracking of youth movement in the facility and counts. Youth movement requests were overheard being transmitted to master control and movement would not begin until authorized by master control. A review of logbooks indicated three formal head counts were conducted on each shift and documented in both the master control and module logbooks. Any time youth were admitted to or released from the center, the Department's

Juvenile Justice Information System (JJIS) was updated to reflect the information and the count was updated in the logbook and on the dry-erase board in master control. Five staff were interviewed and reported counts are completed when youth appear to be missing, when visibility is hindered, after disturbances, and after drills. All interviewed staff indicated counts are conducted at the beginning of the shift, three staff indicated counts are conducted at the end of shift as well, and two indicated counts are conducted before and after meals.

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

The center maintains bound logbooks with numbered pages for master control, vehicles, and the modules. Pages contained headers with the date, shift, and supervisor on duty. Each entry observed began with the time and contained relevant information regarding the youth or staff involved. Entries observed included counts, admissions, releases, logbook reviews, youth movement, transports, codes, drills, and supervision level changes. Highlighting was observed for counts, codes, supervision status changes, and other important topics. Errors were observed with a strikethrough and the staff initials.

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

The center has a policy and procedures regarding logbooks and reviews. Master control, mod, and vehicle logs were reviewed for the past six months. Supervisors consistently logged reviews when they entered the mods. Supervisor reviews were documented daily in the master control logbooks. Superintendent/designee reviews were routinely entered weekly by either the superintendent or the assistant superintendent over operations. The superintendent interview indicated being aware of the requirements for administrative and supervisory logbook reviews.

5.08 Key Control	Satisfactory Compliance

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

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

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

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

A key inventory shall be maintained by the Superintendent or designee at all times. (For the entire indicator statement, please reference the Monitoring and Quality Improvement FY 2020-2021 Detention indicators.)

The center has a policy and procedures for key control. Keys were observed to be maintained on tamper-proof rings. All keys observed were appropriately tagged with a chit and included the key label and another chit identified the number of keys on the key ring. Keys are maintained in lockboxes within master control when not assigned to staff. Keys are issued and assigned to staff by supervisors and non-issued keys are placed back in the key box. Youth do not have access to keys. Emergency keys were located in master control. There were no recent incidents of lost or missing keys at the center. Permanently assigned keys had forms signed by the staff and were limited to select staff and administration. All staff interviewed were able to explain components of the key control process. The center completes key inventories on each shift. A master key inventory is maintained in the assistant superintendent's office as well as a key box for spare keys. Master control staff were able to explain limits on what keys can be assigned which is based on staff roles in order to restrict access to areas such as medical, mental health, and youth property.

5.09 Vehicles and Maintenance	Satisfactory Compliance

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

The center maintains a written policy and procedures for operating and maintaining vehicles used to transport youth. The center has four vehicles which were inspected. No contraband was observed in vehicles and each vehicle had the appropriate seat belts for the available seating. A roadside hazard kit was present in each vehicle. Each vehicle was observed to have a fire extinguisher, a seatbelt cutter, and a window punch. The center's first aid kits are maintained in master control to prevent the first aid supplies within the kits from degrading due to temperature. Vehicle maintenance records were reviewed and indicated regular maintenance is occurring. Vehicle inspections are maintained in SharePoint and were consistently documented on a weekly basis over the past six months with non-systemic exceptions. A transport was not able to be observed during the week of the annual compliance review. Vehicle transport logs indicated the number of youth, staff, and destination for the transport as well as departure and arrival times. Vehicle logbooks documented checks/searches prior to transports with non-systemic exceptions It was noted and observed in master control logbooks vehicle searches are called in over the radio to master control and documented in the master control log.

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

The center has a facility operating policy and procedures for tool management. Kitchen access is limited to supervisory keys, kitchen keys, and administration keys. The kitchen has a locked cabinet where knives are maintained on a shadow board. The maintenance office where tools are located is only accessible to the administrative and maintenance staff. The maintenance office has a locked cabinet where tools are maintained on a shadow board within the cabinet. Tools were randomly select for review. All tools reviewed were etched with Alachua Regional Juvenile Detention Center ‘ARJDC’ on the handles and were found on the inventory. Perpetual inventories were present. Monthly inspections of tools were completed and signed off by the superintendent. The kitchen staff also maintained an equipment inventory and a sharps log. The center maintains a vendor log to track tools used by vendors when on-site. Maintenance and administrative staff advised all vendors are escorted within the center and their tools are identified prior to entering the secured area. No tools or kitchen equipment were noted as being missing or broken during the annual compliance review period.

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

The center has a policy and procedures regarding youth access to tools which limits youth access to only cleaning tools such as mops and brooms. All five interviewed youth indicated they either can only use mops and brooms or do not use any tools. Five staff were interviewed and four stated youth may only have access to cleaning tools. One staff stated youth do not have access to any tools. During the week of the annual compliance review, no youth were observed using any type of tools including mops or brooms.

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

The center has a policy and procedures for managing the inventory of all flammable, toxic, caustic, and poisonous items. All hazardous chemicals within the facility are securely stored with only maintenance, supervisors, and administration having access. Safety Data Sheet (SDS) books were present in each storage location. The books contained SDS for all chemicals present. Inventories are maintained for all flammable, toxic, caustic, and poisonous items. The inventories were reviewed and found to be accurate.

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

The center has a policy and procedures for managing the security of all flammable, toxic, caustic, and poisonous items. All hazardous chemicals within the facility are stored in mop closets behind a secured door in "red dot areas" which youth are not allowed to enter. Doors were labeled with warning signs. The supply cabinet for hazardous chemicals was secured with a padlock, which is only accessible by supervisors, administration, or maintenance. All five interviewed youth stated they do not use any cleaning agents such as bleach, laundry soap, window, or toilet cleaners.

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

The center has a policy and procedures for the disposal of all flammable, toxic, caustic, and poisonous items. The center has three mop closets with disposal drains present. The center also has a grease trap maintained quarterly, as well as a purchase order to dispose of hazardous chemicals at the local recycling center. The center also has a container to use for transporting flammable, toxic, caustic, and poisonous chemicals for disposal.

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

The center has a facility operating policy and procedures governing the use and requirements of confinement. A sample of six confinement reports were reviewed over the past six months. The center utilizes regular sleeping rooms for confinement. Observations of sleeping areas presented no obstructed views and non-fixed items present in rooms beside bedding material. Youth are afforded all basic rights while in confinement. Searches and "Rights to Grieve" were documented on all six reviewed confinement reports. Each report documented youth were immediately informed of the reason for being placed in confinement. The initial supervisory review was documented for all confinements within two hours; although, two of the six confinement reports did not have the reason for the confinement indicated in the initial supervisory review. Subsequent supervisor reviews were completed every three hours with one exception; one review was fifteen minutes late. Visual Observation Reports were maintained on all youth placed in confinement and five-minute checks were conducted over the first hour. Physical injury was not present and pregnancy was not a factor for any of the reports reviewed. Four of the five interviewed staff indicated education material is not provided while youth are in confinement. The education department was notified when confinement affected a youth's school attendance.

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

The center has a written policy and procedures regarding the use of confinement over twenty-four hours. The policy has all the required components of the use of over twenty-four hours confinement. The center did not utilize confinement over twenty-four hours during the annual compliance review period.

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

The center has established a Continuity of Operations Planning (COOP) with annexes present. Four drills were completed prior to the commencement of hurricane season. All five interviewed staff stated they participated in some type of COOP drill. Drill topics included chemical spill, evacuation weather, and bomb threats. The center also participated in a region-wide COOP drill this calendar year (2020).

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

The center has a policy addressing escape and escape prevention. Escape drills were reviewed and found for three of the last four quarters. Drills are conducted during briefing without youth being involved. Three of the five interviewed staff stated they participated in an escape drill. One staff stated drills were discussed but did not physically participate in a drill. Five in-service training records were reviewed. One of the five training records documented escape prevention training in 2019 which was identified during an internal review. Four of the five staff had escape prevention training in 2020.

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

The center has a policy and procedures addressing fire drills. The center's fire safety plan is signed off by the local state fire marshal. The facility egress plan is posted in all housing areas, hallways, common rooms, and classrooms. All five interviewed staff indicated they participated in fire drills within the past six months and fire drills occur monthly. Three of the five interviewed youth indicated they were instructed on fire procedures. A review of fire drills over the past six months confirmed drills being completed at least once a month and some instances twice a month on each shift with the exception of no drills for shifts A and B in the month of October 2020. Fire drills were documented in master control and module logbooks. Fire extinguishers were reviewed and tagged annually by a fire safety company and checked by staff monthly.