STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Broward Regional Juvenile Detention Center

Department of Juvenile Justice
(State-Operated)
222 N.W 22nd Avenue
Fort Lauderdale, Florida 33311

Review Date(s): January 14-17, 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:

Maryann Sanders, Office of Program Accountability, Lead Reviewer (Standard 1)
Teves Bush, Office of Program Accountability, Regional Monitor (Youth and Staff Interviews)
Rosa Flores, Office of Program Accountability, Regional Monitor (Standard 2)
Virginia Jackson, Palm Beach Regional Juvenile Detention, Juvenile Justice Detention Officer Supervisor (Standard 5)
Peter Keelan, DJJ Office of Education, Education Coordinator (Standard 2)
Carol Locke, Pompano Youth Treatment Center, Registered Nurse (Standard 4)
Gary Mogan, Office of Program Accountability, Regional Monitor (Standard 3)

Program Name: Broward Regional Juvenile Detention Center
Provider Name: State of Florida
Location: Broward County / Circuit 17
Review Date(s): January 14-17-2020

MQI Program Code: 473
Contract Number: N/A
Number of Beds: 92
Lead Reviewer Code: 154

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

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

Standard 1: Management Accountability
Detention Rating Profile

Indicator Ratings

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

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

Standard 2: Youth Management
Detention Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Detention Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Detention Rating Profile

Indicator Ratings

Standard 5 - Safety and Security		
5.01	Active Supervision of Youth *	Satisfactory
5.02	Ten-Minute Checks *	Satisfactory
5.03	Census Counts and Tracking	Satisfactory
5.04	Logbook Maintenance	Satisfactory
5.05	Logbook Reviews	Satisfactory
5.06	Key Control	Satisfactory
5.07	Vehicles and Maintenance	Satisfactory
5.08	Tool Inventory and Management	Satisfactory
5.09	Youth Access & Use of Tools, Cleaning Items *	Satisfactory
5.10	Inventory of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.11	Access to all Flammable, Toxic, Caustic, and Poisonous Items *	Satisfactory
5.12	Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.13	Confinement Under Twenty-Four Hours	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

Broward Regional Juvenile Detention Center is a state-owned, ninety-two bed detention program, operated by the Department. The center serves male and female youth in Circuit 17 Broward County who are detained pending adjudication, disposition, or placement in a residential commitment program. 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 Broward County School Board. The center's management team includes the superintendent, two assistant superintendents, two administrative assistants, seven juvenile justice detention officer (JJDO) supervisors, one training officer, one maintenance mechanic, twenty-six JJDO II, sixteen JJDO I, one food service worker supervisor, and five food service workers. Mental health and medical healthcare services are provided through the contracted provider, Maxim Healthcare Services who sub-contracts with Camelot Community Care, Inc. Mental health services are provided by one licensed mental health counselor (LMHC) who services as the designated mental health clinician authority (DMHCA), two licensed mental health therapists, and two non-licensed master's-level therapists. Clinical services provided by the center include mental health and substance abuse evaluations, mental health treatment planning, individual, group and family therapy, mental health crisis intervention services, on-site psychiatric services, and availability for substance abuse services for youth with co-occurring disorders. Medical services are contracted through Maxim Healthcare Services which services are provided by the designated health authority (DHA), one advanced practice registered nurse (APRN), two registered nurses (RN), two licensed practical nurses (LPN), and one medical records clerk. The medical clinic provides nursing coverage seven days a week, from 7:30 a.m. to 8:30 p.m. Monday through Friday and from 8:00 a.m. to 8:00 p.m. on Saturdays and Sundays. Food services are provided by Department staff and include menus, meal planning, meal schedules, special diets, nutritional analysis, daily allowance, food preparation, health certifications, food product standards, sanitation, and cleaning. Staff are responsible for the custody and control of youth in their care, providing youth supervision twenty-four hours a day, seven days a week. The center has four living modules which are divided by male and female. There is a total of ninety-four security cameras at the center, of which all were operational at the time of the annual compliance review. A tour of the center was conducted by the review team. Observations of the center indicated the exterior was free from debris and the grass was manicured. The lobby area of the center was observed clean and had no broken furniture. Observation of the secure area found the floors were clean and the walls contained murals to promote positive motivation. The center has a total of four modules to include three for male youth and one for female youth. Observation of the modules found they were clean and neat with no broken furniture. The youth rooms indicated the beds were neatly made and the bathrooms were clean. There was no graffiti found in the center. According to the superintendent, funds have been allocated to remodel two of the three male bathrooms. At the time of the annual compliance review, the center had seven vacancies, which included four JDO I, one JDO II, one JDOS, and one food service worker.

Standard 1: Management Accountability

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

The center has a written policy and procedures for initial background screening. The center hired thirty new staff since the last annual compliance review. A review of each new staff personnel record verified an initial background screening was completed prior to hire and each new staff received a passing score on the pre-employment assessment tool. The center had four new contracted staff employed by Maxim Health Services, Inc. since the last annual compliance review. A review of Clearinghouse indicated each new contracted staff received an initial background screening prior to hire. There was a total of nine new volunteers obtained since the last annual compliance review. A review of Clearinghouse indicated each received an initial background screening prior to hire. None of the new hires required an exemption by the Department. The center submitted an Annual Affidavit of Compliance with Level 2 Screening signed by the Department's Background Screening unit on January 9, 2020. The Broward County School Board submitted an Annual Affidavit of Compliance with Level 2 Screening on January 9, 2020

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

The center has a written policy and procedures requiring the completion of a five-year background re-screening for staff. There were five departmental staff, one contracted staff, and one volunteer requiring a five-year rescreening since the last annual compliance review. Reviewed documentation found the rescreenings were submitted as required. Each background rescreening was submitted at least ten business days prior to their five-year anniversary.

1.03 Staff Code of Conduct	Satisfactory Compliance

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

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

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

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

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

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

The center utilizes the Department of Juvenile Justice (DJJ) employee handbook to ensue staff adhere to the code of conduct. Seven personnel records were reviewed, and each contained the acknowledgement, receipt, and review of the Department's code of conduct. Seven records were reviewed for disciplinary actions. One applicable reviewed record contained documentation of a disciplinary action. Reviewed documentation validated management took immediate corrective action to address the staff code of conduct when staff violated the policies and procedures which was reported to the Department's Central Communications Center (CCC). The reprimand documented the staff resigned from the position. Internal incident reports for the past twelve months were reviewed, and none were applicable for improper conduct by staff. Seven staff were interviewed, and each knew the process for allowing staff and youth to call the Florida Abuse Hotline or CCC to report suspected abuse. Seven staff were intervened, and three staff never heard staff use profanity when speaking to a youth, two staff occasionally heard staff use profanity when speaking to a youth, and two staff heard staff use profanity once when speaking to a youth. None of the seven interviewed staff observed a co-worker using threats, intimidation, or humiliation when speaking to a youth. Seven staff were interview on how the working conditions in the center over the past year have been. One staff stated very good, four staff stated good, and two staff stated fair. An interview with the superintendent indicated the code of conduct ensures staff communicate and interact with youth and co-workers in a manner which provides a role model of socially accepted behaviors. Staff behavior shall be respectful of others and reflect desired behaviors for youth. Suspicion or knowledge of violation of this policy must be reported to Florida Abuse Hotline. If a youth is at least eighteen years old and not disabled, physical abuse is reported to the Department's CCC and the youth shall be given an opportunity to file a police report. Staff also follow the same guidelines and may face disciplinary action leading up to dismissal for any violations.

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

The center has a written policy and procedures addressing reports to the Department's Central Communications Center (CCC). For the past six months, there were a total of forty-eight CCC incident reports. A review of six CCC incident reports from the last six months found one incident was not called in to the CCC within the mandatory two-hour time frame. A disciplinary action was received by the staff for failure to report the incident to the CCC within the required time frame. A review of facility logbooks, grievances, and internal incidents confirmed there were no additional incidents which should have been reported. Each reviewed CCC report was documented in the center's logbook. The center maintains a CCC binder which documents all reports made to the CCC. Seven staff were interviewed and knew the process for allowing youth to call the Florida Abuse Hotline or the CCC. An interview with the superintendent indicated all reportable incidents must be called into the CCC within two hours by the highest-ranking person on duty. In addition, youth should have unimpeded access to a telephone if they wish to make an abuse call. The number for the CCC and Florida Abuse Hotline is prominently displayed everywhere there is a telephone. Youth are allowed to make the abuse call without the fear of alienation or retaliation.

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.	

The center has a written policy and procedures to ensure staff who utilize Protective Action Response (PAR) completes a PAR report within the required time frame. The center had a total of 415 PAR incidents since the last annual compliance review and 218 PAR incidents for the past six months. The center's PAR rate during the annual compliance review period was 22.60, which is above the statewide Detention PAR rate 12.00. A review of twenty-two PAR reports from the past six months found the reports were completed the same day of the incident by the end of the shift. Each report contained statements from each staff involved. There were no mechanical restraints used in any of the incidents or any allegations made by youth of abuse. One of the seven reports indicated an injury was sustained by a staff member. The incident was reported to the Department's Central Communication Center (CCC); however, it was not reported within the required two-hour time frame. A Post PAR report was conducted for each reviewed incident within the required time frame and a Post PAR medical review was completed by the center's nursing staff. Each of the twenty-two reports were reviewed by the assistant superintendent within the required seventy-two-hour time frame. A review of seven in-service and seven pre-service training records verified staff were trained in the use of PAR. An interview with the superintendent indicated all PAR incidents are reviewed by way of video camera footage to monitor for compliance by supervisors, the PAR instructor, and administrators.

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

The center has a written policy and procedures regarding pre-service certification requirements. The center has a pre-service training plan approved by the Department's Office of Staff Development and Training on January 14, 2019. A review of seven training records indicated each staff was certified within 180 days of hire. Reviewed documentation confirmed staff received and passed Protection Action Response (PAR) training within ninety days of hire, and the required training which included cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED) certification, mental health and substance abuse, suicide recognition, prevention and intervention, safety, security, and supervision, and the Department's facility operations. All training was completed prior to staff being in the presence of youth. Reviewed documentation reflected all pre-service training was entered into 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.*	

The center has a written policy and procedures regarding in-service training. The center provides in-service training to staff through a combination of the Department's Learning Management System (SkillPro) and instructor-led classes. The center has an annual in-service training plan approved by the Department's Office of Staff Development and Training on January 14, 2019. Seven staff training records were reviewed and each staff completed the required twenty-four hours of training on Protective Action Response (PAR) update, first aid, automated external defibrillator (AED), and cardiopulmonary resuscitation (CPR). Additionally, five reviewed staff completed escape prevention and fire prevention trainings, professionalism and ethics, suicide prevention, trauma informed care, emergency response, medication management, infectious control, exposure control, active shooter, and girls' healthcare trainings. Two staff did not complete professionalism and ethics and active shooter training. Three supervisor training records were reviewed, and documentation found each supervisor exceeded the required eight hours of supervisory training. Each supervisor received training in management, leadership, personal accountability, employee relations, communications skills, and fiscal. All completed training was entered into SkillPro. An interview with the superintendent indicated the training they received are the fundamentals of coaching, leadership training, manager's training, and supervisor training. Staff are required to have leadership training and SkillPro courses.

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 entering and sharing alerts. Alerts are entered in the Department's Juvenile Justice Information System (JJIS). Upon review of the alert list, the supervisors distribute the alert list to all working direct-care staff, at each shift briefing. Each staff carry the current alert list throughout their shift. A random review of the shift briefings verified alerts are shared with staff. If any changes to the alert list occur during the shift, JJIS is updated and staff are informed of the changes. Seven random youth were reviewed from the alert list which verified the youth alerts were entered in JJIS as required. The responses and updates by medical, mental health, and other staff were documented in the JJIS alerts as they pertained to each applicable critical alert. A review of the center's Admission Wizard, logbooks, and shift reports found all applicable alerts were documented in JJIS, entered in the appropriate logbook, and noted in the center's shift reports. Seven interviewed staff indicated management inform them about alerts and issues in the center through the logbook, shift briefings, and meetings. An interview with the superintendent indicated youth are interviewed during the intake process where alerts are initially added. Youth are also interviewed during the intake medical process where additional alerts are added. All alerts are read during shift briefing for each detained youth.

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 a written policy and procedures in place concerning youth admission into the center to ensure proper screening, evaluation, and documentation of each youth detained. A review of seven case management records revealed each youth had a completed Detention Risk Assessment Instrument (DRAI), Suicide Risk Screening Instrument (SRSI), and arrest affidavit or order to take into custody. Each reviewed record contained supporting documentation of the youth being electronically searched, frisk searched, and/or strip searched by an officer of the same gender and screened to identify medial, mental health, and substance abuse needs. Seven reviewed case management records documented the youth made a telephone call at the center's expense to their parent/guardian and was served a meal or a snack within the required time frame. Each reviewed case management record contained an Admission Wizard from the Department's Juvenile Justice Information System (JJIS) completed for each youth. An observation of an admission was conducted by the annual compliance review team and validated the youth was frisked and strip searched by an officer of the same gender, provided the opportunity to make a telephone call to their family, and was provided with a snack or meal by the juvenile justice detention officer (JJDO). All admissions case records are reviewed by the shift supervisor for appropriate placement and for appropriate supervision levels.

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 regarding the youth orientation into the center to ensure all youth admitted into the program are notified of the center's rules and regulations. The center's rules and regulations, expectations for behaviors, grievance procedure, dates and times for visitation, telephone calls, how to access mental health, medical, and substance abuse services, letter writing, how to access the Florida Abuse Hotline, youth rights, and the behavior management system are advised both verbally and in writing during the orientation process. During the admission process, staff also explained the Prison Rape Elimination Act (PREA) and have the youth to view the PREA video. The admission process is documented during the intake/booking and signed by both the admitting officer and the youth. A review of seven youth case management records revealed each youth received an orientation within twenty-four hours of admission and verified signed copies of the orientation documentation. Seven youth were interviewed and confirmed they received information about the center's rules and regulations, educational services, visitations, daily schedule, abuse reporting, and the behavior management system at admission. An observation of a new admission validated the center addressed the required areas during the orientation process.

2.03 Classification	Satisfactory Compliance

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

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

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

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

The center has a written policy and procedures regarding classification to ensure all youth admitted to the center are classified by the admitting officer to provide the highest level of safety and security. Youth classification is considered for potential safety and security concerns in room assignment which includes gender, height, weight, age, level of aggressiveness, mental illness, intellectual disabilities, physical disabilities, gang affiliation, criminal behavior, history of sexual offenses, suicide risk, medical, and Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB). Youth may be reclassified if there are any changes in the status or behavior. All room assignments are documented in the Department's Juvenile Justice Information System (JJIS) and no more than two youth may occupy a room. All youth requiring a single room have an alert entered in JJIS. Review of the VSAB results must be documented by the supervisor making the room assignment. Seven youth case management records were reviewed, and documentation reflected each contained the classification process to ensure safety and security while in secure detention. In each reviewed record, a review of the center's alerts found the procedures were followed. There were no gang members, suspected gang members, or associated gang members in secure detention during the annual compliance review week. An interview with the superintendent indicated all gang and associated gang members are referred to the center's gang liaison to ensure an alert is entered into JJIS. All information was documented in the Department's Juvenile Justice Information System (JJIS) Admission Wizard.

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 the sharing of suspected gang involvement with local law enforcement, and ensure a notification is sent to the assigned juvenile probation officer supervisor (JPOS) or the circuit gang representative. The center has identified one officer as the gang representative to communicate all suspected gang activity to local law enforcement and juvenile probation officer supervisor, who serves as the gang representative for Circuit 17. An interview with the center's gang representative indicated once a youth is admitted, notification is sent to the juvenile probation officer (JPO) by electronic mail (e-mail). The alert information is then entered into the Department's Juvenile Justice Information System (JJIS). There were no gang members, suspected gang members, or associated gang members in secure detention during the annual compliance review week. A review of three applicable closed youth case management records identified as gang members indicated the center provided documentation of e-mail communication to support this practice. In each instance, the information was communicated to staff through the internal alert system. The center's gang liaison was interviewed and was knowledgeable in the center's gang notification procedures.

2.05 Admission of Youth Personal Property	Satisfactory Compliance

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

The center has a written policy and procedures in place to ensure the proper safe handling and security of youth's personal property and valuables. At the time of admission, the center's staff inventories all personal property in the youth's possession and documents records of each surrendered item on the center's Property Receipt form. All money and valuables are placed in a tamper-proof clear bag with the youth's name clearly documented with a property form and picture, identifying the property enclosed in the bag. The tamper-proof property bag is placed in a secure cabinet located in the supervisor's office. The secured cabinet is under camera surveillance with limited access to shift supervisors and administration. Personal property such as clothes and non-valuables are stored in a locked storage room specifically for youth property. A notification logbook located in the supervisor's office is used to document each youth's name and property. A review of seven youth case management records confirmed each youth's record contained a Property Inventory form, which verified personal property is collected, inventoried and secured by the booking officer in the presence of the youth during the admission screening process. At the time of admission, youth are informed of the unclaimed personal property procedures and each youth signed a property letter of acknowledgement. The letter is to acknowledge personal property left unclaimed after thirty days will be deemed abandoned and subjected to disposal according to the applicable State of Florida guidelines. A

review of seven case management records indicated each had property receipts and acknowledgements of unclaimed property signed by both staff and youth. An interview with the superintendent indicated youth property is secured in a locked cabinet in the supervisor office under camera supervision. Youth have thirty days from the day they leave the facility to claim it or it can be disposed. Observations of a youth admission and storage of the youth's personal property validated the center's practice. Seven youth were interviewed and indicated, upon admission to the center, staff checked their personal property and each youth signed and received a form listing their personal property was correct.

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 in place related to the youth's personal property inventory for staff to provide control and accountability of the youth's personal property. Non-valuable property is placed in a numbered property bag located in a secured room and valuable property is placed in the supervisor's office within a secured cabinet. Both areas are under camera surveillance. Observation of the property room showed safe guards were in place for youth's personal property until it is returned to the youth or parent/guardian. The center's procedures included a clear process related to disposal of unclaimed property. An interview with the superintendent indicated youth property is secured in a locked cabinet in the supervisor office under camera supervision. Youth have thirty days from the day they leave the facility to claim it or it can be disposed of. In addition, the superintendent indicated there has not been any Central Communications Center (CCC) incidents involving youth personal property since the last annual compliance review. A review of the CCC incident reports for the past six months found there were no incidents of lost or stolen property.

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

The center has a written policy and procedures in place for the release of youth. The releasing officer shall verify all court authorization, and the on-duty supervisor will review and validate all paperwork related to the release, prior to youth's release. Three closed case management records were reviewed for release documentation. Each record contained documentation the

on-duty supervisor reviewed all paperwork prior to the youth's release, verified the youths' identification, and verified the parent/guardian identification. Each reviewed record also contained documentation of all required parties' signature of the release and reminded of any future court appearances. The youth information was uploaded in the Department's Juvenile Justice Information System (JJIS) by the shift supervisor at the youth's departure. An observation of a youth release validated the center verified the youth and parent/guardian identification, all parties signed he appropriate release documentation, and the youth exited the center in their own clothing. A review of the Department's Central Communications Center (CCC) reports for the past six months reflected there were no 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 in place related to youth property. Once a youth is released from the detention center the releasing officer, the youth, and the parent/guardian shall review and sign the Property Receipt form and account for all the youth's personal property. Property not claimed within thirty-days is considered abandoned and after the thirty-day period a Notice of Impeding Disposal of Property is mailed to the last known address. The superintendent shall notify the Department's Central Communications Center (CCC) and file an incident report when a youth's personal property is stolen and/or missing. Unclaimed personal property such as clothes are either donated or discarded and valuables such as money are forwarded to the regional fiscal manager in the form of a money order. The regional fiscal manager will then forward the money order to the Department's headquarters designee in Tallahassee. The program maintains a property record of disposed cash forward to headquarters. The reviewed documentation noted each applicable youth received their personal property as evidenced by the property receipt report being signed and dated by the youth and/or their parent/guardian. A review of three closed youth records indicated signatures of the youth and the releasing office on the Property Receipt form. There were no issues with unclaimed youth property for the applicable case management records reviewed. An observation of a youth release validated the center's practice. The Department's Juvenile Justice Information System (JJIS) Admission Wizard was observed to have been updated on the day of the youth's release. A review of Notice of Impeding Disposal of Property forms for the past six months validated attempts by the center to have the youth or family retrieve any unclaimed property.

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

The center has a written policy and procedures in place related to the correct way to release youth prescribed medication, along with medical instruction to be given to whomever is receiving the youth at the time of release. A review of three applicable closed youth records reflected supporting documentation verifying the youth were released to a parent/guardian with a copy of their identification and the Office of Health Services Medication Receipt form. The medication release form for each youth listed all medications at the time of the youth's release including instructions, appointments, and was signed by the youth, the parent/guardian, and the center's staff.

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 to ensure the proper management of youth and sharing of appropriate information. The purpose of the detention review meetings is to provide a means to screen all youth who may be able to be moved to a less restrictive placement or to their respective commitment placement. The review of youth in secure and home detention is conducted on a weekly basis at the center and facilitated by a designated juvenile justice detention officer (JJDO). All appropriate parties are encouraged to attend such as the center's medical and mental health staff, education staff, Probation and Community Intervention, and residential. Observations of the weekly detention review process indicated information of youth in secure and home detention was shared. In attendance were detention representative, medical, mental health, school board, and probation. A review of detention review documentation for the past six months included sign-in sheets and verified the center conducted reviews weekly with consistent participation of the required parties responsible for the youth. An interview with the superintendent confirmed the detention review specialist facilitates the meeting which is held weekly at the detention center.

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

The center has a written policy and procedures in place to ensure youth are provided the opportunity to participate in constructive activities and keep youth actively involved. The center provides and maintains a weekday, weekend, and holiday schedule posted in all living areas. Youth are provided the opportunity to participate in constructive activities which will benefit all youth at the same time, allowing the maximum use of staff for proper supervision. Observations of the daily schedule reflected the time frames of the daily activities provided to the youth on a regular basis which included wake-up, meal times, personal hygiene, visitation, education, volunteer programing, large muscle exercise, shift change, bed times, groups, and open program times. Seven youth were interviewed, and each stated the center has a daily activity schedule.

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

The center has a written policy and procedures in place to ensure center staff adhere to the daily schedule. The daily schedules are openly posted in all youth living units. Any significant changes to the schedules are approved by the shift supervisor and the reason for the changes

must be documented on the shift report. A review of the facility logbooks for the past six months indicated the schedule is followed. Throughout the annual compliance review week, observations confirmed the center followed the posted activity schedule. A review of the center's shift reports from the past six months verified there were no significant changes in the activity schedule. Seven youth and seven staff were interviewed, and each responded the center follows the daily activity schedule.

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

The center's educational program managed by the Broward County School Board operates on a year-round basis, providing the youth 250 days of instruction distributed over twelve months with a minimum of twenty-five hours weekly. The only restriction in which school would be canceled would be due to natural/climatic emergencies. Upon review of the center's daily education schedule, as well as an interview with the on-site lead education counselor, the teachers have nine dedicated days for professional development. A review of the center's master control logbooks for the past six months supported youth are receiving the required 300 minutes of instruction a day with minimal interruption. A review of eleven separate entries in the center's master control logbook over the past six months found youth arrived at school as early as fifteen minutes early and up to thirty-four minutes late of the scheduled start of academic classes. An interview with the on-site lead education counselor stated the youth may be held back from arriving to the exterior classrooms due to weather conditions, disruptions within the modules, or other issues which may impede the youth from leaving the dormitories. Should the youths be kept in their respective dormitories during the scheduled school time, they will be offered the academic classes and any related activities to be completed within said area under the direct supervision of the attending teacher. Seven interviewed youth reported attending school daily with no interruptions.

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

The center provides appropriate career education to the youth based upon each youth's age, as well as assessed cognitive and educational abilities. The career education component offered is categorized as a Type 1 Career Vocational curriculum. This classification which stresses soft skills, includes but not limited to communication, decision making, and interpersonal skills. An interview with the on-site lead education counselor supported the education component also provides the youth with employment and life skills guidance by an on-site job coach who provides each youth with various exercises which deal directly with exploring career choices, corrective résumé writing, and interviewing 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 in place to ensure the provision of a system of rewards, privileges, and consequences to encourage youth to fulfill the center's expectations regarding the behavior management system (BMS). The center has implemented and maintains a BMS to meet the needs of the youth along with the safety and security of the youth and staff. The reward system consists of three levels and includes rewards for positive behavior and consequences for inappropriate behavior. At the time of admission, each youth enters the center on level two. This level provides youth basic rights and some additional activities and incentives. After three days of positive demonstrated behavior, the youth are able to advance to level three. This level provides youth all the basic rights and youth are eligible to receive additional privileges and incentives. Level one is the most restrictive level and is utilized for negative behavior. A youth may move up or down within the level system based on their positive and/or negative behavior and their ability to respond to staff intervention. Level change requests must be made with the authorization from a shift supervisor. Youth levels are updated in the logbooks and youth are informed of their current level. Observation of the posted BMS in all living areas clearly specify rules, norms, and expectations. Observation of staff interaction with youth while in the living modules, cafeteria and during other movement appeared professional with staff offering encouragement as they interacted with the youth. A review of the center's facility operating procedures regarding the BMS confirmed compliance with the components outlined in the center's policies and procedures. A review of the master control logbook validated at the end of the day and prior to lights-out, entries into the module logbooks reflected youth were receiving daily points to progress within the BMS. An interview with the superintendent indicated the center utilizes the state standardized BMS. Seven youth were interviewed to rate the effectiveness of the center's BMS. Six youth rated the system as being fair, and one youth rated it as very good. Seven staff were interviewed and believe the BMS is effective. Seven staff were interviewed, and each stated staff speak to youth to discuss consequences being imposed, youth are allowed to explain their behavior, and staff speak to youth regarding alternative acceptable behavior. Seven staff were interviewed and stated only points and levels can be taken as a consequence. Each of the seven interviewed staff stated supervisors provide feedback on their implementation of the BMS monthly, weekly and as needed.

2.16 Unauthorized Use of Punishment (Critical)	Satisfactory Compliance

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

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

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

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

The center has a written policy and procedures in place to address the unauthorized use of punishment in the behavior management system (BMS) which restricts certain types of penalties on youth who demonstrate negative behaviors. A review of the center's internal incidents, the Department's Central Communications Center (CCC) reports, and the center's logbooks for the past six months confirmed there were no instances of unauthorized use of punishment. Seven youth were interviewed and indicated they are not allowed to punish other youth, the center does not use group punishment, and have never witnessed any type of unauthorized use of punishment. Seven staff were interviewed, and stated meals, snack, sleep or school is not taken away as a consequence. Seven staff were interviewed and stated they have never seen staff encourage youth to beat up on another youth. Seven youth were interviewed and stated only points and levels are taken as a consequence for negative behavior. Seven youth were interviewed, and stated youth are not allowed to punish other youth. Seven youth were interviewed and five stated they have never been sent to their room form punishment. Two youth state they have been sent to their room for punishment. When asked they stated they were placed in confinement. None of the seven interviewed youth stated handcuffs or leg irons are used to control youth.

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 related to youth grievances to ensure each youth has the right to file a grievance and is treated fairly, respectfully, without discrimination, and their rights are protected. Each youth has the right to grieve the actions of center staff and conditions and circumstances in the center related to the violation or denial of the basic rights. Youth are explained the grievance process during orientation. A review of the center's grievance

process verified it is in accordance with the Florida Administrative Code requirements. A review of grievance documentation, along with an informal interview with the facility superintendent indicated the center had no grievances filed since the last annual compliance review. Observation of the center revealed grievance forms were posted and accessible to the youth in each living module. An interview with the superintendent indicated they were able to explain the grievance process. Seven youth were interviewed on how they rate the grievance process. One youth stated good and six have never filed a grievance. Seven staff were interviewed and was able to explain the grievance process.

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

The center has a written policy and procedures in place to ensure trauma informed practices are placed into current operations to deliver services and to provide care to all youth in custody. The center allows staff to incorporate trauma-informed practice into current operations to deliver services and provide care to youth in custody and recognize the high prevalence of trauma in youth's history. An interview with the superintendent reflected the center's implementation of trauma-informed practices to address youth with a softer approach through yoga/meditation, art, religious services, intensive mental health transitional therapy, incentive parties, and additional family visitations. Observations during center tour confirmed a designated soft room and encouraging murals painting on the walls offers an environment to comfort youth who have experienced traumatic events. A random review of seven staff training records confirmed staff have received trauma informed care training.

Standard 3: Mental Health and Substance Abuse Services

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

The center maintains a written policy and procedures ensuring there is a single licensed mental health professional designated as the designated mental health clinician authority (DMHCA) who is responsible for the coordination and implementation of mental health and substance abuse services. The Department maintains a contract with Maxim Healthcare Services, Inc., who sub-contracts with Camelot Community Care to provide mental health and substance abuse services to all applicable youth in the center. Camelot Community Care provides a licensed clinical social worker (LCSW) to serve as the center's DMHCA and holds a clear and active license in the State of Florida with an expiration date of March 31, 2021. The DMHCA is full-time and scheduled to be on-site forty hours each week, Monday through Friday. A review of sign-in sheets confirmed the DMHCA was on-site as required. The DMHCA is also available seven days a week, twenty-four hours a day, by way of telephone for consultation. A review of the Camelot Community Care job description found the DMHCA is responsible for oversight of all clinical and administrative operations ensuring clinical quality and integrity of the therapeutic program. In addition, the DMHCA is responsible for participating in or providing assistance in therapeutic interventions, court hearing, as well as school and community meetings. An interview with the DMHCA confirmed they are responsible and accountable for ensuring the mental health and substance abuse services are provided as it relates to Florida Administrative Code 63N. The DMHCA supervises one licensed mental health counselor (LMHC), one registered mental health counselor intern, and two non-licensed master's-level therapists. Reviewed documentation and observations supported the DMHCA meets with the psychiatrist and nursing staff weekly for mini-treatment team meetings.

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

The center maintains a written policy and procedures ensuring services are provided by individuals with appropriate qualifications. The designated mental health clinician authority (DMHCA) ensures the center's clinical staff are working under direct supervision and are providing qualified services based on education, training, and experience. The center's contract with Maxim Healthcare Services, Inc. who subcontracts with Camelot Community Care, Inc., provides for a regional mental health and substance abuse clinical director for the south region, one full-time DMHCA, two licensed mental health counselors (LMHC), and a psychiatrist contracted for five hours each week. The psychiatrist is a medical doctor (MD) and is also subcontracted with Camelot Community Care, Inc. Reviewed licenses for all licensed professionals found each maintained a clear and active license to practice in the State of Florida as required by Chapter 491 of the Florida Statutes. The center's DMHCA is a LMHC in the State

of Florida with an active license due to expire on March 31, 2021 A review of the psychiatrist's license confirmed the psychiatrist is a licensed with a specialty in child and adolescent psychiatry. The psychiatrist's license is clear and active in the State of Florida with an expiration date of March 31, 2020. The psychiatrist is available by telephone twenty-four hours a day seven-days a week.

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

The center maintains a written policy and procedures ensuring metal health and substance abuse services are provided by individuals with appropriate qualifications. The clinical supervisor ensures the clinical staff working under their supervision are performing services they are qualified to provide based upon education, training, and experience. The center is licensed through the Department of Children and Families under Chapter 397 to provide substance abuse services. The center has three non-licensed master's-level mental health and substance abuse clinical staff who work under the direct supervision of the licensed clinical social worker (LCSW). The LCSW serves as the center's designated mental health clinician authority (DMHCA). The non-licensed master's-level therapists hold degrees in forensic psychology, master's in social work (MSW), and counseling, respectively. Each non-licensed clinician is on-site approximately ten to fifteen hours a week. Reviewed documentation also supported all three non-licensed staff completed the required twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. The training included five Assessments of Suicide Risk (ASR) or crisis assessments conducted on-site in the presence of the DMHCA and/or license mental health counselor (LMHC). A review of direct supervision logs verified the DMHCA provided at least one-hour of weekly face-to-face supervision documented on the Department's Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log form. During the week of October 13-19, 2019, there was no weekly supervision conducted during this period for one of the master's-level clinicians working under the direct supervision of the DMHCA. Reviewed documentation supported each ASR completed by the non-licensed clinician was reviewed by the DMHCA within twenty-four hours of the referral for assessment.

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

The center maintains a written policy and procedures ensuring the mental health and substance abuse needs of youth are identified through a comprehensive screening process in which referrals are made when youth are identified with mental health and/or substance abuse needs or are identified as a possible suicide risk. The superintendent has established procedures for a

thorough review of each youth's preliminary screening conducted by the juvenile probation officers (JPO) and existing documentation of mental health or substance abuse problem needs or risk factors, administration of the Suicide Risk Screening Instrument (SRSI) upon the youth's admission, and referral to the center's mental health and substance abuse clinical staff. The policy was approved by the superintendent and the designated mental health clinician authority (DMHCA) on January 6, 2020. An interview with the superintendent indicated while the youth is in the juvenile assessment center (JAC), the JPO completes the mental health, substance abuse, and suicide risk screenings utilizing the SRSI and the Massachusetts Youth Screening Instrument - Second Version (MAYSI-2) assessment. A review of seven youth mental health and substance abuse records indicated the center's staff reviewed all prior documentation completed by the JPO when the youth was admitted to the center. The SRSI and MAYSI-2 were completed for each youth upon intake electronically in the Department's Juvenile Justice Information System (JJIS). Each of the seven SRSIs were reviewed by a mental health clinical staff member and documented their recommendations. Each of the SRSIs had completed entries which also had a summary and recommendations included in the screening results section. Four of the seven reviewed records documented a history of suicide risk and each youth was placed on Precautionary Observation (PO) and a referral for an Assessment of Suicide Risk (ASR) was submitted. Each youth remained on PO until the ASR was completed by the center's clinical staff. The results of the ASR indicated each youth was placed on standard supervision. The center's staff completed the Department's Screening for Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) assessment for each youth upon their intake admission. An interview with the superintendent confirmed the center's intake officer completes the detention officer portion of the SRSI for each youth.

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

The center maintains a written policy and procedures establishing an intake and admission screening process ensuring youth identified through preliminary screenings in the juvenile assessment center (JAC) or upon admission to the center as having mental health and substance abuse issues or needs are referred for further in-depth mental health and/or substance abuse assessment. All youth identified by screening or by staff observations or behavior after admission are referred for further in-depth mental health and substance abuse evaluation. The center utilizes the Department's Mental Health/Substance Abuse Referral Summary form. Youth identified at the JAC as in need of further assessment are referred to a community provider for a comprehensive assessment. The center maintains a contract with Maxim Health Services, Inc., who sub-contracts services with Camelot Community Care to ensure youth identified during the preliminary screening process receive an in-depth mental health and/or substance abuse assessment shortly after intake. A review of seven youth mental health and substance abuse records reflected four youth were screened and a referral was made to Camelot Community Care for each to receive a comprehensive mental health and substance abuse evaluation based on the Massachusetts Youth Screening Instrument - Second Version (MAYSI-2) assessment and/or Suicide Risk Screening Instrument (SRSI). All four youth were recently admitted; therefore, the comprehensive evaluation was not completed at the time of the annual compliance review week. A review of the applicable youth mental health and substance records supported each youth received a completed evaluation documented on the

Substance Abuse and Mental Health Assessment (SAMHA) form. The assigned juvenile probation officer (JPO) is responsible for ensuring pre-disposition comprehensive evaluations for detained youth are forwarded to the detention center in a timely manner. Reviewed documented practice did validate the clinical staff contacted the assigned JPO by electronic correspondence (e-mail), requesting a status update on the comprehensive assessment completed by the community provider. Each reviewed SAMHA was completed in full and contained all required information including the diagnostic impression, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, summary of findings, and recommendations.

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

The center maintains a written policy and procedures ensuring mental health and substance treatment planning focuses on providing mental health treatment and/or substance abuse treatment which will reduce or alleviate the youth's symptoms of mental disorder or substance abuse impairment and enable youth to function adequately in the juvenile justice setting. Each youth determined to need mental health treatment, including treatment with psychotropic medication or substance abuse treatment, must be assigned to a mini-treatment team. Youth may request to receive mental health and/or substance abuse treatment services. A review of the contract indicated mental health clinical staff are required to be on-site seven days a week. Reviewed schedules support clinical staff are on-site as required. Seven youth mental health and substance abuse records were reviewed for mental health and substance abuse treatment services. Five youth records were applicable for receiving treatment services. Each reviewed youth record was applicable for treatment in individual therapy, supportive counseling, and life skills group. Three of the youth were applicable for treatment with psychotropic medication management. Reviewed documentation confirmed each applicable youth requiring treatment was assigned to a mini-treatment team consisting of mental health, medical, education, direct care staff, and administrative staff. The designated mental health clinician authority (DMHCA) maintained documentation of weekly treatment team meetings. Each applicable record had a valid Authority for Evaluation and Treatment (AET) form and proper consent for treatment. Treatment notes were documented on the Department's Counseling/Therapy Progress Note form and in the Mental Health Chronological Notes. Reviewed sign-in sheets confirmed mental health group therapy is limited to ten or fewer youth and group therapy is limited to fifteen or fewer youth with substance abuse diagnoses for substance abuse treatment groups. Five youth were identified to be in need substance abuse treatment and education while each signed the Department's Consent for Substance Abuse Treatment and Youth Consent for Release of Substance Abuse Treatment Records. Groups are conducted in a multi-purpose room or the dining hall based on the group size. Mini-treatment teams are conducted weekly for youth receiving services. Observations made during the annual compliance review week found the mini-treatment team was composed of the DMHCA, the psychiatrist, medical staff, direct care staff, and the youth. Seven youth were interviewed and two rated the mental health and

substance abuse services provided as very good and one indicated fair. The remaining four youth indicated they were not receiving mental health and/or substance abuse services while in the center.

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

The center has a written policy and procedures ensuring all youth who receive mental health and/or substance abuse treatment while in the center shall have a discharge summary completed documenting the focus and course of the youth's treatment recommendations for mental health and/or substance services upon the youth's release. The center ensures all youth who receive mental health and/or substance abuse treatment shall have an initial treatment plan and/or individualized treatment plan, as well as a discharge summary. Seven reviewed youth mental health and substance abuse records found four youth were applicable for receiving treatment. Each applicable youth requiring mental health and/or substance abuse treatment due to observations, youth admission information, or indications on their initial assessments were referred for services, utilizing the Department's Mental Health and Substance Abuse Referral Summary form. All four youth had an Initial Treatment Plan developed within seven days of initiation of treatment. Each plan contained the reason for referral for treatment, initial Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, initial treatment methods and goals, and psychiatric services. Three youth were receiving pharmacological intervention. Each was signed by the youth and the mini-treatment team members. Reviewed documentation and an interview with the designated mental health clinician authority (DMHCA) confirmed each youth received services as identified on their initial treatment plan and/or individual treatment plan. None of the youth were applicable for modifications to their developed plan. An interview with the DMHCA confirmed the center's practice is if they are aware a youth will remain at the center for an extended period beyond thirty days due to a court order, outstanding charges, or a youth being committed pending placement, they will initially create an individualized treatment plan instead of the initial treatment plan. Reviewed progress notes documented in the Office of Health Services Electronic Medical Records validated each youth received treatment services, as stipulated in their treatment plan. Three applicable closed youth records were reviewed and supported each youth received mental health and/or substance abuse treatment while in the center and a Mental Health and Substance Abuse Discharge Summary was completed upon discharge from the center. Reviewed documentation supported a copy of each summary was sent to the youth's juvenile probation officer (JPO) by way of electronic correspondence (e-mail) and a copy was provided to the youth and parent/guardian.

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

The center maintains a written policy and procedures ensuring psychiatric services are provided to youth in need as indicated by symptoms of mental disorder or substance-related disorder, or youth who are being treated with psychotropic medication prior to or subsequent to admission. The center maintains a contract with Maxim Health Services, Inc., who subcontracts psychiatric services with Camelot Community Care for the provisions of a licensed psychiatrist to provide psychiatric services for applicable youth in the center. Camelot Community Care provides a part-time psychiatrist who is contracted to provide services for five hours each week. The psychiatrist is a medical doctor (MD) with a clear and active license in the State of Florida which expires on March 31, 2022. The center does not utilize a psychiatric advanced practice registered nurse (APRN). Reviewed documentation and the medical and mental health sign-In logbook for November and December 2019 found the psychiatrist was not on-site the required five hours each week as outlined in contract amendment six, executed June 12, 2019. The center utilizes the Department's Mental Health/Substance Abuse Referral Summary form to request a psychiatric evaluation. The psychiatrist signs and dates the referral form. Psychiatric services include an initial diagnostic psychiatric interview, psychiatric evaluations, psychiatric follow-up assessments and consultations, coordination of services, crisis interventions, treatment planning, communication, and emergency procedures. A review of seven mental health and substance abuse records indicated four youth were applicable for receiving psychiatric services. Each applicable record contained a current Authority for Evaluation and Treatment (AET) form. All four youth were admitted with prescribed psychotropic medications and each youth received an in-depth psychiatric evaluation which included all required elements. Each evaluation was documented on the Department's Clinical Psychotropic Progress Note (CPPN) and completed within fourteen days of the youth's admission. All reviewed mental health and substance abuse documentation was completed utilizing the Department's required forms. The psychiatrist indicated there have been no applicable youth requiring a newly prescribed psychotropic medication or had any changes to the existing psychotropic medication while in the center since the last annual compliance review. None of four youth required the monitoring of Tardive Dyskinesia.

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

The center maintains a written policy and procedures ensuring youth with elevated risk of suicide are safely screening, referred, monitored, and protected in the least restrictive means possible. The plan outlines the center's procedures addressing the use of suicide precautions. suicide prevention training, and the process by which any youth identified as having suicide risk factors at any time must be placed on suicide precautions and receive an Assessment of Suicide Risk (ASR). The suicide prevention plan was approved and signed by the superintendent and the designated mental health clinician authority (DMHCA) on January 6, 2020. The plan includes the identification and assessment of youth at risk of suicide utilizing the Department's ASR and Follow-Up ASR. The plan identifies the levels of supervision, referral

process, communication, notification, and documentation requirements. In the event of a life-threatening suicide attempt, staff are to call 9-1-1 immediately. Decisions to use extra precautions are determined on a case-by-case basis based upon the individualized risk factors and needs of each youth. Clinical staff assist in training detention officers throughout the fiscal year on suicide prevention, including verbal and behavioral cues indicating a suicide risk. The plan outlined emergency contact telephone numbers to include the superintendent, on-call administrator, DMHCA, Broward Sheriff's Office (BSO), psychiatrist, designated health authority (DHA), emergency room, crisis stabilization unit, and poison control. The plan is located in the superintendent's office, medical clinic, and DMHCA's office. A review of seven random staff training records validated suicide prevention training was provided to each staff.

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

The center maintains a written policy and procedures addressing the use of suicide precautions, suicide prevention training, and the process by which any youth identified as having suicide risk factors at any time must be placed on suicide precautions and receive an Assessment of Suicide Risk (ASR). Youth placed on suicide precautions are maintained on one-to-one or constant supervision. A review of five youth mental health and substance abuse records validated each youth is screened upon admission for suicide risk factors. Each youth is screened utilizing the Department's Suicide Risk Screening Instrument (SRSI) and Massachusetts Youth Screening Instrument – Second Version (MAYSI-2). When further assessment is indicated by the SRSI or MAYSI-2 suicide ideation subscale, as well as any information obtained during the admission process which may suggest the youth is a possible suicide risk, the youth is placed on suicide precautions and constant supervision until the ASR is completed by the licensed mental health clinician (LMHC). All three of the non-licensed master's-level clinicians' training records were reviewed and supported the completion of the required twenty hours of training to complete an ASR, which included five ASRs completed under the direct supervision and within the physical presence of the licensed mental health clinical staff member. A review of seven youth mental health and substance abuse records found four youth identified with an elevated risk of suicide identified during the admission screening process. Each of the four youth was placed on Precautionary Observation (PO) until the ASR was completed. Each of the ASRs were completed within twenty-four hours by a master's-level non-licensed clinical staff and reviewed by the designated mental health clinician authority (DMHCA). A review of the completed ASRs found each youth placed on PO was stepped down to standard supervision. An alert was placed in the Department's Juvenile Justice Information System (JJIS) and a referral was made to the clinical staff utilizing the Department's Mental Health/Substance Referral Summary form. A review of four applicable youth mental health and substance abuse records supported the mental health staff conducted a Follow-Up ASR prior to the removal of PO and stepped down to Close Supervision. The conference with

the superintendent and the DMHCA was documented and the discontinuation of Close Supervision was documented in accordance with the center's approved Suicide Prevention Plan. Reviewed facility logbook entries supported administrative and supervisory staff provided instructions related to the applicable youth's elevated suicide risk levels and precautions. The center utilizes Secure Observation for potentially suicidal youth. An interview with the superintendent indicated when a youth is on PO and actively trying to harm themselves, the youth will be placed on Secure Observation. All items are removed from the youth and a juvenile justice detention officer is assigned to the youth to maintain constant visual observation while the youth is in a secure room. The supervisor then completes the necessary documentation in the Department's Juvenile Justice Information System (JJIS), such as the health checklist, producing a Secure Observation Log, and a JJIS Incident Report. Administration is notified of the incident. A review of three youth requiring Secure Observation was conducted. All three Secure Observations documentation supported each placement was authorized by the superintendent and the DMHCA. There was documentation of a mental health referral for each of the three youth placed on Secure Observation. The secure room was designated in writing and the Department's Health Status Checklist was completed as required. The center staff completed the Suicide Precaution Observation Logs in their entirety and in real time. All three youth were removed from Secure Observation within twenty-four hours of placement. A review of JJIS indicated appropriate alerts were entered and removed, as required, for each youth placed on suicide precautions. A review of the facility logbooks validated each youth placed on precautions had documentation regarding the beginning and ending times of their precaution periods. Seven interviewed staff indicated in the event a youth expressed suicidal thoughts, staff indicated they would notify the mental health authority, put in a mental health referral, and notify the supervisor. Seven interviewed staff indicated the suicide response kit is located in a sub-control unit, five responded in master control, while five also stated in medical.

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

The center maintains a written policy and procedures outlining staff supervision of youth placed on suicide precautions, one-to-one supervision, or when constant supervision must be maintained, including documenting the youth's behavior on the Department's Suicide Precautions Observation Log. Seven reviewed youth mental health records found four youth were placed on Precautionary Observation (PO). A review of the four applicable youth records found a Suicide Precautions Observation Log was maintained for the duration each youth was on precautions and each was reviewed and signed daily by the shift supervisor, as well as the mental health clinician. Reviewed documentation reflected staff observations did not exceed the required intervals and were documented in real time with one exception. On January 2, 2020, the A-Shift PO Observation Log reflected staff did not complete the form for this shift in real time. The documentation reflected staff signatures at precisely thirty-minute interval beginning at 8:00 a.m. up to and including 3:00 p.m. On January 2, 2020, A-Shift noticed a discrepancy in the recording of the actual times. Time began at 12:45 p.m. to 1:14 p.m., 1:43 p.m. back to 1:13 p.m. and 1:45 p.m. until accurate time resumed. Safe housing areas were clearly documented on each reviewed log. The licensed mental health clinical staff member conferred with the superintendent prior to revising the supervision level, which was recorded on the ASR in the date/time sections. There was one youth detained who was placed on PO at the time of the

annual compliance review. An interview with the youth indicated when he was on suicide precautions, staff watched the youth all of the time. An interview with seven staff indicated they received training in suicide prevention.

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

The center maintains a written suicide prevention plan outlining the training requirements for all staff who work with youth. Camelot Community Care's clinical staff assist in training juvenile justice detention officers throughout the fiscal year on suicide prevention, including verbal and behavioral cues indicating a suicide risk. The plan outlines all staff who work with youth must receive six hours of annual training on suicide prevention and implementation of suicide precautions. Suicide prevention trainings are completed and documented in the Department's Learning Management System (SkillPro). The plan reflects all staff with direct contact with youth, on a day-to-day basis, must participate in at least one quarterly mock suicide drill semi-annually. The mock drills are designed to practice responses to a suicide attempt or incident of serious self-injury. A review of seven staff training records validated each staff completed at least two hours of suicide prevention training in SkillPro. All staff further completed the required four hours of instructor-led suicide prevention training. Reviewed documentation of mock suicide drills completed since the last annual compliance review reflected the center completed drills on Alpha, Bravo, and Charlie shifts monthly from January through December 2019. Reviewed documentation supported the center ensured each staff participated in at least one mock suicide drill at least semi-annually. Most staff participated in multiple drills. Staff who are not present during a drill have the opportunity during the monthly all-staff meeting to review each drill scenario, procedures, and critique in an effort to understand the process and receive the necessary training to respond to an incident of a suicide attempt or incident of serious self-inflicted injury. The provision of life saving measures such as cardiopulmonary resuscitation (CPR) was demonstrated monthly for the medical drills and the use of a suicide response kit was documented for each suicide drill.

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

The center maintains a written mental health Crisis Intervention Plan ensuring the center will respond to youth in crisis in the least restrictive means possible to protect the safety of the youth and others while maintaining control and safety of the center. The plan was reviewed and approved by the designated mental health clinician authority (DMHCA) and superintendent on October 7, 2019. The plan details crisis intervention procedures including a notification and alert system, means of referral including youth self-referral, communication, supervision, documentation, and review. The center's procedures outline conducting a crisis assessment to evaluate a youth presenting with acute emotional or psychological distress which is extreme and does not respond to ordinary interventions conducted by a mental health clinician to determine the severity of the youth's distressing symptoms, level of risk to self or others, and

recommendations for treatment and follow-up care. The Crisis Intervention Plan is placed in the superintendent's office, medical clinic, DMHCA's office, on the center's designated computer drive, and SharePoint.

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

The center maintains a written Emergency Care Plan outlining mental health and substance abuse emergency procedures and ensuring youth who are believed to be an imminent danger to themselves or others because of mental illness or substance abuse impairment receive emergency mental health or substance abuse services. The plan was last reviewed and approved by the designated mental health clinician authority (DMHCA) and the superintendent on January 6, 2020. The center's plan reflects the superintendent, assistant superintendent, and DMHCA are to review all critical incidents and discuss the circumstances surrounding the incident, center procedures relevant to the incident, and recommendations. The center's plan includes procedures for immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services (Baker Act or Marchman Act), documentation, and training. The center has identified Fort Lauderdale Behavioral Health as their crisis stabilization unit for Baker and/or Marchman Acts emergency substance abuse assessment and treatment. A review of seven staff training records supported each was trained on the center's Emergency Care Plan.

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

The center maintains a written mental health crisis intervention plan and services. The plan details crisis intervention procedures including a notification and alert system, means of referral, including youth self-referral, communication, supervision, documentation, and review. The center's plan was reviewed and approved by the designated mental health clinician authority (DMHCA) and superintendent on January 6, 2020. There were two youth applicable for crisis assessments covering the past six months. The assessments were observed to have been completed on the required Department form by a licensed mental health professional within the required twenty-four hours, outlining the justification, mental status, clinical impressions, supervision recommendations, coupled with an alert being entered into the Department's Juvenile Justice Information Center (JJIS). One youth had their parent/guardian notification

while the second was over eighteen years of age and did not require parent/guardian notification.

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

The center maintains a written policy and procedures for youth determined to be an imminent danger to themselves or others due to mental illness or substance abuse impairment. The program has had three youth requiring a Baker Act since the last annual compliance review. Reviewed documentation supported the youth were placed on suicide precautions upon re-admission from the Baker Act. A mental status examination (MSE) was conducted and an Assessment of Suicide Risk (ASR) was completed, as required. The completed ASR reflected the youth were maintained on Precautionary Observation (PO). The clinical staff completed a Follow-Up ASR and maintained the youth on PO pending reassessment. Suicide risk alerts were updated and discontinued, as required in the Department's Juvenile Justice Information System (JJIS). The center maintains five suicide response kits each containing a knife-for-life, wire cutters, and needle nose pliers. Observations found the kits were located in the kitchen area, and four in each of the youth modular units. The center utilizes Fort Lauderdale Behavioral Health for Baker Act crisis stabilization and Marchman Act emergency substance abuse assessment and treatment. The center had no youth applicable for Marchman Acts since the last annual compliance review.

Standard 4: Health Services

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

The center has a written policy and procedures to ensure clinical services are provided to youth who are in the center. The center has a contract agreement with Maxim Healthcare Services, Inc. A licensed physician, who specializes in pediatrics, serves as the designated health authority (DHA) and holds as unrestricted, clear and active license which meets all requirements for independent and unsupervised practice in Florida, which expires on January 31, 2021. There is an advanced practice registered nurse (APRN) who holds an unrestricted, clear and active licensed to practice in the State of Florida. The center also has one registered nurse (RN) and two licensed practical nurses (LPN) whom also hold unrestricted license to practice in the State of Florida. The APRN has a Collaborative Practice Protocol in place which identifies the licensed physician as the DHA, filed with the Department of Health and approved by the DHA. The DHA is on-site one day a week and at no time more than nine days pass between an on-site visit. A review of the medical sign-in and out logs for the past six months verified this practice. When the DHA is on vacation or on an unscheduled absence**,** a substitute licensed physician is designated by the DHA to provide clinical services in their absence. A review verified the substitute physician holds an unrestricted clear and active license in the State of Florida, which expires on January 31, 2022, and has a specialty in pediatrics. The DHA is available twenty-four hours a day, seven days a week to communicate with center staff regarding youth medical needs, acute medical concerns, emergency care and coordination of off-site care as needed. An interview with the DHA indicated they are on-site once a week and on call twenty-four-hours a day, seven days a week.

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

The center has a written policy and procedures to address health-related procedures and protocols. A review of the center's facility operating procedure (FOP) for all health-related treatment and protocols utilized found they were signed and dated by the designated health authority (DHA) and superintendent. There was one new medical staff hired since the last annual compliance review. A review of the policy and procedures cover page found the newly hired medical staff received comprehensive clinical orientation to the Department healthcare policies and procedures during their pre-service training and each licensed nurse was re-trained on January 3, 2020.

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

The center has a written policy and procedures addressing authorization of treatment for youth. A review of seven youth Individual Healthcare Records found six records contained an Authority

for Evaluation and Treatment form (AET). One youth is eighteen years old and did not require parent/guardian consent. Each reviewed AET contained the parent/guardian signatures of which three were stamped “COPY” and three were original. An additional youth healthcare record was reviewed and found the youth to be in the Department of Children and Families (DCF) custody. Review documentation found a court ordered AET. In accordance with practice, non-emergent medical services were provided to youth after receipt of the signed and dated AET.

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

The center has a written policy and procedures to ensure the center notifies the parent/guardian of significant changes of the youth condition and to obtain consent when new or changes to medication and treatment are prescribed. A review of seven youth Individual Healthcare Records found four applicable for parental notification. Each reviewed record contained documentation indicating the parents/guardians were notified. Three of the Individual Healthcare Records were applicable for new medication. Documentation indicated the parents/guardians were notified by way of telephone and written notice. One applicable record was reviewed for off-site care. Review of the record validated written notification was obtained and subsequently in writing. There was no parental notification required for immunizations or new psychotropic medications.

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 to ensure a Healthcare Admission Screening and Rescreening form is completed on each youth in the center. Seven youth Individual Healthcare Records were reviewed. Each reviewed record contained a Medical and Mental Health Admission Screening form completed by a juvenile justice detention officer (JJDO) on the date of admission and each screening was reviewed by the licensed practical nurse (LPN) within twenty-four hours of the screening. None of the reviewed youth had a change in physical custody since their arrival. One applicable youth who is sexually active and missed her mensural cycle received a qualitative urine pregnancy screening test, with her approval, upon arrival. The information was entered into the Department’s Juvenile Justice Information System (JJIS) Admission Wizard. An interview with the superintendent indicated the doctor, nurse, and staff complete the healthcare admission screening form.

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

The center has a written policy and procedures to ensure each youth in the center receives an orientation to healthcare services and health education. A review of seven Individual Healthcare Records indicated a general healthcare orientation was completed and documented on the Department’s Health Education form within twenty-four-hours of the youth admission. Each youth received the required orientation topics to include access to medical care, sick call use

and access, what constitutes an emergency and how to notify staff, medication process, right to refuse care and how it is been documented, what to do in case of sexual assault or attempt sexual assault, non-disciplinary role of healthcare staff, and a review of a list of healthcare contacts. An informal interview with two youth confirmed these practices.

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

The center has a written policy and procedures to ensure the designated health authority (DHA) is notified within twelve hours of the admission of any youth with emergent need, chronic medical condition, and youths taking psychotropic medications. Notification is documented by a licensed staff during review of the intake progress note and maintained in the youths' Individual Healthcare Record (IHCR). A review of seven youth IHCRs found four were applicable. One youth was in need of emergent care, two youth had a chronic condition, and one youth was taking psychotropic medications. Each youth was referred to the advanced practice registered nurse (APRN). Each applicable record indicated the DHA was notified within twelve hours and documented in the youth's IHCR.

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

The center has a written policy and procedures to ensure each youth in the center has a standard Department Health-Related History (HRH) form completed. A review of seven Individual Healthcare Records validated four contained a new HRH form and three contained an updated HRH form. Each form was completed on the most recent HRH form by a licensed nurse within seven days of the youth's admission. Each HRH was reviewed by the advanced practice registered nurse (APRN) by checking the box on the Comprehensive Physical Assessment (CPA) form. Each reviewed HRH was completed prior to the CPA.

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

The center has a written policy and procedures to ensure each youth in the center has a completed Comprehensive Physical Assessment (CPA). A review of seven youth Individual Healthcare Records verified each contained a CPA completed within seven days of admission. Each CPA was reviewed and initialed by the advanced practice registered nurse (APRN). Three of the seven reviewed records documented a medical grade of two to five and were placed on the center's alert system; however, there was one pregnant youth where her last known menstrual period was not documented on the CPA. None of the seven reviewed records documented the youth refused any part of the exam and the Department's Problem List was updated as required. Each of the seven records documented a tuberculosis (TB) skin test was documented on the CPA. None of the reviewed youth required further evaluation prior to them entering the general population.

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

The center has a written policy and procedures to ensure each youth in the center is evaluated and treated for sexually transmitted infections (STI). The center provides human immunodeficiency virus (HIV) counseling by two certified counselors for youth who consent to HIV testing. Seven Individual Healthcare Records (IHCR) were reviewed and documented the youth admitted to being sexually active. Five youth were screened for an STI and required further evaluation. Two youth refused testing in writing. One of the seven youth receive a gynecological evaluation. None of the reviewed youth were out of the Department's custody for more the thirty-days. None of the applicable youth required screening results to be documented on the youth's Infectious and Communicable Disease form located in the IHCR. Each of the seven reviewed youth were offered counseling, testing, and treatment for HIV. Five youth consented to HIV testing and two youth refused in writing to have HIV testing**.** A review of the five applicable IHCRs verified written consent was obtained by the center, documented pre-test and post-test counseling, and conducted by certified HIV counselors. A review of the counselors' credentials verified they were trained to provide the service. A review of the five applicable records validated the HIV results were placed in a sealed envelope stamped "Confidential" and filed in the youth's IHCR. Seven youth were interviewed, and each stated they were offered HIV testing at the center.

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 procedures to ensure all youth can make Sick Call Requests at any time and have their complaints treated appropriately. Sick call is documented electronically and communicated to medical staff. A review of seven youth Individual Healthcare Records found four youth were applicable for placing a Sick Call Request. Each of the four youth Sick Call Requests were filled out completely and the youth signature was documented on the Sick Call Log. Observation of sick call during the annual compliance review week indicated the youth's privacy was maintained during the process. None of the sick calls required an off-site referral. There were no instances in which a youth presented with a similar sick complaints three or more times in a two-week period. Seven youth were interviewed regarding the time period they were seen once they made a request. Each interviewed youth reported they were seen within one day of requesting a sick call. Seven staff were interviewed regarding who conducts sick call. Each of the seven staff stated the nurse. In addition, one staff stated the doctor and two staff stated supervisors when medical staff are not on-site.

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 for the provisions of episodic care and first aid. The center utilizes an Episodic Care Log to document episodic care and first aid treatment. The log documents the date and time of the treatment, nature of the complaint, person rendering aid, treatment, and if an off-site care is needed. Three applicable youth Individual Healthcare Records (IHCR) were reviewed and identified the youth in need of episodic care or first aid. Each reviewed record contained a process note identifying first aid or emergency care, the date and time of care, nature of the complaint, findings regarding care, and treatment rendered. Each of the three applicable youth had an Off-Site Care Referral and follow-up plans for future care. In each of the four records, none were required to be placed on the center's alert list and one required parental notification. Each of the three reviewed progress notes identified the staff rendering aid, signature of the staff, the center's name, and was entered on the Episodic Care Log. One of the three reviewed youth received episodic care from a non-healthcare professional and a follow-up evaluation was conducted by the licensed healthcare professional. The center has a total of twenty-one first aid kits strategically located in areas frequented by youth. Observation of four first aid kits verified each kit is stocked with approved supplies, none of the contents were expired, are monitored monthly by the nursing staff, and are replenished as needed. The center has two automated external defibrillators (AED) located in the medical clinic and master control with automated instructions. The nurse checks the AED weekly to ensure the battery and pads are operable. A review of the AED Check Log for the past six months verified this practice and indicated the expiration dates for the batteries and pads for both AEDs expire on March 2021. During the annual compliance review, observations were conducted while the nurse completed a self-test of both AEDs. The center conducts mock emergency drills at least quarterly on each shift and emergency drills including cardiopulmonary resuscitation and AED are conducted once a year on each shift. Emergency and cellular telephone numbers are located in master control and accessible to all staff. A review of emergency drills for the past six months verified the center is conducting drills as required. Seven reviewed staff training records verified staff received CPR/AED/first aid training. A review of the licensed healthcare records verified each healthcare staff maintains a current certification in CPR/AED. Seven staff were interviewed, and each stated they are able to call 9-1-1 if they feel it is necessary.

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

The center has a written policy and procedures to provide for timely referrals and coordination of medical services to ensure youth have timely access to off-site care. A review of seven youth Individual Healthcare Records found none of where applicable. Three additional Individual Healthcare Records were reviewed for off-site emergency care. Each record found a Summary of Off-Site Care form and discharge instructions. Each youth record documented the designated health authority (DHA) or the advanced practice registered nurse (APRN) reviewed and signed all off-site care findings instructions and information. None of the youth required further off-site follow-up or appointments.

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

The center has a written policy and procedures to ensure youth with chronic conditions receive regular scheduled evaluations and follow-up care. A review of seven youth Individual Healthcare Records indicated four youth had a medical grade between two and five and identified with a chronic condition. None of the four applicable youth were diagnosed with a communicable disease, considered obese, or taking medication for tuberculosis. In each of the four records, periodic evaluations were conducted prior to renewing of prescription medication. Three of the four youth take prescribed medication. One youth was pregnant and is undergoing treatment for physical health condition and is evaluated as required by the primary doctor. The three applicable youth who were prescribed medication received on-site care which was documented in the healthcare chronological progress notes with clearly written treatment orders; however, did not require periodic evaluations due to not being in the center more than three months. Periodic evaluations for the pregnant youth were not conducted due to being in the center less than two weeks. There were no indications of missed or lapsed periodic evaluations.

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 for medication management. All medications were from a licensed pharmacy with a current patient-specific label intact with the original medication. Medications have a current valid order and are given pursuant to the practitioner order. Verification of medication is conducted by the nurse and notification to the designated health authority (DHA) or psychiatrist to resume specific medications prescribed prior to admission. Documentation of youth prescription medications occur in the chronological progress notes in the Electronic Medication Record. Medications are administered by healthcare professionals for youth on prescribed medications while in the care of the detention center. There were no youth in restricted housing during the annual compliance review week. Supervisors are trained in medication administration and administer medication in the absence of the healthcare professionals. A review of three supervisor training records verified they were trained in medication management. Seven youth Individual Healthcare Records were reviewed and four were applicable. Each applicable record contained documentation their medication was verified by a licensed pharmacist or the youth's primary physician. There was no youth taking over-the-counter medication not listed in the Authorization for Evaluation and Treatment (AET). There was no undocumented explanation for lapse or errors in administered medication in each of the four applicable records. An interview with the nurse verified there were no standing orders of psychotropic medication, no emergency treatment orders for psychotropic medication, and no pro re nata (PRN) orders for psychotropic medication. A review of four applicable youth records who were admitted with medication verified the medication administration was documented on the standard Department Medication Administration Record (MAR) which documented the youth's name, Department identification (DJJID) number, date of birth, allergies, precautions, medical grade, medical alerts, youth current picture, start and stop dates, and monitored side effects. There was one youth who did not have their medical and mental health alerts listed on the MAR. Further review of the MAR indicated the youth received the medication as ordered, and staff and youth initialed the MAR after the administration of the medication. Two of the four

youth refused medication and a “R” was documented on the MAR where the youth would have initialed and a refusal form was signed. One of the four youth require parenteral medication which was administered by the nurse. Two youth were on psychotropic medication prior to admission. In each instance, the designated health authority (DHA), psychiatrist, and the designated mental health clinician authority (DMHCA) were notified upon admission, and the medication was continued until a diagnostic psychiatric interview was conducted within fourteen days. There was one applicable youth who remained in the center over thirty days and received a review of medication monitoring by the psychiatrist. An observation of medication management indicated the Six Rights of Medication Administration is verified for each youth, the nurse verified any allergies to the medication, the nurse observed the youth swallowed the medication, and the nurse and youth initialed the MAR. None of the medication was pre-poured from the original packaging or placed in another container. Observation of the medication storage indicated all medications are separated by type, designated youth specific sections, stored in a locked area designated for storage, and inaccessible to youth. There was no controlled medication on-site during the annual compliance review. The center maintains a list of staff who are trained to have access to the clinic and medications. Medication requiring refrigeration is stored in a secured refrigerator used for medication only. Medication which cannot be returned to the pharmacist for a credit or medication requiring disposal is documented on the Medication Disposal form and disposed of using RX Destroyer. Syringes and sharps are secured in a locked cabinet. The center maintains a contact with Seri Cycle who disposes all biohazard material once a month. Seven staff were interviewed and five stated they do not administer medication to youth. Only supervisors, nursing staff, and the doctor administer medications. Two supervisors were interviewed and indicated they are trained in administering medication in the absence of medical staff.

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 procedure to ensure medical equipment and medications are secured and inventoried. The center maintains a perpetual daily inventory of medications to include prescribed and over-the-counter (OTC) medications. Documentation of each individual dosage of medication administered to youth is maintained on the Medication Administration Record (MAR) to demonstrate the distribution of medications. There is a process for the destruction and disposal or returned of expired or discontinued medication. Medications are sent back for credit and the center utilized a RX Destroyer when medications are destroyed on-site. There were no controlled medications being stored at the time of the annual compliance review. Medical equipment to include sharps is secured and inventoried using a perpetual inventory count subtracting from the count as a sharp is used. Observation of the clinic indicated it is secured with limited access to the healthcare professional, supervisors, superintendent, and assistant superintendent. The healthcare professionals maintain a locked medication cart which contains prescribed and OTC medications, as well as sharps. Controlled mediations are maintained within the locked medical cart within a separate locked storage box. A random review of three prescribed medications, and three OTC medications verified the counts to be accurate. A review of the daily inventory of prescribed and OTC medications matched the random count. The center has an inventory of all sharps to include items such as sutures, butterfly, scissors, needles, and syringes. A review of the perpetual inventory for the past six months verified the inventory count was accurate.

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

The center has a written policy and procedures to address infectious and communicable diseases. The Exposure Control Plan is written in accordance with Occupational Safety and Health Administration (OSHA), Florida Administrative Code, federal regulations, and the Center for Disease Control and Prevention (CDC) guidelines. A review of seven youth Individual Healthcare Records indicated each youth received infection control training on the day of admission. The comprehensive education plan includes pre-service and in-service for the staff to include but not limited to common infectious disease, bacterial meningitis, tuberculosis, lice and scabies, food borne illness, Hepatitis A, B, C, and HIV infectious disease cause by blood-borne pathogens. The Exposure Control Plan addresses risk assessment to include a list of job specifications in which employees have the potential for exposure and tasks or procedure causing staff to have occupational exposure. Methods of compliance include infection control practices and engineering workplace controls including handwashing facilities, proper disposal of needles and sharp, procedures for handling contaminated laundry and procedures for post-exposure evaluation and follow up. An interview with nursing staff confirmed staff have access to protective equipment. Hepatitis B immunization is made available to staff by referral. There were no incidents involving any contagious diseases requiring the quarantine or hospitalization of at least ten percent of the total population of youth and staff since the last annual compliance review.

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

The center has a written policy and procedures for the care of pregnant youth to include procedures for medical issues, nutrition, education, and medication. During the time of the annual compliance review week, there was one applicable pregnant youth detained at the center. A review of the youth's Individual Healthcare Record indicated the youth was receiving prenatal care as recommended by their primary doctor, including off-site medical prenatal, obstetrical, or gynecological appointments. Healthcare chronological notes indicated daily monitoring of danger signs of pregnancy complications. A review of the healthcare education records indicated the youth received pre-natal education to include alcohol and drug use, smoking, nutrition, sexually transmitted infections, contraception, prenatal care, birthing process, postpartum care, basic baby care, child/infant development, and parenting skills. While at the center, nursing staff monitored the youth for weight and nutritional status. The youth also receives nutritious meals in quantities appropriate for a pregnant youth. A pregnancy alert was entered into the Department's Juvenile Justice Information System (JJIS). A review of seven staff training records verified each staff received Girl's Health training specific to working with pregnant youth. One applicable pregnant youth was interviewed and stated they received prenatal care.

Standard 5: Safety and Security

5.01 Active Supervision of Youth (Critical)	Satisfactory Compliance

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

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

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

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

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

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

The center maintains a written policy and procedures ensuring youth are actively supervised by staff. Staff communicate by way of two-way radio with master control any issues pertaining to the center and youth supervision. The center utilizes a roster generated in the Department's Juvenile Justice Information System (JJIS) to track the daily census of the youth. During the annual compliance review week, daily observations of youth were conducted throughout the center which confirmed the active supervision of youth by detention staff. Staff were observed supervising youth during school, transport, line movements, lunch, outside recreation, and in the modules. Each observation found there were always at least two or more detention staff with each group of youth. Each observation indicated staff were alert, properly positioned in a manner providing them full view of youth in the area. Staff were aware of how many youth were being supervised and were in sight and sound of youth. Prior to any youth movement, staff requested permission from master control. There were no inappropriate actions observed between youth and staff. Staff were observed having positive interactions with youth. A review of the master control logbooks for the past six months confirmed youth headcounts were conducted consistently at the beginning and end of each shift, after all admissions and releases, and randomly during the shift. When facility counts are conducted, no movement occurs until cleared by master control. Seven staff were interviewed, and each staff reported they believe there is enough staff at the center to provide for the safety and security of the youth and 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 a written policy and procedures ensuring ten-minute checks are conducted when youth are in their rooms for sleeping purposes and confinement. The center has a total of ninety-two operable cameras with a recording capacity of thirty days. The center utilizes the Guard One Plus which is an electronic system to document ten-minute checks. Staff utilize the electronic Guard One Plus wand by placing on the check point sensor located on the outside of each youth's room door. The data from the wand is downloaded daily to ensure no data is lost. The juvenile justice detention officer (JJDO) is responsible to visually observe the youth when conducting the ten-minutes checks by looking inside the room and observe the youth behind the closed door before the check point sensor is activated with the wand to ensure there are no issues with the youth. The superintendent was interviewed and validated this practice. Observations of youth living modules and rooms confirmed there were no obstructions over the windows and areas in which direct line of sight is needed. Observations of ten-minute room checks on four different modules, from three different shifts, and seven different days and times along with the corresponding Ten-Minute Log supported checks were being conducted every ten-minutes, or less, and in real time.

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 ensuring headcounts are conducted as required. Staff must always know the exact number and location of all youth under their supervision. At the beginning and ending of each shift, and randomly during the day, census counts are taken, called into master control, and documented in the center's master control logbook. Counts are also conducted following emergency, drills, power outages and any code called inside or outside the secure walls. Living module counts are recorded in their assigned living module logbook. During the time master control is conducting the count, no youth movement is conducted until master control confirms the counts, reconciles the count, and authorizes the center's activity to resume, if necessary. An interview with the center's superintendent was conducted which confirmed this practice. A review of the master control module logbooks for the past six months validated headcounts are documented at the beginning and end of each shift, following any emergency, inclusive of any mock or emergency drills, whenever a population change occurs, prior to any youth movements, and randomly at least once on each shift. Seven staff were interviewed regarding youth counts and each staff responded counts are conducted at the beginning and end of each shift, before and after school, and before and after each meal. Each interviewed staff reported emergency counts are conducted when a youth is believed to be missing, when visibility is hindered such as an electrical outage, and after any major disturbance. Each interviewed staff was able to explain the process to be followed if counts were not able to be reconciled.

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 ensuring logbooks are maintained at master control and in each living area in accordance with Florida Administrative Code. The center maintains separate logbooks in master control and for each living module, as well as one for visitors, and one for contracted staff. Logbooks are also maintained to document emergencies and emergency drills. Observations of each logbook confirmed they were bound together with numbered pages. The center does not utilize electronic logbooks. A review of logbooks for the last six months for each living module and master control revealed all entries were legible and written in ink, with no erasures or whiteout areas. Each entry included the date and time of the event or incident with the name of the staff and youth involved. All entries for the last six months revealed safety and security of the center, including medical, special needs, and mental health alerts were highlighted. Reviewed logbooks reflected all errors are struck through with a single line and dated and initialed by the person correcting the error. Reviewed master control logbooks included emergency situations, incidents, fire and escape drills, population counts at the beginning and end of each shift, group movements, admissions and releases, presence of law enforcement, and name of youth placed in confinement, including the time confinement began and the time confinement ended, name of youth placed on Precautionary/Secure Observation, including the time Precautionary/Secure Observation began and the time Precautionary/Secure Observation was discontinued. However, a review of the master control logbook did not consistently document times when Protective Action Response (PAR) was used and when the Department's Central Communications Center (CCC) was contacted.

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 has a written policy and procedures ensuring logbook reviews are conducted as required. The superintendent or designee reviews the logbooks on a weekly basis and documents any issues and/or discrepancies. The juvenile justice detention officer supervisor reviews the living module logbooks each shift, including the master control logbook prior to accepting a shift, to document they are aware of all current relevant situations in the center. The juvenile justice detention officer assigned to the living modules reviews the living module logbook when accepting responsibility for the living area at shift change. A review of the master control and living unit logbooks for the past six months supported these practices. The superintendent was interviewed and confirmed this practice.

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

The center maintains a written policy and procedures ensuring the inventory and control of all center keys, as well as replacing lost or damaged keys. Center keys are maintained on a tamper-resistant ring with a brass tag identifying the ring number and the number of keys on the ring. All center keys are colored coded for identification. Center keys for education, medical, and mental health staff are stored in master control in a locked key box accessible by the master control operator. Juvenile justice detention officers (JJDO) and juvenile justice detention officer supervisors (JJDOS) keys are in the supervisor's office in a locked box and is only accessible by the JJDOS and administrative staff. Emergency keys providing egress through exterior doors are stored in the module sub-control rooms in which only staff can access. All keys are inventoried in the Facility Management System (FMS). The center maintains a master key inventory which accounts for all key rings by ring number, the number of keys on each ring, to

the staff assigned to the key, and the capability of each key. Staff secure their personal keys in a locker assigned to them in the break room before entering the secure side of the center. All other staff and visitors are issued a key daily by master control to secure their personal keys in a locked box located in the lobby before entering the center. The key is returned to master control before departing the center. The JJDOS issue keys from the locked key box in the supervisor's office at the beginning of each shift during shift briefing. A review of the master control logbook and observation of distribution and collection of keys validated the issuance of keys. Education, mental health, and medical staff keys are documented on a sheet with the date and key number of the staff receiving the key and is signed by the staff the key is being issued to. Each JJDO is required to sign and enter the date and time in the key control logbook when issued their keys. Each JJDO return their keys to the JJDOS at the end of their shift, sign, date, and enter the time returning the keys in the key logbook. The JJDOS returns all keys to the secured lock box located in the supervisor office at the end of their shift. Observations conducted during the annual compliance review week confirmed this practice. A review of the master key control inventory during the annual compliance review validated the inventory report matched the actual keys in use. Observations during the annual compliance review week found staff were carrying their assigned keys on their person at all times, and youth did not have access to any keys. An informal interview with two youth was conducted. Each youth denied having access to any center keys. All center keys were accounted for during the annual compliance review. An informal interview was conducted with the center's superintendent. The superintendent reported staff are not issued permanent keys. There have been no incidents of lost keys or incidents in which staff have left the center with center keys since the last annual review. The superintendent confirmed if for some reason keys were lost in the center, the center would be locked down and a search would be conducted immediately. A report would be initiated to the Department's Central Communications Center (CCC) if the keys were not found within two hours. Seven staff were interviewed, and each responded restricted keys included access to medical records, mental health records, and case management records. Each staff reported youth do not have access to center keys. Each interviewed staff could explain the daily process for tracking keys at the center, including the usage of a Key Control Log.

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

The center has a written policy and procedures ensuring vehicles to transport youth are properly maintained, inspected annually, and in good repair. The maintenance mechanic is responsible for weekly and monthly vehicle inspections. The center has a total of nine vehicles used to transport youth. Reviewed documentation validated each vehicle had an annual safety inspection conducted by a certified automobile mechanic. Observations of the nine vehicles verified each vehicle was locked when not in use. Inspections of the nine vehicles confirmed each had the appropriate number of seat belts, seat belt cutter, a window punch, up-to-date fire extinguisher, and a first aid kit with approved and up-to-date items. The center's facility operating procedures prohibits tobacco usage in vehicles and is supported by "No Smoking" stickers posted in the driver cabin of each vehicle. Each vehicle was observed to have a binder which contained the vehicle mileage log, mechanical restraint key, gas card, vehicle policy, and vehicle registration. Each vehicle is inspected prior to transporting youth using the Department's

approved checklist and is recorded in a logbook designated for each van. Reviewed documentation supported this practice. Weekly visual vehicle inspection checks are conducted on each vehicle as required and documented on the maintenance check sheets to include water coolant, lights, oil, emergency equipment, brakes, horn, interior/exterior, and cleanliness of the vehicle. Monthly vehicle checks are also conducted on the tires, battery, windshield, wipers, windows, mirrors, and other visual damage and documented on the mandatory maintenance form. Reviewed documentation supported a pre-trip inspection is completed on each vehicle by two staff. Each vehicle is inspected prior to transporting youth using the Department's approved checklist and in a logbook designated for each van. During the annual compliance review week, an observation of the post-transport activities was conducted. Observations found the vehicle was searched by staff after the transport. Staff searched the youth after removing the youth from the van. Youth and staff were observed using their seatbelts. The transport staff were in possession of the vehicle logbook and a binder containing the vehicle log, gas credit card, and vehicle registration.

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

The center maintains a written policy and procedures ensuring tools and equipment are properly maintained, stored, and inventoried. The center's maintenance tools are maintained in a secure locked room only accessible to maintenance staff and administrators. Tools are stored on a shadow board and marked with an identification number. A perpetual tool inventory list of tools is maintained by the center to document what tools are being used by the maintenance staff including the times the tools were checked-out, the location of the tools, and times the tools were returned. An interview with the maintenance mechanic confirmed inventory is conducted monthly by maintenance staff and reviewed by the superintendent or designee. The center's kitchen tools, inclusive of knives and scissors, are securely stored in a locked box, with an inventory sheet, located in the kitchen. A perpetual inventory of kitchen tools is maintained, and counts are documented three times each day. Any maintenance or kitchen tools in need of disposal or replacement is requested by completing a tool disposal/replacement report which the maintenance or food service manager signs and gives to the superintendent for approval. Additionally, when tools are lost or if there is suspicion a youth may be in possession of a tool, the juvenile justice detention officer supervisor (JJDOS) is notified immediately, and a search is conducted. A review of the monthly inventory sheets confirmed there were no missing maintenance or kitchen tools. An informal interview with the center's superintendent confirmed there have been no missing tools in the past six months. During the annual compliance review week, an observation of interactions with service vendors and staff were completed. Observations found staff accompanied service vendors at all times, and positively identified service vendors prior to allowing vendors access to secure areas. Once the work was completed, the supervisor inspected the area prior to allowing youth access. Seven staff were interviewed regarding center's practice for lost or damaged tools. Six staff were able to explain the practice for lost or damaged tools and reported they would notify their supervisor. One staff was not aware of the practice for lost or damaged tools.

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

The center has a written policy and procedures ensuring youth do not have access to any tools, including kitchen or medical equipment. The center only allows youth to have access to mops, brooms, buckets, cleaning rags, and other common household items for general cleaning. Youth are constantly supervised when utilizing these items. An observation during the annual compliance review supported this practice. Seven youth were interviewed, and each confirmed they are not allowed to use any tools. Seven staff were interviewed, and stated youth are not to handle any chemicals but are allowed to use mops and brooms and clean once staff spray the cleaning solution in the area to be cleaned. All seven interviewed staff reported youth do not have access to any tools.

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

The center has a written policy and procedure to address the inventory of flammable, toxic, caustic, and poisonous items. Flammable, toxic, caustic, and poisonous items are maintained in a locked, secure storage area with limited access and not accessible to youth. Safety Data Sheets (SDS) logbooks are located at the location the chemicals are stored. All items are inventoried weekly by the maintenance mechanic and securely stored when not in use. Each item observed had an SDS on record for each item stored. Observation of the secure storage area and the inventory list indicated all items matched the inventory list and are stored in the locked storage. The SDS and inventories were compared to the items on-site and were found to be accurate and complete.

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 has a written policy and procedure ensuring limited access to flammable, toxic, caustic, and poisonous items. Youth are not permitted to access any materials which are flammable, toxic, caustic, and/or poisonous. The center maintains a list of authorized staff who are allowed access to chemical storage. An informal interview with the center's superintendent confirmed flammable, toxic, and caustic materials are stored in secure storage areas in the kitchen and maintenance storage area, and are only accessible to maintenance staff, supervisors, administrators, and the food service director. Observations conducted during the annual compliance review week found there are no toxic, flammable, or poisonous materials stored in any placed accessible to youth. Seven staff were interviewed, and each reported youth are not allowed to use any toxic, flammable, or poisonous substances. Seven youth were interviewed, and each confirmed they are not allowed to use any cleaning agents such as bleach, laundry soap, window, or toilet cleaner.

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

The center has a written policy and procedures which address proper use, storage, and disposal of flammable, toxic, caustic, and poisonous items. The center has a safety plan in place to address any chemical spills or leaks. The plan addressed what procedure to follow in the event of a chemical leak or spill. The maintenance mechanic confirmed materials are disposed of by transport to the Broward County Public Utilities Department, Solid and Hazardous Waste Management Facility. The kitchen has a container located outside to store used grease which a contract is maintained with Douglas Orr Plumbing, Inc. for disposal. The maintenance mechanic confirmed there have been no chemical spills or leaks within the annual compliance review period. If a chemical spill occurs, procedures indicate a staff will notify master control of the location of the spill, a juvenile justice detention officer supervisor and/or master control shall direct the shutdown of all air handlers, ventilation system, and close all windows and doors. The center will then obtain assistance from outside the center by contacting the necessary emergency contacts. Biohazardous waste disposal is the responsibility of the medical staff.

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 maintains a written policy and procedures ensuring confinements under twenty-four hours are used as an immediate, short-term response strategy during volatile situations with a youth's sudden or unforeseen onset of behavior imminently and substantially threatens the physical safety of others or self. The center utilizes the module rooms for confinement. Youth who are placed in confinement have no contact with the general population. A search of the room is conducted prior to the youth being placed, and all non-fixed items are removed from rooms. The center documents confinements under twenty-four hours in the Facility Management System (FMS). A review of six confinement reports found each youth was afforded the same services as youth in general population. Confinement reports confirmed all rooms were searched prior to youth being placed in confinement and each room was free from any obstructions. Each report supported visual observation was documented and conducted in accordance with the Department's policy. Each reviewed report indicated the juvenile justice detention officer supervisor (JJDOS) completed reviews within two hours, evaluated the youth every three hours, and documented the need for confinement based on the severity of the rule, violations, past disciplinary history of behaviors while in confinement. Each of the six confinement reports indicated the superintendent and/or designee reviewed the confinement report within twenty-four hours. An informal interview with the superintendent validated this practice. Seven staff were interviewed, and each staff reported when a youth is placed in confinement staff must complete the confinement report, search confinement room, and document room checks.

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 has a written policy and procedures addressing confinement over twenty–four hours which requires confinement reports to be submitted within one hour of the incident and reviewed

within two hours by the superintendent or designee. The center had one confinement over twenty-four hours documented since the last annual compliance review. A review of the confinement report found it was approved by the superintendent. The juvenile justice detention officer supervisor (JJDOS) completed reviews within two hours and evaluated the youth every three hours. The confinement report reviewed included a review by the mental health professional and approval by the regional director within twenty-four hours. The reviewed confinement did not extend beyond three days; therefore, no confinement hearings were required.

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

The center has a written policy and procedures ensuring a plan in place to manage various emergencies and disaster events. The center's Continuity of Operations Plan (COOP) was approved by the Department on January 1, 2019. Documentation confirmed there were eight COOP drills conducted since the last annual compliance review. Out of eight drills, one was conducted prior to hurricane season as required. Review of the documentation verified hurricane drills were conducted in January, September, and November of 2019. Observations made of the drill indicated each contained written scenarios to include critique and follow-up instructions, if necessary, on the COOP drill form. All reviewed drills were documented on the drill form and in the logbooks. Seven staff were interviewed and asked what drills they have participated in the last six months. Each staff reported participating in a fire, major disturbance, escape, and weather drill. One staff reported participating in a bomb threat and terrorism drill. None of the staff responded to have participated in a hostage drill.

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

The center has a written policy and procedures ensuring there is a plan in place to prevent, manage, and address youth escapes. A review of the prevention plan confirmed it contained all required elements outlined in the Department's policy. The center requires escape drills to be conducted at least once a quarter. A review of the center's escape drills since the last annual compliance review, along with corresponding logbook entries, verified the center exceeded the requirements and conducted five drills since the last annual compliance review. Drills are reviewed during staff meetings and shift briefings. Reviewed documentation found all drills were documented on drill forms and in the logbook. Additionally, staff signed a roster acknowledging they participated in the drill. An interview with the center's superintendent indicated monthly safety meetings with all departments are held to ensure safety issues are addressed. A walkthrough of the center is also conducted with the maintenance mechanic to address any work projects which need immediate attention. A review of seven staff training records validated annual escape training was completed by each reviewed staff. Seven staff were interviewed and asked what drills they have participated in the last six months. Each stated they have participated in an escape drill.

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

The center has a written policy and procedures ensuring fire prevention and safety of the center. The center's fire prevention and safety plans were reviewed and approved by the state fire marshal on August 15, 2019. Annual inspections are conducted by the fire marshal. The center has evacuation egress plans posted throughout the center. Each egress plan defines primary and secondary exit routes and the locations of emergency equipment, such as fire extinguishers and first aid kits. A review of the emergency drills and logbook documentation for the past six months did not confirm the center conducts fire drills consistently every month as required on B and C shifts. B-shift was missing fire drills for the month of September, and November of 2019 and C-shift did not conduct a fire drill for the month of August 2019. A-shift consistently conducted fire drills as required. The center superintendent and juvenile justice detention officer supervisor (JJDOS) confirmed all drills are reviewed during shift briefings. A review of seven staff training records validated annual fire prevention training was completed by each reviewed staff. Seven staff were interviewed, and each staff reported fire drills take place monthly and they have participated in at least one monthly drill. Seven youth were interviewed and asked have they been instructed on what to do in case of a fire. Three youth stated yes and four stated no. The superindent was made aware of the youth not being instructed on what to do in case of a fire.