STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Bay Regional Juvenile Detention Center

Department of Juvenile Justice

(State-Operated)

450 East 11th Street

Panama City, Florida 32401

Review Date(s): April 20-24, 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:

Ken Phillips, Office of Program Accountability, Lead Reviewer (Standards 1 and 5)
Jill Foy, Office of Program Accountability, Regional Monitor (Standards 2, 4, and 5)
Tara Frazier, Office of Program Accountability, Regional Monitor (Youth and Staff Interviews)
Patrick McKinstry, Office of Program Accountability, Regional Monitor (Standards 3 and 5)

Program Name: Bay Regional Juvenile Detention Center
Provider Name: State Operated
Location: Bay County / Circuit 14
Review Date(s): April 20-24, 2020

MQI Program Code: 33
Contract Number: NA
Number of Beds: 32
Lead Reviewer Code: 145

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.02 Five-Year Rescreening	5.06 Key Control
5.10 Inventory of all Flammable, Toxic, Caustic, and Poisonous Items	5.07 Vehicles and Maintenance
	5.08 Tool Inventory and Management

Standard 1: Management Accountability
Detention Rating Profile

Indicator Ratings

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

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

Standard 2: Youth Management
Detention Rating Profile

Indicator Ratings

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

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

Indicator Ratings

Standard 3 - Mental Health and Substance Abuse Services		
3.01	Designated Mental Health Clinician Authority (DMHCA)	Satisfactory
3.02	Licensed MH/SA Clinical Staff *	Satisfactory
3.03	Non-Licensed MH/SA Clinical Staff	Non-Applicable
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*	Non-Applicable
4.02	Facility Operating Procedures	Non-Applicable
4.03	Authority for Evaluation and Treatment	Satisfactory
4.04	Parental Notification/Consent	Non-Applicable
4.05	Healthcare Admission Screening & Rescreening Form	Satisfactory
4.06	Youth Orientation to Healthcare Services/Health Education	Satisfactory
4.07	DHA/Designee Admission Notification	Non-Applicable
4.08	Health-Related History	Non-Applicable
4.09	Comprehensive Physical Assessment/TB Screening	Non-Applicable
4.10	Sexually Transmitted Infection Screening & HIV Screening	Non-Applicable
4.11	Sick Call Process	Satisfactory
4.12	Episodic/First Aid Care/Emergency Care	Satisfactory
4.13	Off-Site Care/Referrals	Non-Applicable
4.14	Chronic Conditions/Periodic Evaluations	Non-Applicable
4.15	Medication Management	Satisfactory
4.16	Medication/Sharps Inventory and Storage Process	Satisfactory
4.17	Infection Control/Exporsure Control/Education	Satisfactory
4.18	Prenatal Care/Education	Satisfactory

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Standard 5: Safety and Security
Detention Rating Profile

Indicator Ratings

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

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Program Overview

The Bay Regional Juvenile Detention Center is a state-owned detention facility, operated by the Department, located in Panama City, Florida. The center is co-located within the Juvenile Assessment Center. Male and female youth who are detained pending adjudication, disposition, or placement in a residential commitment program are housed in the thirty-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 the Bay County School Board. The center's management team includes the superintendent, assistant superintendent, administrative assistant, training manager, and juvenile justice detention officer supervisors and officers. The center was closed in October 2018 due to major facility damage from a hurricane. The center re-opened September 13, 2020. The previous annual compliance review was conducted February 2018.

Mental health and healthcare services are provided through the contracted provider, Camelot Community Care. Mental health services have been provided through this contractual agreement since the center's re-opening in September 2019. Mental Health services are provided by a licensed mental health professional who serves as the designated mental health clinician authority (DMHCA). The center also has two other licensed mental health counselors. Clinical services provided by the center include mental health and substance abuse evaluations, mental health treatment planning, individual, group, and family therapy, mental health crisis intervention services, on-site psychiatric services, and availability for substance abuse services for youth with co-occurring disorders. The medical services, provided through the contractual agreement with Camelot Community Care, did not initiate health services for the center until March 2020. Medical services are provided by a medical doctor who serves as the designated health authority (DHA), registered nurse (RN), advanced practitioner registered nurse (APRN), one full-time licensed practical nurse (LPN), and one part-time LPN. The medical clinic maintains nursing coverage forty-hours a week, Monday through Friday.

Food services are provided by Department staff and include menus, meal planning, meal schedules, special diets, nutritional analysis, daily allowance, food preparation, health certifications, food product standards, sanitation, and cleaning. Staff are responsible for the custody and control of youth in their care, providing youth supervision twenty-four hours a day, seven days a week.

The center has three living modules which are divided by male and female. Due to the low number of utilized beds, the center currently is using only one of the modules, while the remaining two are undergoing construction repairs, which are being completed through an outside vendor. The center had no female youth during the annual compliance review. There are fifty-six security cameras at the center, of which all but one was operational. At the time of the annual compliance review, the center had numerous vacancies, which included nineteen direct care positions, one food service director, and a maintenance mechanic.

Standard 1: Management Accountability

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

Eleven staff records were reviewed for the completion of an initial background screening. All eleven personnel records revealed each staff was eligible for hire and received a background screening prior to their hire date. Nine of the eleven staff were direct care staff. All nine of these staff completed an Ergometric assessment, which is the pre-employee assessment tool used by the center. Each of the staff who completed the assessment had a passing score, which was documented in their personnel record. In addition, there were sixteen volunteers added since the last annual compliance review. Each of these sixteen records were reviewed and found the volunteers completed and eligible background screening completed prior to their hire. The program submitted the Annual Affidavit of Compliance with Level Two Screening Standards to the Background Screening Unit on January 6, 2020. Education services are provided to youth through the Bay County School District. The center submitted the Annual Affidavit of Compliance for Bay District Schools on January 6, 2019.

1.02 Five-Year Rescreening	Limited 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.	

Since the last annual compliance review, the center had five staff who required a five-year re-screening. All five personnel records were reviewed. All the staff records had documentation indicating a completed five-year re-screening completed, which determined the staff were eligible. Three of the five background re-screenings were submitted after their five-year anniversary date. One was submitted eighteen days late, one was submitted nine days late, and one was submitted forty-two days late.

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.

A review of three staff personnel records was completed to demonstrate staff signing and acknowledgement of the Code of Conduct. All three staff signed the Code of Conduct upon hire. A review of incident report information, reports to the Central Communications Center (CCC), Protective Action Response information, and grievances were completed to determine if there were any violations of the center's Code of Conduct. Two staff received disciplinary action for violation of the Code of Conduct. These two personnel records were reviewed and found evidence both staff received a written reprimand as a result of their actions. In addition, three separate personnel records were reviewed for commendations received during the scope of the annual compliance review. All three staff received commendations for their actions, thus receiving Employee of the Month honors. The three staff were recognized by administration and received certificates and a monetary reward.

Three youth were interviewed. Two youth reported never having had to report abuse. One stated he has never been stopped form making an abuse report. All of the youth reported staff were respectful when speaking with them or other youth. All reported they have heard staff use profanity when speaking. One stated he heard this once, and two stated occasionally. All three denied staff ever threatened them. All reported they felt safe at the center.

Three staff were interviewed. All three denied ever hearing a co-worker threaten youth. The staff reported they have heard staff use profanity occasionally, but it was typically a new officer, and they were pulled aside and reminded of professionalism. One staff reported the working conditions have been poor and two staff reported they were good. The superintendent was questioned regarding the employee Code of Conduct. She stated staff must adhere to a behavior problem which prohibits any form of abuse, profanity, threats, harassment, intimidation, or personal relations with youth. If there is a suspicion or knowledge of abuse, the Florida Abuse Hotline and the CCC, and law enforcement are contacted and a report is completed. If abuse occurs, disciplinary action, up to termination, would take place.

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.	

Five incident reports to the Central Communications Center (CCC) were reviewed. Four of the five incidents were reported to the CCC within the required two-hour timeframe. The remaining incident was reported thirty-minutes late. All five reports were observed to be documented in the logbook. A review of internal incidents and grievances found no further incidents which should have been reported to the CCC. A review of CCC report information was compared with those of the previous annual compliance review. Based on this review, the center has had a decrease in the total number of incidents reported. The superintendent was interviewed concerning the reporting process and stated anytime a reportable incident occurs it is reported within two hours of the incident, or two hours of staff becoming aware of the incident. If the incident requires an update, this is completed on the same day, or by 9:00 a.m. the following day.

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

A review of the center's facility operating procedures regarding Protective Action Response (PAR) was completed. The center had a total of twenty-four PAR incidents within the scope of the annual compliance review. Five PAR reports were reviewed. Four of the five reports were completed by the end of each staff workday. All included statements from each staff involved in the incidents. None of the incidents required the use of mechanical restraints. None of the reports documented the youth were injured as a result, or required contact to the Central Communications Center (CCC). Each of the five reports were reviewed by a supervisor or PAR instructor to determine the force used was consistent with policy. All but one contained evidence and documentation of the Post-PAR interview completed with the youth by the administrator within thirty-minutes of the incident. In one of the five reports, the Post-PAR interview was conducted the following day. All youth were seen by medical staff based on documentation on the Post-PAR Medical Screening completed by medical staff, although no injuries were reported or identified. No medical reviews were required. Four of the five reports were applicable for and documented a review by the superintendent/designee, which was completed within seventy-two hours, as required. One was not applicable, as the incident occurred during the time of the annual compliance review, and the superintendent/designee had not yet reached the seventy-two-hour timeframe. A review of internal incidents and grievances found there were no additional PAR incidents which were not previously documented. The center's PAR rate is 7.56, which is below the statewide average rate of 12.00. The superintendent was interviewed and stated all incident reports are reviewed by the administration and shift supervisors to ensure all staff involved are complying to the PAR rule. All staff must submit their reports into Facility Management System (FMS) before exiting the center. The Department's regional and headquarters staff will review video of all CCC reports with PARs, as well as any incidents involving three or more youth. Three interviewed staff all reported staff try to talk with youth prior to the use of any physical or mechanical restraints.

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

Three staff training records were reviewed for pre-service training requirements. Two of the three staff were certified within180 days of hire. The remaining staff was within the initial 180 days from hire date. All three staff received training in Protective Action Response (PAR), cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), and first aid. All staff completed training in mental health and substance abuse services, suicide prevention, and emergency planning and procedures. All three staff received training in human trafficking, Department of Juvenile Justice Operations, and Prison Rape Elimination Act (PREA). All three staff completed Phase One training. Two of the three staff completed Phase Two training. The remaining staff had not completed Phase Two but was within the initial 180 days of hire. All trainings were documented within the Department's Learning Management System (SkillPro).

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

Three staff records, which included one juvenile justice detention officer (JJDO) and two juvenile justice detention officer supervisors, were reviewed for in-service training requirements. All in-service trainings were documented within the Department's Learning Management System (SkillPro). All three staff received Protective Action Response (PAR) update training, as well as cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), and first aid refresher training. Each of the three staff had both the required two-hour SkillPro training and the four-hour instructor-led suicide prevention training. Each staff received professionalism and ethics and active shooter trainings. Both JJDO supervisors at least eight hours of additional supervisory training in areas such as management, leadership, personal accountability, employee relations, communication skills, and fiscal management. The center's training manager maintains an annual in-service training calendar, which is updated as changes occur. The superintendent was interviewed and reported receiving trainings in professional development, Leading in Difficult Times, Budget Overview, and is currently enrolled in the Certified Public Manager program.

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

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

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

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

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

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

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

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

The center has a written policy and procedures regarding the entering and sharing of youth alert information. The Department's Juvenile Justice Information System (JJIS) alerts are reviewed daily by supervisors, administrators, and staff. Hard copies of all JJIS alerts are distributed to detention staff during each shift briefing. Shift briefing minutes were reviewed to confirm the reviewing and sharing of alert information. The center's superintendent was interviewed and stated if a youth informs a staff during the intake process he or she has a food allergy, medication or medical issue of any type, this will be verified with the parent/guardian and entered into JJIS, as applicable. Medical alerts such as asthma will be entered as critical alert information. Once the medical department completes the intake screening process, any medical alert will be updated by the medical staff. Three staff were interviewed concerning alerts. All staff reported they are notified of youth alerts and center-related issues through logbook reviews, shift debriefings, alert forms, and JJIS. Three youth records were reviewed for the input, documentation, and verification of alert information. Ten total alerts were reviewed for all three youth combined. All alerts were entered by appropriate staff and verified prior to entry. All alerts were entered into JJIS and the internal alert system, as required. A review of the logbook determined nine of the ten alerts were documented, as required.

Standard 2: Assessment and Performance Plan

2.01 Admission	Satisfactory Compliance

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

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

The center has written policy and procedures in place to ensure the proper screening, evaluation and documentation is provided for each youth admitted to the center. Three youth records were reviewed for admission. The Admission Wizard for all three youth reflected the following documents were reviewed: arrest affidavit/custody order, Detention Risk Assessment Instrument (DRAI), and Suicide Risk Screening Instrument (SRSI). Additionally, all three Admission Wizards indicated youth were frisk and strip searched, received a telephone call, were given a meal, and had medical, mental health, and substance abuse screenings completed. An admission was unable to be observed during 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 has a written policy and procedures ensuring youth are advised of the center's rules and regulations, expectations for behavior and related consequences for failing to meet those expectations and youth rights within twenty-four hours of admission to the center. Three youth records were reviewed for orientation. All three youth records contained an orientation checklist, which was signed and dated by both the youth and staff. The signature dates corresponded with the date of admission for all three youth. In addition, each youth record contained a copy of the youth handbook which was also signed by the youth. Orientation is provided both verbally and in writing and includes a review of 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 (CCC), behavior expectations and consequences, and possible new law violations. The orientation includes all elements, as outlined in the center's policy. In addition, orientation includes the youth to watch a video on the Prison Rape Elimination Act (PREA). An admission was unable to be observed during the annual compliance review. All three interviewed youth reported they received an orientation to the center upon admission.

2.03 Classification	Satisfactory Compliance

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

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

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

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

The center has a written policy and procedures to ensure all youth admitted to the center are classified by the admitting officer to provide the highest level of safety and security. Three youth records were reviewed for classification procedures. Documentation indicated the arrest affidavit/custody order, Detention Risk Assessment Instrument (DRAI), and Suicide Risk Screening Instrument (SRSI) were reviewed prior to classifying the youth. Consideration of potential safety and security concerns in room assignments include sex, height, weight, age, and level of aggressiveness. Identified special needs include mental illness, intellectual disabilities, physical disabilities, history of violent behavior, gang affiliation, criminal behavior, history of sexual offenses, Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB), medical, suicide risk, escape, and security. Documentation in all three records reflected special needs of each youth were identified upon admission. Each record contained a completed VSAB and reflected the officer's signature and date on page three, as required. Room assignments are made based on each youth's classification. In the event there is a change in behavior or status, room assignments will be changed, if deemed necessary. Two of the three reviewed youth records reflected youth had a history of sexual offenses in which both youth were placed in single room. Youth alerts are entered, updated, and/or removed upon admission and throughout the youth's time in the center, as required. A review of the youth's

VSAB, face sheet, admission screening, alerts, and Human Trafficking Screening Instrument (HTSI) (if applicable), all assist staff in identifying youth who are vulnerable to victimization, as well as the youth's type of aggression. One of the three youth records reviewed was applicable for gang affiliation which was previously noted by the youth's juvenile probation officer (JPO). The center provided an additional record for review in which the center notified the youth's assigned JPO of suspected gang affiliation. This documentation was in the form of an email which included pictures of the youth's tattoos.

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 written policy and procedures to ensure all youth admitted to the center are classified by the admitting officer to provide the highest level of safety and security.. Three youth records were reviewed for notification of suspected gang activity. One of three youth reviewed was applicable for suspected gang activity. In this record, the youth was previously identified by law enforcement as a suspected gang member. An appropriate alert was entered in the Department's Juvenile Justice Information System (JJIS) for the youth by the assigned juvenile probation officer (JPO). The center's gang liaison is responsible for sharing information of suspected gang activity with the circuit's gang representative. The center provided an additional applicable record in which the center notified the youth's assigned JPO of suspected gang affiliation. This documentation was in the form of an email and included pictures of the youth's tattoos. The center's gang representative was interviewed and confirmed the center's process.

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

The center has a written policy and procedures to ensure a youth's personal property is maintained securely and returned in a timely manner upon release. Three youth records were reviewed for personal property. All three youth records contained a Personal Property Receipt Form which documented signatures from the youth and staff. Additionally, each record contained a letter of acknowledgement regarding unclaimed property signed by the youth. None of the youth were applicable for a Valuable Property Receipt Form. The drop safe logbook was available for review and contained all required information with the exception of the youth's identification number. There were no instances in the previous six months in which a youth refused to sign the Property Receipt Form. All three youth's personal property was observed bagged, including a copy of the Property Receipt Form, and stored in a secure locker in the center's sally port. Except for the youth's Department identification number, each of the property bags documented all of the required information including the date, the youth's name, a listing of the items in the bag, the youth's signature, and the signature of the staff who placed the items in

the property bag and sealed it. An admission was unable to be observed during the annual compliance review. All three interviewed youth reported staff checked their personal property and had youth sign a form stating the personal property was correct. According to the superintendent, when a youth is admitted to the center with valuables or property, the intake screening officer will complete a property receipt and on the property receipt, anything of value will be listed as “in the safe” in the description area of the form.

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 has a written policy and procedures to ensure a youth’s personal property is maintained securely and returned in a timely manner upon release. All youth personal property was observed to be stored in a white mesh bag which included a copy of the personal Property Receipt Form (inventory) and secured in lockers in the center’s sally port. Access to youth’s personal property is limited to designated staff. The drop-safe is under video surveillance and includes a bound safe logbook. None of the three reviewed youth records reflected the youth were admitted with valuable property. In the event a youth is admitted with valuable property, the property is stored in clear, tamper-proof bag and stored in the drop safe. Valuable youth property stored in the drop safe corresponded with documentation observed in the drop-safe logbook. A review of Central Communications Center (CCC) reports for the previous six months reflected there were no incidents involving youth property. According to the superintendent, personal property is stored in lockers in the sally port and anything of value is placed in the safe and documented in the drop-safe logbook.

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

The center has a written policy and procedures to ensure all releases from the center occur promptly and accurately. The center provided three closed youth records for review. Documentation in all three records reflected the on-duty supervisor reviewed all the paperwork prior to the youth’s release. Prior to each release, the youth’s identification was verified, identification of the parent/guardian was photocopied (for each youth was under the age of eighteen), and the youth and the parent/guardian the youth was released to was reminded of

any future court dates. Documentation in all three records reflected appropriate parties signed the release forms and the date of admission and release corresponded with the admission and release dates in the Department's Juvenile Justice Information System (JJIS). A release was unable to be observed during the annual compliance review. A review of Central Communications Center (CCC) reports for the previous six months reflected there were no incidents involving unauthorized releases.

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

The center has a written policy and procedures to ensure a youth's personal property is maintained securely and returned in a timely manner upon release. The center provided three closed youth records for review. All three records contained a property receipt which was signed by both the youth and the youth's parent/guardian. The center provided twenty-one examples of written notification to the youth's parent/guardian for property held for more than thirty days. In addition to written notification, the center attempts telephone contact with the youth's parent/guardian. For each of the twenty-one examples, the property was claimed by the youth's parent/guardian. There have not been any instances in the previous six months where a youth's property has been disposed. A release was unable to be observed during the annual compliance review. According to the superintendent, after thirty days, a notice of impending disposal of property shall be mailed to the last known address and if the youth or parent/guardian cannot be located, all money and property are counted and inventoried. In addition, a money order will be sent to the Regional Fiscal Manager, who will forward the money order to the Department's headquarters designee.

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.	

Three closed applicable youth records were provided for review . All three youth reviewed were released with prescription medication. Each record contained the required Department form, which was signed by the parent/guardian the youth was released to. Each youth reviewed was under the age of eighteen. The youth and the parent/guardian the youth was released to was reminded of any health or welfare issues upon their release from the center. A copy of the parent/guardian identification was found in all three closed records.

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 has a written policy and procedures in place outlining a systematic process to ensure youth are held in secure detention for the shortest amount of time possible. Detention reviews were observed during the annual compliance review. The detention reviews were facilitated by a juvenile justice detention officer supervisor (JJDOS). Participants of the detention review included the registered nurse (RN), designated mental health clinical authority (DMHCA),

assistant chief probation officer, three juvenile probation officer supervisors, and an education representative. Each youth in secure detention was reviewed and updates were provided, as needed. Detention review documentation was reviewed from the previous six months. Documentation consistently reflected participation by representatives from all parties who have responsibility for the youth. According to the superintendent, detention reviews are held weekly and are conducted by the assigned detention review specialist. The superintendent added, all youth in secure detention and on home detention status are reviewed, and any medical or mental health issues, release dates, educational issues, questionable court orders, and commitment placements are reviewed.

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.	

Postings of the daily activity schedule were observed throughout the center. The daily schedule reflects times the youth are to participate in school activities, conduct personal hygiene/showers, have meals/snacks, attend visitation, recreation activities, and participation in small group discussions or social activities. The schedule reflects when educational programming is offered, times for telephone calls and letter writing are permitted, bedtimes for youth with higher levels in the behavior management system, and when to conduct unit/facility cleaning. Each of the three interviewed youth reported the center's daily activity is followed as outlined.

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

The center has a daily activity schedule for weekdays and a separate schedule for weekends. A review of the center's logbook reflected adherence to the daily activity schedule with a few exceptions. Observations made through video surveillance of the daily schedule during the annual compliance review week found staff adhering to the daily schedule, as written. In the previous thirty days, the daily schedule has been adjusted due to the Corona Virus Disease (COVID-19) crisis. Examples of these adjustments were observed to be earlier hygiene and bedtimes and the suspension of visitation. All three interviewed staff reported the center's daily schedule is followed. Each of the three interviewed youth reported the center's daily activity schedule is followed as outlined.

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.	

All youth in the center receives educational services. Youth attend school 300 minutes (five hours) a day, Monday through Friday. A review of the education schedule revealed the youth are provided education 250 days a year distributed over twelve months, with a minimum of twenty-five hours of instruction each week. Teachers are given ten days for training and planning throughout the school year. Youth enrolled in educational programs at the center have an opportunity to earn course credit for completion of the education and training experience. Due the COVID-19 crisis, the delivery of educational instruction has changed. As of March 30, 2020, the youth are receiving educational instruction through virtual school. A review of the logbooks reflected adherence to the education schedule with few exceptions. In addition, video surveillance was reviewed throughout the annual compliance and found youth to be in school during the scheduled times each day. All three interviewed staff reported minimal interference with educational instruction. Each of the three interviewed youth reported minimal interference with educational instruction. The superintendent reported minimal interference with educational instruction.

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

An interview with education staff revealed the center is providing the requirements for Type 1 programming to include life skill groups activities and instructions. Career education programming includes communication, interpersonal, and decision-making skills.

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

The center has a written policy and procedures ensuring all centers have a uniform behavior management system (BMS) which offers a predictable set of rewards, privileges, and consequences for behavior. The center's BMS is a part of a statewide Department-approved system for all detention centers. Postings of the BMS were observed throughout the center. The system includes rewards for positive behavior and consequences for inappropriate behavior. The center's facility operating procedures regarding the BMS is in compliance with the components outlined in the center's policy. Youth point cards were available for review and were observed to be completed appropriately by staff to include rewards and consequences in accordance with the BMS. The center's BMS includes a Stop Orient and Self Check (S.O.S) tool

which is used to teach youth how to access help when they are in pre-crisis. S.O.S is used by staff as a prompt to help prevent precursory behaviors from turning into full blown major incidents. A youth may request a S.O.S. and are given brief break from the environment or situation. S.O.S posters were observed throughout the center. All three interviewed staff reported they feel the BMS is consistent. The staff also reported staff speak with youth to discuss consequences imposed, youth are given an opportunity to explain their behaviors, and staff speak with youth about alternative acceptable behaviors. Two of the three interviewed youth described the BMS as very good and one described it as good. All three staff added they receive feedback on their implementation of the BMS from their supervisors on a weekly basis. All three youth reported when they received consequences, they believed the consequences were fair. In an interview, the superintendent explained the center's BMS.

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

The center has a written policy and procedures ensuring all centers have a uniform behavior management system (BMS) which offers a predictable set of rewards, privileges, and consequences for behavior. All three interviewed staff reported meals, snacks, sleep, and school cannot be taken away from youth as a result of inappropriate behavior. All of the staff added they have never seen co-workers taking away meals, clothing, or medical care from youth, nor have they witnessed co-workers encouraging youth to beat up other youth. Each of the interviewed youth reported their points and levels could be taken away from them as a consequence for inappropriate behavior. The youth added bedding items and/or certain clothes can be taken away if they are placed on precautionary observation. All of the youth reported they have never witnessed the use handcuffs or leg irons on disruptive youth. Each youth reported youth are not allowed to punish other youth and all of the youth reported they have been sent to their room for punishment. A follow-up interview was conducted with all three youth and each youth reported they were sent to their room as part of a Stop Orient and Self check (S.O.S) they requested. Each youth explained what an S.O.S was and were able to request it at any time.

2.17 Grievances	Satisfactory Compliance

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

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

The center has a written policy and procedures in place to ensure each youth has the right to grieve and ensure all youth are treated fairly, respectfully, without discrimination, and their rights are protected. The center has had two grievances since reopening in September 2019. Documentation for both grievances reflected the grievances were filed and completed in appropriate timeframes. The center's grievance procedures reflect officers attempt to resolve any dispute or issue which could lead to a grievance prior to the actual filing of a grievance and grievance forms are entered into the Facility Management System (FMS) on behalf of the youth. Grievance forms were observed to be available to youth throughout the center. Each of the three staff interviewed were able to explain the center's grievance process. All three interviewed youth reported they have never filed a grievance. The superintendent explained the center's grievance process.

2.18 Trauma-Informed Care	Satisfactory Compliance

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

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

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

The center has incorporated trauma-informed practices into current operations to deliver services and to provide care to youth in custody. The center has a soft room, which has been repainted using soothing colors. A review of six staff training records (three in-service and three pre-service) reflected all six staff completed trauma-informed care training. The use of Stop Orient and Self Check (S.O.S) has been incorporated to the Department's statewide detention Behavior Management System (BMS). S.O.S. provides the youth an opportunity to take a break or timeout from a situation which could potentially become a major incident. Staff are encouraged to offer youth who may be in pre-crisis a S.O.S to prevent major incidents. The superintendent reported the physical appearance of the center has been updated with bright

colors, a soft room to include furniture such as rocking chairs, and staff training to improve trauma knowledge and sensitivity have all been implemented.

Standard 3: Mental Health and Substance Abuse Services

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

The center has identified a single licensed mental health professional as the designated mental health clinician authority (DMHCA). The DMHCA is a full-time employee at the center and is on-site forty hours a week. The DMHCA is a licensed mental health counselor (LMHC), under Chapter 491. A copy of the LMHC's licensure and contract was available while on-site during the annual compliance review. The Department has a contract with Camelot Community Care, Inc., to ensure appropriate coordination and implementation of mental health and substance abuse services are conducted at the center. An interview with the DMHCA was conducted; she confirmed she is on-site, Monday through Friday, and as needed. In addition, the DMHCA is on-site on weekends, if coverage is needed. The DMHCA reported her role is to coordinate all mental health services and implement treatment for youth. The center does not currently offer any type of specialized services. The DMHCA has an open-door policy with other clinical staff at the center. In addition, she conducts a daily briefing with clinical staff. She meets with the psychiatrist at a minimum of once a week and telephone consultation when necessary.

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 clinical supervisor ensures the two other licensed clinical staff working under her supervision are performing services they are qualified to provide. The two clinical staff hold licenses as licensed mental health counselors (LMHC), under Chapter 491.

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

The center does not employ any non-licensed mental health and substance abuse clinical staff.

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

Three youth records were reviewed for mental health and substance abuse admission screening. The following preliminary screening instruments were completed by probation staff: Suicide Risk Screening Instrument (SRSI), Victimization and Sexually Aggressive Behavior (VSAB), and Massachusetts Youth Screening Instrument – Version 2 (MAYSI-2). Documentation observed, supports a review for each of these instruments are completed by detention staff. Each of the three reviewed youth records contained an SRSI, which was completed at the youth's intake. Both the SRSI and MAYSI-2 were completed within the Department's Juvenile Justice Information System (JJIS). Each of the three youth records reviewed had a nurse and/or mental health staff sections of the SRSI, which were completed. Complete entries were observed, including summaries and recommendations in the "Screening Results" sections. All of the records contained a "Yes" response on the SRSI. The youth were appropriately placed on suicide precautions and a mental health referral was completed. In each of the three records reviewed, results of the SRSI and MAYSI-2 indicated a need for further assessment. A referral was generated for each of the youth reviewed. In addition, the superintendent was notified of the screening instrument findings. In each of the records reviewed, a MAYSI-2 assessment indicated elevated suicide risk subscales. Subsequently, each youth was placed on suicide precautions and referred for an Assessment of Suicide Risk (ASR). None of the youth required a referral for a comprehensive assessment.

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

Three youth records were reviewed for mental health and substance abuse evaluations. Two of the three youth reviewed were applicable for completion of a comprehensive mental evaluation. Both of the applicable comprehensive mental health evaluations were completed by the detention provider within thirty days. The completed comprehensive mental health and/or substance abuse evaluations consisted of the substance abuse and mental health (SAMH) evaluation, which was completed within the Department's Office of Health Services (OHS) Electronic Medical Record (EMR) system. None of the reviewed youth records required a comprehensive assessment through a community provider.

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

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

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

Three youth records were reviewed for mental health and substance abuse treatment. One of the three reviewed youth records required mental health and/or substance abuse treatment. The one youth requiring treatment, was assigned to a mini-treatment team. The mini-treatment team consisted of a mental health clinical staff, staff from a different service area, the youth, and when possible, youth's parent/guardian. Reviewed documentation confirmed the applicable youth received of individual counseling. The counseling was conducted, as required by the youth's plan. The youth's mental health and substance abuse services reflected the youth's individual diagnosis and treatment needs, as prescribed. None of the three youth records reviewed, required any substance abuse treatment. The one youth requiring mental health treatment had a proper consent for treatment; an Authority for Evaluation and Treatment (AET). In addition, the record contained a consent and information release, related to substance abuse. Treatment notes were found documented on the Department's form, Counseling/Therapy Progress Note (MHSA 018).

Mental health staff have adequate access to youth in order to provide treatment services. The on-site provider typically provides individual counseling for youth identified with either a mental health or substance abuse diagnoses. The designated mental health clinical authority (DMHCA) described her role in coordination and implementation of mental health and substance abuse services at the center, is to implement treatment for youth. Three youth interviewed and were asked how you would rate the mental health and substance abuse services you are receiving. One youth responded, fair and the remaining two youth responded, very good.

3.07 Treatment and Discharge Planning [Contract Provider]	Satisfactory Compliance

The superintendent and DMHCA or mental health and substance abuse clinical staff are responsible for ensuring the development and review of an initial and/or individualized mental health/substance abuse treatment plan for each youth receiving mental health and/or substance abuse treatment in the center.

All youth who receive mental health and/or substance abuse treatment while at the center shall have a discharge summary completed documenting the focus and course of the youth's treatment and recommendations for mental health and/or substance abuse services upon youth's release from the center.

Three youth records were reviewed for treatment planning, of which only one youth was applicable for a treatment plan. The one youth's initial treatment plan was in place within seven days of initiation of treatment. The initial treatment plan was developed on the Department's form, Initial Mental Health/Substance Abuse Treatment Plan (MHSA 015). The form documented reason of referral for treatment and an initial Diagnostic Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis. The treatment plan included initial treatment

methods, along with initial treatment goals. The one applicable youth required psychiatric services, which included psychotropic medication and frequency monitoring. The initial treatment plan included the signature of the licensed mental health and substance abuse professional. In addition, the signature of the youth and the mini-treatment team members involved in development of initial treatment plan.

One of the three reviewed youth records was applicable for the completion of an individualized treatment plan. The one individualized treatment plan was completed within the period of thirty-one days of the youth's admission. The one applicable individual treatment plan included the signature of the licensed mental health professional within ten days of completion. The individual treatment plan included an initial DSM-5 diagnosis. The treatment plan included symptoms which were treatment-focused, treatment goals, strengths/abilities, and preferences/needs. In addition, psychiatric services were noted, which included psychotropic medication and frequency of monitoring, along with pharmacological interventions. The one applicable youth record contained progress notes, which validated the youth was in receipt of treatment services, as stipulated on the treatment plan. The individual treatment plan reviewed was signed and dated by the youth, mental health and substance abuse professionals, treatment team members, and the parent/guardian, (when possible). There was one thirty-day period requiring the completion of an individual treatment plan review. The plan was reviewed on the thirty-third-day; three days outside the thirty-day timeframe. Modifications were clearly identified and documented on the review form. The individual treatment plan review was signed and dated by the clinical staff, youth, and licensed mental health professional. The one youth was applicable for psychiatric treatment services. The youth's treatment plan included treatment and services provided for by a licensed psychiatrist. None of the three youth records reviewed were an alleged victim of a Prison Rape Elimination Act (PREA) event.

Three additional closed youth records were reviewed for mental health and substance abuse treatment discharge summaries. The three youth records contained a Mental Health and Substance Abuse Treatment Discharge Summary form (MHSA 011), which was completed upon each youth's transition or discharge from the center. The three mental health and substance abuse treatment discharge summaries were provided to the juvenile probation officer (JPO), parent/guardian (as allowed), and the youth.

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 employs a psychiatrist, who is licensed pursuant to Chapter 459, Florida Statutes. The center does not employ a licensed certified psychiatric advanced practice registered nurse (APRN), under Chapter 464, Florida Statute. Three youth records were reviewed for receipt of psychiatric services. One of the three youth records reviewed were applicable for psychiatric services. The one applicable youth was referred for an initial diagnostic interview and seen within fourteen days of the youth's admission. The initial psychiatric interview included the reason for the referral, history (medical, mental health and substance abuse history), mental status examination, Diagnostic Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis and symptoms, treatment recommendations, prescribed medication (if applicable), explanation of the need for psychotropic medication, and frequency of medication monitoring/management. An in-depth psychiatric evaluation was conducted for the one

applicable youth referred within thirty days of admission. The psychiatric evaluation contained all required elements and included a Clinical Psychotropic Progress Note (CPPN). The youth in receipt of psychotropic medication had documented monitoring for Tardive Dyskinesia on a monthly basis as indicated. The consent for psychotropic medication was included within the one youth's record, an Authority for Evaluation and Treatment (AET) form (HS 002).

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 has a written plan, detailing suicide prevention procedures. The written suicide prevention plan includes identification and assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and a review process, as referenced in the Department's Rule.

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

Three youth records were reviewed for suicide prevention services at the center. Each of the three reviewed records were applicable and were identified to be at risk during admission. The three youth were placed on precautionary observation (constant supervision). An alert was initiated for each of the youth, which was input into the Department's Juvenile Justice Information System (JJIS). The youth had a suicide risk assessment referral at time they were assessed and placed on precautionary observation. An Assessment of Suicide Risk (ASR) was completed for the three youth and documented the assessment in real time. The ASRs were administered and indicated the level of supervision for each youth. All three youth records indicated the youth were placed on standard supervision at the time the ASR was administered. A total of five suicide precautionary observation logs were generated between the three youth reviewed. Three of the five precautionary observation logs were not completed entirely. Two of the precautionary logs were missing the alert type. The third log was missing documentation of "safe housing areas." The remaining two logs contained all necessary requirements. In each of the three youth reviewed records, for each of the precautionary logs completed, a qualified mental health professional was involved. None of the youth reviewed were released prior to receiving an ASR or released while on suicide precautions. For each of the ASRs completed, documentation was found indicating a consultation occurred with the designated mental health clinical authority (DMHCA) or licensed mental health professional. In addition, the superintendent or designee was notified immediately of the youth's suicide risk. The ASR for each of the three youth was completed within twenty-four hours. None of the youth were identified as having been in crisis. Each of the three youth placed on precautionary observations

were placed on standard supervision at time of the assessment. Each of the ASRs were conducted by a licensed mental health professional and included recommendations for supervision. There was evidence within the center's logbook and on the ASR documenting administrative or supervisory staff were provided instructions related to the suicide risk assessment findings. Alerts within JJIS were found for each of the three youth; alerts discontinued once youth was removed from precautionary observation. There were no youth requiring secure observation.

The superintendent has an established review process for every serious suicide attempt or serious self-inflicted injury and a mortality review for a completed suicide. Documentation of the multidisciplinary review included circumstances surrounding the event, written procedures relevant to the incident, relevant training received by involved staff, pertinent medical and mental health services involving the victim, possible precipitating factors, and recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and/or operational procedures. Two of the three interviewed youth reported they have been placed on suicide watch while at the center and the third youth stated they had not been placed on suicide watch. Both of the youth who had been on suicide watch indicated while on suicide watch, staff watched them all of the time. Three staff were interviewed and were able to identify practices each are responsible for, if a youth expresses suicidal thoughts.

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.	

Three youth records reviewed for the use of suicide precautionary observation logs. Five suicide precautionary observation logs were generated between the three youth reviewed. The center completes observations of each youth, utilizing the Department's Suicide Precaution Observation Log (MHSA 006) form. Each of the reviewed logs were maintained for the duration the youth was on suicide precautions. The precautionary observation logs documented the appropriate level of supervision and observations of the youth's behavior. The documentation recorded was in real time and did not to exceed thirty-minute intervals. There were no warning signs observed. All five precautionary observation logs contained signatures by each shift supervisor. All the precautionary observation logs contained signatures of the mental health clinical staff. One of the five precautionary observation logs reviewed, were missing documentation to support "safe housing areas." Three youth were interviewed face-to-face separately and asked, while you were on suicide precautions, were staff with you at all times; each youth replied yes.

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.	

Six staff training records were reviewed for completion of suicide prevention training. Each staff received a minimum of six hours annual suicide prevention and implementation of suicide precautions training. Training consisted of two hours of web-based training in the Department's Learning Management System (SkillPro) and four hours of instructor-led training. Training at the center included a total of twelve suicide drills. The drills were held no less than quarterly on each of the centers two shifts. The drills included all staff who come in contact with youth, which

included kitchen and maintenance staff. A review of suicide drills demonstrated staff participated in quarterly drills (with a minimum of one quarterly drill semi-annually). In addition, direct-care staff participated in at least one drill, which included the use of cardiopulmonary resuscitation (CPR) annually. Staff members who are not present during a quarterly drill have the opportunity to review each drill scenario and procedures during shift briefings. Three staff were interviewed and able to identify locations where the "Knife for Life," wire cutters, and needle nose pliers (suicide response kit) are kept.

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 mental health crisis intervention plan which details crisis intervention procedures. The written mental health crisis intervention plan included the following procedures: notification and alert system, means of referral (including self-referral), communication, supervision, documentation, and review process.

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

The center has a written emergency care plan which included immediate staff response, notifications, communication, and supervision. In addition, the written emergency care plan included process for authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment under Chapter 394, Florida Statute (Baker Act), transport for emergency substance abuse assessment and treatment under Chapter 397, Florida Statute (Marchman Act). The written emergency care plan included procedures for documentation, training, and a review process. The center’s written emergency care plan was last approved July 31, 2018 and last update on April 21, 2020. The location of the written emergency care plan is in the superintendent’s office and accessible to all staff.

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 has had only one youth requiring a Crisis Assessment during the annual compliance review period. The center utilizes the Department's Crisis Assessment (MHSA 023) form, to capture a youth's crisis (psychological distress). The reviewed crisis assessment included, reason, mental status, danger to self and or others, initial clinical impressions, supervision recommendations, treatment recommendations, and any recommendations for follow-up. A mental health alert was completed within the Department's Juvenile Justice Information System (JJIS). The Crisis Assessment was completed by a licensed mental health professional. The reviewed Crisis Assessment was conducted within twenty-four hours based upon the needs of the youth. There was no indication or allegation the youth was a victim of a Prison Rape Elimination Act (PREA) event.

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 had one youth requiring Baker or Marchman Act services during the annual compliance review period. The youth was placed on suicide precautions upon re-admission from the Baker Act facility. A mental health referral was completed for a mental status examination. The mental status examination was completed by the licensed mental health professional. The youth was maintained on a minimum of constant supervision until properly transitioned to a lower level of supervision. The youth's level of supervision was not lowered until the appropriate assessment was conducted and mental health staff conferred with the center's superintendent. The youth returning from Baker Act was placed on constant supervision upon return. A mental health referral was completed, indicating a mental status examination be completed. The discontinuation of the youth's suicide risk alert was based upon an assessment of suicide risk.

Standard 4: Health Services

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

The center's medical services are provided through a contractual agreement with Camelot Community Care, which initiated contract service delivery March 2020; Therefore, this area will not be reviewed as part of this annual compliance review due to the provider not having six-months of demonstrated practice.

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

The center's medical services are provided through a contractual agreement with Camelot Community Care, which initiated contract service delivery March 2020; Therefore, this area will not be reviewed as part of this annual compliance review due to the provider not having six-months of demonstrated practice.

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

The center has a written policy and procedures to ensure, to the fullest extent possible, parents/guardians are afforded the right to give or withhold consent with regard to the healthcare provided to their children. Three youth individual healthcare records (IHCRs) were reviewed for an Authority for Evaluation and Treatment (AET). All three records contained an AET. Two records contained the original AET and one record contained a copy with was stamped "copy" with red ink. Documentation in all three records reflected the AET was obtained prior to providing medical services. None of the youth were applicable for involvement with the Department of Children and Families (DCF) where the parental rights had been terminated.

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

The center's medical services are provided through a contractual agreement with Camelot Community Care, which initiated contract service delivery March 2020; Therefore, this area will not be reviewed as part of this annual compliance review due to the provider not having six-months of demonstrated practice.

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

The center has a written policy and procedures which ensure at the time of admission to the center, each youth will receive a facility entry screening by the intake officer. Three youth individual healthcare records (IHCRs) were reviewed for a Medical and Mental Health Admission Screening. All three records contained documentation in which an admission screening was completed on the day of admission for each youth by a juvenile justice detention officer (JJDO). Additionally, documentation for all three youth reflected the screening was reviewed by a licensed practical nurse (LPN) or higher within twenty-four hours. One of the three youth records reflected a change in custody since the youth's arrival to the center. The applicable record reflected a healthcare admission re-screening was completed by a JJDO and reviewed within twenty-four hours by an LPN or higher. According to the superintendent, a doctor, nurse, staff, or advanced practitioner license nurse (APRN) can complete the Healthcare Admission Screening.

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

The center's medical services are provided through a contractual agreement with Camelot Community Care, which initiated contract service delivery March 2020; Therefore, this area will not be reviewed as part of this annual compliance review due to the provider not having six-months of demonstrated practice.

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

The center's medical services are provided through a contractual agreement with Camelot Community Care, which initiated contract service delivery March 2020; Therefore, this area will not be reviewed as part of this annual compliance review due to the provider not having six-months of demonstrated practice.

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

The center's medical services are provided through a contractual agreement with Camelot Community Care, which initiated contract service delivery March 2020; Therefore, this area will not be reviewed as part of this annual compliance review due to the provider not having six-months of demonstrated practice.

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

The center's medical services are provided through a contractual agreement with Camelot Community Care, which initiated contract service delivery March 2020; Therefore, this area will not be reviewed as part of this annual compliance review due to the provider not having six-months of demonstrated practice.

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

The center's medical services are provided through a contractual agreement with Camelot Community Care, which initiated contract service delivery March 2020; Therefore, this area will not be reviewed as part of this annual compliance review due to the provider not having six-months of demonstrated practice.

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

The center has a written policy and procedure in place to ensure all youth in the center will be able to make sick call requests and have their complaints treated though the center's sick call system. According to the written policy and procedures, for those times of day when licensed health care staff are not on-site, the supervisor on-duty will review all sick call requests for issues requiring immediate attention. All supervisors and administrators receive notification upon submission of a sick call request, with the youth's complaint present. Staff are required to immediately report any youth who appears distressed to their supervisor and/or on-site health care staff. Until nursing staff are on-site, supervisors must refer to non-healthcare protocols for the youth's immediate needs. There were no instances of youth complaining of severe pain in which staff were unfamiliar with.

Sick call forms were observed available to youth throughout the center. Sick call is provided twice daily at 8:00 a.m. and 4:00 p.m. by either the doctor or nursing staff. Three interviewed staff reported the nurse or shift supervisors respond to and conduct sick call. Three interviewed youth reported the nurse responds to sick call; two reported they are seen within one day and one reported they are seen within three days. Two of the three youth reported medical care at the center is very good and one reported care is good.

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

The center has a written policy and procedures addressing episodic and emergency care. The center provided two applicable instances in which an episodic event occurred when non-licensed health care staff were not on-site. In both instances, Emergency Medical Services (EMS) was contacted and the youth was transported off-site to the local hospital. The center's episodic log reflected both of these events. The center has thirteen first aid kits: five assigned to transport vans, one in each living unit (three), one in the courtyard, one in the kitchen, one in the supervisor's office, one assigned to master control, and one in the medical office. First aid kits are stocked with designated health authority (DHA) approved items. Two first aid kits were opened and were both observed to be stocked with the approved DHA items. First aid kits are inspected monthly by the registered nurse (RN). The inspection log was available for review and reflected the kits are being monitored as required and replenished as needed.

The center has two automated external defibrillator (AED): one located in the custodial closet of the common area between living units and one in medical. Both AEDs are brand new. Instructions can be found within the AED. The pads expire March 28, 2021 and the batteries expire in August 2022. A self-test was conducted on both AEDs in which both were found to be operational. The superintendent conducts a remote electronic check (computer) monthly to ensure AEDs are operational and the nurse conducts a visual check monthly (green light). The center conducts medical drills quarterly and on each shift. The center has two twelve-hour shifts.

Drill documentation reflected the center conducted medical drills quarterly, on each shift, and included the use/demonstration of cardiopulmonary resuscitation (CPR) and/or AED, as required, since reopening in September of 2019. The center's emergency numbers, to include the Poison Information Center, can be found in master control and medical. These numbers are inaccessible to youth. A review of six staff training records (three in-service and three pre-service) found all six staff completed the required CPR/AED/first aid training, as required. All three interviewed staff reported they are able to contact 9-1-1 if they feel it is necessary.

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

The center's medical services are provided through a contractual agreement with Camelot Community Care, which initiated contract service delivery March 2020; Therefore, this area will not be reviewed as part of this annual compliance review due to the provider not having six-months of demonstrated practice.

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

The center's medical services are provided through a contractual agreement with Camelot Community Care, which initiated contract service delivery March 2020; Therefore, this area will not be reviewed as part of this annual compliance review due to the provider not having six-months of demonstrated practice.

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

The center has a written policy and procedures outlining the process for the usage of the Medication Administration Record (MAR) by licensed and non-license staff. The center uses the Department's standard MAR. Three youth individual healthcare records (IHCRs) were reviewed for medication management. All three youth had a MAR which included all required elements. Two of the three youth records were for youth who were prescribed medication; the remaining one youth was not prescribed medication. The center provided another applicable IHCR for review. A review of the three applicable records reflected each youth had been given medication by a non-licensed staff member. The center currently has nine supervisory-level staff members trained in the administration of medication. All three records reflected medication was administered by staff members who had been trained. The nine staff records reviewed reflected training was completed in 2019. All three records reflected the non-licensed staff members initialed each administered medication. There was no undocumented explanation or lapses in the three applicable records reviewed. Over-the-counter (OTC) medications are documented on the MAR.

Medication administration was observed during the annual compliance review. Medication delivery is the sole responsibility of the nurse/staff during the time of administration. Staff administering medication are not required to conduct or supervise any other center activities during this time. It is the center's practice to verify the Six Rights of Medication Administration for each youth, youth are required to approach nursing staff individually and initial the MAR, pre-pouring medication is not allowed. Refusals of medication are clearly documented on the MAR. One of the three IHCRs reflected a refusal on the MAR. Only medical staff and supervisory-level staff are permitted access to the clinic and medical storage area. One of three interviewed staff reported they give medication to youth, in which this staff was a supervisor. All three interviewed youth reported they are given their medication by a nurse.

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

The center has a written policy and procedures outlining the process for inventory of medications and sharps (including narcotics and psychotropics). A shift-to-shift count for controlled substances was observed to include non-licensed staff participation. The center

currently has nine non-licensed supervisory-level staff trained to assist with medication administration when nursing staff is not on-site.

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

The center has a written policy and procedures ensuring staff have knowledge of appropriate prevention, containment, treatment and reporting requirements of infectious diseases. The center's infection control procedures in place to include prevention, containment, treatment, and reporting requirements related to infectious diseases, according to the Occupational Safety and Health Administration (OSHA) federal regulation and the Centers for Disease Control and Prevention (CDC) guidelines. The center's infection control procedures include the following: common, infection diseases of childhood, self-limiting, episodic contagious illness, viral or bacterial diseases, tuberculosis, hepatitis A, B, C, and HIV, pediculosis and/or scabies, methithicillin-resistant staphylococcus aureus (MRSA), food borne illnesses, bio-terrorist agents, and chemical exposure. Staff have access to protective equipment. Additionally, the hepatitis B immunization is available to staff. There has recently (within the previous thirty days) been three instances in which the local health department, CDC, or the Central Communications Center (CCC) were notified, as required. The center has a comprehensive process for needle stick post-exposure evaluation. The superintendent or designee maintains a separate file containing all documents for youth and staff who have experienced facility exposure, as necessary.

The center's exposure control plan was found to be written in accordance with OSHA standards. The plan is available to all staff. The plan is reviewed and signed annually by the superintendent, most recently on April 21, 2020. The plan includes a risk assessment, methods of compliance, and process for needle stick post-exposure. A review of six training records (three in-service and three pre-service), found all six staff reviewed completed training on the center's exposure control plan. The superintendent reported the exposure control plan is located in medical.

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 to ensure appropriate medical treatment and consideration is given for youth admitted who are pregnant. A review of six training records (three in-service and three pre-service) reflected all six staff completed training on girls' healthcare by a licensed nurse.

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.*	

Observations were made of active supervision by staff during the annual compliance review. Youth were observed supervised by staff in classrooms and during meals. Youth movement from one program area to another was also observed. No youth were seen without staff directly supervising them. The center tracks the youth daily census for youth in detention. A review of logbooks revealed youth counts were conducted, as required. The master control room operator authorizes all youth movement. Youth were observed accounted for and accompanied by staff at all times. Two of the three interviewed staff felt the center has enough staff to provide for the safety and security of the youth. The remaining staff reported the center needs more male staff.

5.02 Ten-Minute Checks (Critical)	Satisfactory Compliance
Staff shall visually observe youth on standard supervision at least every ten minutes while they are in their sleeping quarters, either during sleep time or at other times, such as during an illness or room restriction. *Staff conducts observations in a manner ensuring the safety and security of each youth and documents each check in real-time, manually or electronically. Documentation must include the actual time of each visual observation and initials of the staff conducting the check; pre-printed times are not acceptable.* *There shall be no obstructions (e.g., clothing, memos, pictures) over windows and areas where direct line of sight is needed.* *If an officer, in the course of completing visual observation, is unable to see the youth or any part of the youth's body, the officer shall, with the assistance of another officer, open the door to verify the youth's presence.*	

The center has fifty-six cameras. All but one was operational. The center's administration reported a work order has been completed to have this camera repaired. Video storage is kept for a total of thirty-days. A sample of six days and time periods were reviewed for the completion of ten-minute checks. The sample reviewed included two weekend dates and four separate staff performing checks.

Observations determined staff were utilizing the electric wand to activate the door censor, which automatically records the time of the check conducted. Staff were seen performing checks every ten minutes, as required. Staff were seen stopping and looking into rooms as the checks were made. A review of the electronic read-out of observation checks was completed, as required, to ensure accuracy and compared with real-time video footage. No issues were found. The assistant superintendent was interviewed and stated she completes a review of the ten-minute checks each day for compliance by staff. This documentation was observed maintained in a binder in administration. Three interviewed staff all reported room checks for youth who are in their rooms for sleeping or non-punishment reasons are completed every ten minutes.

5.03 Census, Counts, and Tracking	Satisfactory Compliance

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

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

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

The center has a written policy and procedures outlining counts, census, and tracking. A review of the master control logbooks for the previous six months reflected the center conducted counts at the beginning, middle, and end of each shift. Additionally, counts were observed to be documented prior to and following movements, when a population change occurs, and randomly. The center is also required to conduct counts following emergency situations. Staff do not include youth in the count who are not physically present with the staff at the time of the count. Random counts were observed throughout the annual compliance review. Each of the three interviewed staff reported counts were conducted at the beginning, end, and middle of the shift. Additionally, two staff reported if count is not correct, staff are to recount and lockdown and search the facility.

5.04 Logbook Maintenance	Satisfactory Compliance

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

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

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

The center has a written policy and procedures in place to ensure logbooks are maintained to document all events which occur at the center in the event other sources of information are lost or destroyed. The center has separate logbooks for master control and each living area (two currently in use), visitors, and contracted staff. Logbooks were observed to be bound with numbered pages. Dates are documented on the top of each page of the logbook. All reviewed entries included the time of the event in a.m./p.m. and not military time, the name of the staff

and youth involved, a brief description of the event, and the initials of the staff making the entry. All entries impacting the safety and security of the center, including medical/special needs and mental health alerts are highlighted. All errors were observed to be struck through with a single line and dated by the staff correcting the error. The juvenile justice detention officer (JJDO) or supervisor recorded comments regarding corrected errors. The center does not utilize an electronic logbook. The master control logbook includes the following: emergency situations, incidents, documentation of receipt of medical/mental health alerts, population counts at the beginning and end of shift, as well as throughout the day, youth movement, admissions and releases, presence of law enforcement, confinement documentation, and youth placed on precautionary observation.

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

The center's logbooks for the previous six months were available for review. Documentation reflected the superintendent or designee reviews all logbooks on a weekly basis and provides recommendations as to the accuracy and completeness of the information recorded. Additionally, the juvenile justice detention officer supervisor (JJDOS) reviews the logbooks maintained within master control when assuming center responsibility. The JJDOS and/or lead officer reviews logbooks maintained in each living area (mod) daily. The juvenile justice detention officer's (JJDO) review logbooks maintained in their assigned living area (mod) when accepting responsibility for the living area upon shift change. The superintendent, assistant superintendent, or designee tours the youth living areas at least once during each shift and documents the visit in each area's logbook.

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

The center has a written policy and procedures identifying key control practices. The center's key inventory is missing elements necessary for key control safety, security, and accountability. The center has six observed locations for key inventory; one box in master control, one box in the supervisor office, one box located in the maintenance office, and three boxes in the assistance detention superintendent's office. The inventories observed were inconsistent with content of keys in each observed location, as the number of keys on rings and ring tags did not specify correct key counts. In addition, there were five separate key rings observed which were needed for repair (broken) keys on rings. A work order within Facility Maintenance System (FMS) is required to be submitted in order to notify the center of the needed repairs. However, none of the staff have completed a work order for any of the five broken keys found. Keys are maintained on a tamper-resistant ring. Key inventories did not reflect an accurate count of keys in locations or assignment of staff for key rings observed. A review of the assistance detention superintendent's (ADS) key ring found numerous keys attached (not secured on tamper-resistant ring), with a separate key ring to the inventoried assigned key ring. The assigned key ring for the ADS, indicated ten assigned keys; however, the key ring itself contained seven.

A juvenile justice detention officer (JJDO) key ring was observed and found it contained the correct key count. However, the published key inventory for the set of keys, did not reflect the correct location of the keys (current module is closed for construction), but the staff was assigned to a different module then the key ring assigned. The third staff sample was a nurse. The nurse key ring is inventoried to contain ten keys, however the ring observed had twelve keys. One of keys on the nurse's key ring, was attached by a separate key ring (not secured on tamper resistant ring). A set of emergency keys were located in master control, all staff have access to these keys. The center's key log has several noted discrepancies, whereas, the logbook for key control was missing entries of log-in/out times and dates . Key control practices allow staff to either secure personal keys in the breakroom or secure keys in the bathroom, within a locker.

Staff report some supervisory staff conduct uniform inspections of staff at shift briefing to see if staff have any personal keys on them; this is conducted after the staff have entered onto the secure side of the center. There have been no documented instances of lost keys or any staff having left the center with keys. The practice for daily tracking and reconciliation of keys is difficult to ascertain. No discernable inventory of keys with correct counts of keys on rings exist; there are six separate location for keys to be stored. An example included, kitchen keys to a

locked cabinet, were discovered hanging on a cork board located in the food service office (keys were not included in the centers key control inventory). Additionally, one key was found (not on inventory) which was for the desk in the food service office. Three staff were interviewed, staff were able to identify which center staff keys are restricted. In addition, each staff explained the center's daily process for tracking keys.

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

The center has a written policy and procedures in place to ensure any vehicle used by the center to transport youth is properly maintained and documentation is maintained on the use and maintenance of each vehicle. The center currently utilizes five vans to transport youth. The center was unable to provide any documentation showing any of the five vehicles had an annual inspection within the previous year. The superintendent was interviewed and reported they are coordinating with a vehicle maintenance shop to have the vans inspected by the end of the week. Weekly safety inspections for all five vans by maintenance staff or designee were available for review and were observed to be completed, as required.

The center was unable to provide documentation for any five vans indicating monthly vehicle checks were completed using the Monthly Vehicle Checklist which includes: tires (including spare), battery (test), windshield and wipers, windows, mirrors, and damage (to include all scratches/dents), had been completed within the previous six months (since reopening). A visual inspection of the vans revealed four of the five vans contained the required equipment. One van was missing the seatbelt cutter and window punch. Staff reported when this van is used, these items are borrowed from another van. Each van contained a logbook in which the following information was documented: acknowledgement the vehicle was checked, destination, number of youth and staff, name of the officer driving and name of the office riding, and the time the transport began and ended. A transport was not observed during the annual compliance review; however, the transport logbooks reflected documentation indicating vehicle checks were completed on the corresponding days in which the vehicles were in use. All five vans were observed to be secured.

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

The center has a maintenance and kitchen written tool policy. Inspection of the kitchen revealed no discernable inventory for any kitchen tools on-site; there is not an itemized inventory of all kitchen equipment. The kitchen staff completes a count of sharps daily; however, the count does not include two pairs of scissors, found located with the kitchen knives. The kitchen count only encompasses eight knives on-site; no other kitchen tools are included in a count or inventoried. The eight knives were found to be secured in the food service office in a locked cabinet drawer, however no shadow board or clear marked identification code were found on any of the kitchen tools. The keys to the locked cabinet were discovered hanging on a cork

board located in the food service office (keys were not included in the center's key control inventory). Additionally, one key was found (not included in the inventory) which was for the desk in the food service office. There were no signatures by the superintendent or designee of tools found for any counts conducted within the kitchen area. Kitchen staff indicated if a tool went missing or was damaged, they would contact administrative staff to report the issue.

The maintenance office has an inventory for some of the tools found within the maintenance office; however, several tools were found throughout the shop which were not included on the inventory provided. Additionally, there were two shovels found outside, which were not noted on the inventory. Most of the tools observed are located and locked in the maintenance office, which is not accessible to youth. Some tools observed were found hanging up on what appeared to be a shadow board; however, the tools were not in-line with any of the shadow board outlines. Not all tools listed on the inventory were present and there were additional tools found hanging up, not listed on the inventory. In addition, not all tools observed had clear marked identification codes on them. A count of some of the tools is conducted, however, what is counted is unclear, as the inventory of all the tools is not complete. The last signature by the superintendent or designee for maintenance tools was approximately three months ago in December 2019. An additional page was provided for demonstrating a count was supposedly conducted in January 2020; however, the month was not recognizable, and the year was 2019.

A maintenance tool bag also exists, where tools are used (carried) in and out of the maintenance shop into the center. The inventory for these tools was incomplete. The count log sheet for the tool bag was missing actual count/inventory of bag items. In addition, the form utilized was improperly filled out; missing fields where the user should have filled in when conducting a perpetual inventory. The observed forms for the maintenance tool bag, did not contain Superintendent signature, and on some forms was missing signature of the maintenance person. The last perpetual count for the maintenance tool bag was completed September 2019. A key box was found in the maintenance office, no inventory was present for any of these keys. Currently the center does not have a maintenance person employed. The center has maintenance staff from other area detention centers come on-site periodically to assist with general maintenance issues.

Service vendors are not accompanied at all times while on-site in the secure areas of the center. On-site observations of contractors conducting maintenance/repairs within a couple of the center's modules noted no Department staff present. There was no accountability (identification) of vendor(s) on-site, prior to access to the centers secure area. A book with previous visitor/contract personnel was found; however, the book did not document any identification of those vendors currently on-site during the annual compliance review. In addition, there was no accountability of tools brought in by each of the vendors (check-in or out procedures). It was unable to be determined as to whether or not tools are lost upon completion of work projects conducted by vendors, as no inventory of tools is taken upon entry into the center. An interview with staff revealed an inspection of the area would be conducted; however no documentation existed which substantiated such inspections occurred.

One closet which contained the center's cleaning tools (mops, brooms, buckets, etc.), was observed. The center maintains a perpetual count for each item; however, upon review, there was an extra dust mop noted in the closet not on the inventory. In addition, not all shifts were signing off on the count when and if checks were completed. The closet next to the broom closet had items with no inventory of what items were secured in the closet; (ladder, vacuum, and toilet snake).

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

The center has a written policy and procedures addressing tools and chemicals. According to the written policy and procedures, youth are not permitted to use tools, including kitchen and medical equipment. Youth are allowed to use cleaning items such as mops, brooms, and other common household items under direct staff supervision. None of the youth were observed using tools or cleaning items during the annual compliance review. Each of the three interviewed staff reported youth are allowed to use mops, brooms, and scrub brushes. All three interviewed youth reported they are allowed to use mops and brooms. Additionally, two of the three youth interviewed reported they can use scrub brushes.

5.10 Inventory of all Flammable, Toxic, Caustic, and Poisonous Items	Limited 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 written policy and procedures regarding the inventory of all flammable, toxic, caustic, and poisonous items. The center's Safety Plan was inclusive of the Continuity of Operations Plan (COOP) which was last updated in 2017. Observations were made of all areas used to store chemicals. Each area was observed secured and inaccessible to youth. Five areas within the secured center contained chemicals or cleaning items within. The five locations included the following: the kitchen, B1Mod, B2Mod, custodial closet, and G1Mod. In each area, there was a binder with Safety Data Sheets (SDS) which included the center's FOP for chemicals, as well as Occupational Safety and Health Administration (OSHA) standards. Each item observed within these storage places contained an SDS with the exception of no SDS for 'Citra-Germ' within B2 Mod. In addition, there was not a SDS for 'Chlor-San' and 'Maach Drymate' in the kitchen area. Only one storage area for chemicals included a perpetual inventory for items being removed for use by staff. There were no updated inventories observed for the other areas observed.

Three interviewed staff all reported youth are not permitted to use any cleaning substances which may be toxic, flammable, or poisonous. All three interviewed youth also denied directly

handling any chemicals. The youth reported when cleaning, the staff sprays the product and youth wipe the product off.

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

The center authorizes staff to use any cleaning products for the purpose of performing daily cleaning activities within the living areas. Only kitchen staff are permitted to use kitchen cleaning products. Observations made during the annual compliance review found all flammable, poisonous, caustic, and toxic materials were stored in secure areas and inaccessible to youth. Three interviewed staff all reported youth are not permitted to use any cleaning substances which may be toxic, flammable, or poisonous. All three interviewed youth denied directly handling any chemicals. The youth reported when cleaning, the staff sprays the product and youth wipe the product off.

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

The center has a written policy and procedures regarding the inventory of all flammable, toxic, caustic, and poisonous items. The center reported having had no instances of chemical spills or disposal of any flammable, toxic, poisonous, or caustic items during the scope of the annual compliance review. The kitchen has a grease trap used to maintain grease for disposal. There is a contractual agreement with a provider who comes as-needed to the center to dispose of the grease used. Copies of invoices were observed to confirm this practice. An interview with kitchen and direct care staff revealed dirty mop water is disposed of through floor drains and mop sinks.

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

The center's confinement room was observed to meet all Departmental requirements. There were no non-fixed items found in the confinement room and the windows were free from obstructions. Youth who are placed in confinement are afforded living conditions approximating those available to the general population. A sample of eleven confinement reports for confinement under twenty-four hours was reviewed. All confinement reports were observed to be entered into the Facility Management System (FMS). All contained documentation the rooms were searched prior to placement of the youth. All reports were completed within one hour and

submitted to the juvenile justice detention officer supervisor, who reviewed the report within two hours of receipt. In all reports, there was evidence the supervisor talked with the youth within every three hours. Ten of eleven reports documented a review by the superintendent or designee within forty-eight hours. One was reviewed ten days late.

Education materials are provided to youth who are in confinement. According to the assistant superintendent, the mental health, medical, and educational staff receive a daily update which discloses any youth who may be in confinement and require services. All eleven confinement reports reviewed had evidence the supervisor approved the confinement prior to youth placement. No more than one youth is placed in a confinement room. In each report, the supervisor conducted an initial review with the youth no later than two hours after the incident.

Visual Observation Reports (VOR) are required to be completed by staff when a youth is in confinement. Each youth must be observed every five minutes during the first hour, and every ten minutes thereafter. Observations are documented on the VOR. All VORs were reviewed for the eleven confinement reports selected. Each had evidence of staff documenting the observations, as required, with two exceptions: For one youth, it was documented he was observed by staff at 3:35 p.m. and then at 3:58 p.m. In another VOR the staff documented the youth in confinement was observed at 4:00 p.m. and then at 4:15 p.m., both of which are outside the timeframe required. Nine of the eleven confinement reports included report from the staff involved as to the reason for the confinement. These reports were completed by the end of the staffs' shift. One did not have the staff report documented. For the other incident, one staff involved provided a report two days after the incident. Three staff were interviewed concerning placement of youth in confinement. All three staff reported when this occurs, they are required to document room checks every ten minutes. They are also required to complete a confinement report and search the confinement room.

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

The center had one example of a confinement over twenty-four hours during the annual compliance review period. A review of the Facility Management System (FMS) in the

Department's Juvenile Justice Information System (JJIS) was completed to ensure the center met all requirements for the placement. A review of the documentation revealed the staff searched the confinement room prior to placing the youth. The confinement was approved by the superintendent. Documentation indicating the placement was approved by the regional director every twenty-four hours. The juvenile justice detention officer supervisor (JJDOS) documented conversation and evaluation of the youth's status in confinement at least every three hours after the initial placement and documented the reason for continued confinement. Mental health staff provided documentation of a review of the youth's status as required. The placement in confinement did not exceed three days.

Email documentation revealed evidence of the Confinement Review, which was chaired by the regional director. The review was conducted over the telephone and was held within two hours prior to the end of the twenty-four-hour period in confinement. The superintendent provided the regional director with a copy of the Confinement Report and all reviews and interviews with the youth. The superintendent designee and the mental health staff met with the youth prior to the review to discuss the continued confinement. The review chairperson concurred with extending the placement beyond twenty-four hours and indicated the youth continued to present a clear and present danger to others. Email verification was found indicating the review chairperson received a Copy of the Confinement Review documentation. The information was also sent to the assistant secretary for detention services and uploaded in FMS.

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

A review of the center's Continuity of Operations Plan (COOP) was completed. Annexes were attached to the COOP. The program is required to complete at least two disaster related drills each year. Drill documentation revealed the program has completed a hurricane drill in April 2020. The documentation indicated the date and time, participants, findings and recommendations. Three interviewed staff reported they have participated weather, escape, fire, and medical drills.

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

A review of the center's escape prevention plan verified inclusion of the Department's policies and procedures concerning escapes. The center conducts escape drills quarterly, as required. Drill documentation revealed escape drills were completed during the annual compliance review period. Three staff training records also revealed the staff have completed escape prevention training as part of their annual training requirement. Three staff were interviewed and stated they have participated in various drill types, to include escape, weather, fire, and medical related incidents.

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

The center's fire prevention plan was reviewed. Drill documentation provided found evidence the center conducts fire drills monthly and on each shift. The center is operating on two shifts. The center's fire prevention practices have been approved by the local fire marshal, who completed the center's fire inspection prior to their re-opening August 2019. Documentation from the fire inspection specialist revealed no major fire safety violations found. Procedures for fire prevention were approved by the local fire marshal. All three interviewed staff reported they have participated in fire drills.