STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

PROGRAM REPORT FOR

ESCAMBIA REGIONAL JUVENILE DETENTION CENTER

Department of Juvenile Justice

(State-Operated)

1800 Saint Mary Avenue

Pensacola, Florida 32514

Review Date(s): September 11-14, 2018

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 that 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 that 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 that 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:

Jill Foy, Office of Program Accountability, Lead Reviewer (Standard 1)
James Blanchet, DJJ Probation, Senior Juvenile Probation Officer, Circuit 14 (Standard 2)
Lea Herring, Office of Program Accountability, Regional Monitor (Standard 4)
Patrick McKinstry, Office of Program Accountability, Regional Monitor (Standard 3)
Retha Smith, Leon Regional Juvenile Detention Center, Sergeant (Standard 5)

Program Name: Escambia Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: Escambia County / Circuit 1
Review Date(s): September 11-14, 2018

MQI Program Code: 2
Contract Number: N/A
Number of Beds: 60
Lead Reviewer Code: 168

Methodology

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

Persons Interviewed

- ☒ Program Director
- ☐ DJJ Monitor
- ☐ DHA or designee
- ☒ DMHCA or designee
- _____ # Case Managers
- 1 # Clinical Staff
- _____ # Food Service Personnel
- 2 # Healthcare Staff
- 1 # Maintenance Personnel
- 1 # Program Supervisors
- _____ # Other (listed by title): _____

Documents Reviewed

- ☐ Accreditation Reports
- ☐ Affidavit of Good Moral Character
- ☒ CCC Reports
- ☒ Confinement Reports
- ☒ Continuity of Operation Plan
- ☐ Contract Monitoring Reports
- ☐ Contract Scope of Services
- ☒ Egress Plans
- ☐ Escape Notification/Logs
- ☒ Exposure Control Plan
- ☒ Fire Drill Log
- ☒ Fire Inspection Report
- ☒ Fire Prevention Plan
- ☒ Grievance Process/Records
- ☒ Key Control Log
- ☒ Logbooks
- ☒ Medical and Mental Health Alerts
- ☒ PAR Reports
- ☒ Precautionary Observation Logs
- ☒ Program Schedules
- ☒ Sick Call Logs
- ☒ Supplemental Contracts
- ☒ Table of Organization
- ☒ Telephone Logs
- ☒ Vehicle Inspection Reports
- ☒ Visitation Logs
- ☒ Youth Handbook
- 7 # Health Records
- 7 # MH/SA Records
- 33 # Personnel Records
- 14 # Training Records/CORE
- 7 # Youth Records (Closed)
- 3 # Youth Records (Open)
- _____ # Other: _____

Surveys

- 7 # Youth
- 7 # Direct Care Staff
- _____ # Other: _____

Observations During Review

- ☒ Admissions
- ☒ Confinement
- ☒ Facility and Grounds
- ☒ First Aid Kit(s)
- ☐ Group
- ☒ Meals
- ☒ Medical Clinic
- ☒ Medication Administration
- ☒ Posting of Abuse Hotline
- ☒ Program Activities
- ☒ Recreation
- ☒ Searches
- ☒ Security Video Tapes
- ☒ Sick Call
- ☒ Social Skill Modeling by Staff
- ☒ Staff Interactions with Youth
- ☒ Staff Supervision of Youth
- ☒ Tool Inventory and Storage
- ☒ Toxic Item Inventory and Storage
- ☐ Transition/Exit Conferences
- ☐ Treatment Team Meetings
- ☐ Use of Mechanical Restraints
- ☒ Youth Movement and Counts

Comments

Items not marked were either not applicable or not available for review.

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	Classification of Gang Members	Satisfactory
2.05	Notification of JPO Circuit Gang Rep	Satisfactory
2.06	Admission of Youth Personal Property	Satisfactory
2.07	Storage of Youth Personal Property	Satisfactory
2.08	Release	Satisfactory
2.09	Release of Youth Personal Property	Satisfactory
2.10	Release of Meds, Aftercare Instructions	Satisfactory
2.11	Review of Youth in Secure Detention and Home Detention	Satisfactory
2.12	Daily Activity Schedule	Satisfactory
2.13	Adherence to Daily Schedule	Satisfactory
2.14	Educational Access	Satisfactory
2.15	Career Education	Satisfactory
2.16	Behavior Management System	Satisfactory
2.17	* Unauthorized Use of Punishment	Satisfactory
2.18	Grievances	Satisfactory
2.19	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	Satisfactory
4.05	Notification - Clinical Psychotropic Progress Note	Satisfactory
4.06	Immunizations	Satisfactory
4.07	Healthcare Admission Screening Form	Satisfactory
4.08	Medical Alerts	Satisfactory
4.09	Suicide Risk Screening Instrument	Non-Applicable
4.10	Youth Orientation to Healthcare Services	Satisfactory
4.11	DHA/Designee Admission Notification	Satisfactory
4.12	Healthcare Admission Rescreening	Satisfactory
4.13	Health Related History	Satisfactory
4.14	Comprehensive Physical Assessment	Satisfactory
4.15	Female-Specific Screening/Examination	Satisfactory
4.16	Tuberculosis Screening	Satisfactory
4.17	Sexually Transmitted Infection Screening	Satisfactory
4.18	HIV Testing	Satisfactory
4.19	Sick Call Process - Requests/Complaints	Satisfactory
4.20	Sick Call Process - Visits/Encounters	Satisfactory
4.21	Restricted Housing	Satisfactory
4.22	Episodic/First Aid Care	Satisfactory
4.23	Emergency Care	Satisfactory
4.24	Off-Site Care/Referrals	Satisfactory
4.25	Chronic Conditions/Periodic Evaluations	Satisfactory
4.26	Medication Management - Verification	Satisfactory
4.27	Medication Management - Orders/Prescriptions	Satisfactory
4.28	Medication Management - Storage	Satisfactory
4.29	Medication and Sharps Inventory	Satisfactory
4.30	Medication Management - Controlled Medications	Satisfactory
4.31	Medication Administration Record	Satisfactory
4.32	Medication Administration By Licensed Staff	Satisfactory
4.33	Medications Provided By Non-Licensed Staff	Satisfactory
4.34	Psychotropic Medication Monitoring	Satisfactory
4.35	Infection Control - Surveillance, Screening, and Management	Satisfactory
4.36	Infection Control - Education	Satisfactory
4.37	Infection Control - Exposure Control Plan	Satisfactory
4.38	Prenatal Care - Physical Care of Pregnant Youth	Satisfactory
4.39	Prenatal Care - Nutrition and Education of Youth	Satisfactory
4.40	Prenatal Staff 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	Kitchen Tools	Satisfactory
5.10	* Youth Access & Use of Tools, Cleaning Items	Satisfactory
5.11	Inventory of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.12	* Access to all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.13	Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.14	Confinement Under Twenty-Four Hours	Satisfactory
5.15	Confinement Over Twenty-Four Hours	Satisfactory
5.16	Continuity of Operations Planning (COOP) Drills	Satisfactory
5.17	Escape Drills	Satisfactory
5.18	Fire Drills	Satisfactory

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Strengths and Innovative Approaches

- A new program called Kim's Closet assists youth in secure detention, on probation, as well as any youth in need within the community. The center maintains boys and girls closets with clothing, shoes, and other accessory items received from donations. Both closets help youth prepare for job interviews, school, church, and other casual functions. Their motto is "when you look good, you feel good."

Standard 1: Management Accountability

Overview

The Escambia Regional Juvenile Detention Center is a sixty bed, hardware secure facility located in Pensacola, Florida at the Theodore Bruno Juvenile Justice Center. The center is co-located with the Escambia Juvenile Courthouse, Juvenile Assessment Center (JAC), and the Intake and Screening Probation Unit. The center serves youth in Circuit 1 who are detained pending adjudication, disposition, or placement in a commitment program. The center serves both male and female youth and provides supervision of youth in a safe, secure, and humane environment. Services for youth include education, mental health, substance abuse, and health care. Medical and mental health are contracted services. Education services are funded by the Department of Education through the local school district. At the time of the annual compliance review, the center had six vacancies: one juvenile justice detention officer supervisor (JJDOS), one juvenile justice detention officer II (JJDO), and four JJDO I positions. The administrative staff at the center includes the superintendent, two assistant superintendents, administrative assistant, and training coordinator.

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. A contract provider may hire an employee to a position that 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 that he or she exhibits no behaviors that 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 addressing background screenings for all employees, contracted staff, and volunteers. Since the last annual compliance review, the center has had thirty-three new staff and one new volunteer. Each new staff member and volunteer had a background screening completed by the Department's Background Screening Unit (BSU) prior to their hire date. There have been no new contracted staff hired since the last annual compliance review. Twenty-nine of the thirty-three new staff members are considered direct care staff. All twenty-nine applicable staff members were given a pre-employment assessment. Two of these staff members did not receive a passing score. In both cases, an Ergometric (ERGO) Score Request Form was submitted to and approved by the assistant secretary of detention services. Both employees received follow-up training by the center's field training coordinator. The center submitted the Annual Affidavit of Compliance for Level 2 Screening Standards on January 30, 2018, meeting the annual requirement.

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

The center has a written policy and procedures addressing five-year background rescreening for all staff, contracted staff, and volunteers. Three staff were eligible for a five-year rescreening. Each of the five-year rescreenings were completed prior to the staff's anniversary date of initial hire. No contracted staff or volunteers were eligible for a five-year rescreening.

1.03 Staff Code of Conduct	Satisfactory Compliance
Program 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 detention or who has been in the custody of the Department.* *Officers shall not verbally abuse, demean, or otherwise humiliate any youth, and shall not use profanity in the performance of their job.* *Officers shall not engage in or allow horseplay, either verbal or physical with and/or between any youth.* *Officers shall not engage in personal relationships nor discuss personal information related to themselves or other officers with any youth.* *Management takes immediate action to investigate or address all allegations or violations of the code of conduct.*	

The center has a written policy and procedures to ensure staff communicate and interact with youth in a manner which demonstrates socially acceptable behaviors and staff behavior shall be respectful of others and reflect desired youth behaviors. According to the written policy and procedures, staff must adhere to a code of conduct which prohibits any form of abuse, profanity, threats, harassment, intimidation, or personal relationships with youth. Seven personnel records were reviewed. Each of the records contained a signed receipt of the employee handbook which outlines the staff code of conduct. One staff received a verbal reprimand for excessive tardiness. The date the disciplinary action was received by management was included in the documentation observed in the record. Re-training was provided by the facility training coordinator. A review of incidents and Central Communications Center (CCC) reports indicated there were no allegations or findings of improper conduct by staff for the review period. Five of seven interviewed youth reported they feel staff are respectful when speaking to them. Two youth reported they have never heard staff use profanity when speaking to youth, two youth reported they have heard staff using profanity once, two stated staff use profanity occasionally, and one youth reported staff use profanity often. Each of the seven youth stated they have

never witnessed staff using threatening behavior and all seven reported they feel safe at the center. Four of the seven interviewed staff reported they have never heard staff using profanity. Three staff members reported hearing co-workers using profanity once or occasionally but reported these staff members were no longer employed at the center. All of the staff reported they have never observed a co-worker using threatening behavior towards a youth. Further, all of the staff reported they felt the working conditions at the center have been very good or good in the past year.

1.04 Incident Reporting (CCC) (Critical)	Satisfactory Compliance
Whenever a reportable incident occurs, the program 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 the reporting of incidents to the Central Communications Center (CCC). The center had thirteen reportable incidents to the CCC in the previous six months. This is only an increase of three incidents compared to the previous annual compliance review period. Five reportable incidents were reviewed. All five CCC reports reflected the incidents were reported within the required two-hour timeframe. There were no internal incidents/grievances which should have been reported to CCC. Each of the seven interviewed staff were able to articulate the process in which staff and youth are allowed to contact the Florida Abuse Hotline or CCC. All seven interviewed youth reported they have never been denied the right to call the Florida Abuse Hotline. According to the superintendent interview, all incidents are reported in accordance with Facility Operating Procedure (FOP) 1.14.

1.05 Protective Action Response (PAR)	Satisfactory Compliance
The program 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.	

There were twenty-two Protective Active Response (PAR) incidents at the center within the past six months, of which five were reviewed. All five reports were completed by the end of the staff member's work day, included statements from all staff involved, did not require mechanical restraints, did not result in serious injuries to youth or staff, and there were no instances in which youth alleged abuse. Each of the reports were reviewed and processed within seventy-hours by all required parties. Post-PAR interviews with the youth were conducted within thirty minutes of the incident. One of the five reports required a PAR medical review which was conducted on-site with the appropriate medical staff. A review of incidents/grievances did not reveal any additional PAR incidents. The center's PAR rate for the last quarter was 4.42, which is below the statewide PAR rate of 9.29. Additionally, the center will be receiving an award for the highest PAR reduction rate, at eighty-five percent, for July 2018. Each of the seven interviewed staff reported staff try and talk with youth prior to using any physical interventions or mechanical restraints. According to the superintendent interview, PARs are reviewed in accordance with Facility Operating Procedure (FOP) 3.10 and any issues are addressed immediately.

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

The center has a written policy and procedures addressing pre-service/certification training requirements. Six of the seven reviewed staff records contained documentation indicating staff completed all required pre-service trainings prior to any contact with youth. Six of the seven staff completed the required 120-hours of training and were certified within 180 days of hire. All pre-service trainings were documented in the Department's Learning Management System (SkillPro). One of the seven staff did not participate the following pre-service trainings: human trafficking, legal, DJJ: The Organization, and gang awareness. This staff was hired in the position of assistant superintendent (ASD) in February 2018 and was previously certified. This staff member had a break in service for more than four years; however, an e-mail from the north region detention services director verified anyone hired into the position of assistant superintendent or superintendent was not required to attend the juvenile justice detention officer (JJDO) academy. Protective Active Response (PAR) training was not documented in SkillPro but was observed in the ASD's training record.

1.07 In-Service Training	Satisfactory Compliance
All detention staff completes 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 completes 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 addressing in-service training. Seven staff training records were reviewed for in-service training. All of the records indicated staff completed all of the required in-service trainings, including Protective Active Response (update), cardiopulmonary resuscitation (CPR), first aid, suicide prevention, and professionalism and ethics. One of the reviewed staff members is a certified PAR trainer, in which her certificate was observed and is only required to complete a refresher course every four years, and is not due for a refresher course until the year 2020. Three of the seven records reviewed were applicable for supervisory trainings. Each of the three reviewed supervisory staff exceeded the required eight hours of in-service training. All in-service trainings were documented in the Department's Learning Management System (SkillPro), apart from two staff missing women's health; however, each of the staff's records contained documentation of training completion. The center has an annual in-service training plan which was observed posted in the employee conference room. Additionally, the center provided an annual training calendar, which is updated when changes occur. According to the superintendent interview, management receives a continuation of superintendent training to include leadership and management. Supervisors receive management training through classes designated for leadership, as well as monthly supervisor meetings and SkillPro trainings (supervisors and staff).

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 facility 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 that critical 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 in place to ensure the safety and well-being of youth with critical or special alerts and to ensure alerts are reviewed, responded to appropriately, and documented. Seven youth records were reviewed for mental health and medical alerts and all of the youth were applicable for alerts. In each of the records, alerts were entered, reviewed, and updated as required. The appropriate staff member entered and updated the alerts for all seven youth records reviewed. Logbooks and shift reports were reviewed and reflected alerts were documented as needed. Alerts are immediately entered into the program's alert system if a youth is admitted with special needs/risks such as suicide, mental health, substance abuse, physical health, or security risk factors. Appropriate staff are notified based on the nature of the youth's alert to include medical, mental health, and food service. The Department's Juvenile Justice Information System (JJIS) alert reports are reviewed daily by supervisors and administrators and information regarding youth alerts are made available to all staff. During each shift briefing, JJIS alert reports are provided to each juvenile justice detention officer (JJDO) by the JJDO supervisor. Every youth on the alert report is reviewed during the shift briefing and JJDOs have the alert report on their person during their shift. A shift briefing was observed during the annual compliance review and this practice was observed. All seven interviewed staff reported they were informed of alerts during shift briefings, JJIS, review of logbooks, and the alert board.

Standard 2: Assessment and Performance Plan

Overview

The Escambia Regional Juvenile Detention Center houses youth who meet admission criteria to be held in secure detention for a period of time pending disposition and/or commitment to a residential program. Each admitted youth participates in an orientation, where youth are provided with the rules and regulations of the center, youth rights information, visitation and telephone schedules, grievance process information, view a Prison Rape Elimination Act (PREA) video, and have expectations for behavior explained to include related consequences of unacceptable behaviors which are outlined in the center's policy on behavior management. Youth attend regularly scheduled activities which include personal hygiene, meals, education, and recreation, both indoors and outdoors. The youth have access to medical and mental health staff and services. The center provides twenty-four-hour safety and security for the youth detained at the center.

2.01 Admission	Satisfactory Compliance

All youth are admitted to the program 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. *Review of inactive files shall be conducted, if available, to obtain useful information.*
3. *All youth shall be electronically searched, frisk searched, and stripped searched by an officer of the same sex as the youth.*
4. *All youth shall be allowed to place a telephone call at the facility'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.*
5. *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.*
6. *All youth shall be screened to identify medical, mental health, and substance abuse needs.*

The center has a written policy and procedures to ensure the proper screening, evaluation, and documentation is provided for each youth admitted into the center. Seven active youth records were reviewed and contained an arrest affidavit and/or court order, detention risk assessment, substance abuse and mental health assessment, and suicide risk screening instrument. Each youth also had a documented telephone call, as well as a meal offered for screenings which were more than two hours before the serving of the next scheduled meal. During an admission observed during the annual compliance review, the staff offered a light snack to the youth when the next meal was approximately one hour away. All seven records contained mental health, medical, and substance abuse screening documentation and any youth identified as being at risk for suicide was appropriately placed on precautionary observation pending an evaluation from a licensed mental health provider. All records contained documentation indicating the youth were electronically searched, frisk searched, and strip searched by an officer, yet no mechanism could be found to record the sex of the officer performing the search on the admission wizard. The master control logbook was reviewed and clearly reflected an admission search being conducted by an officer of the same sex as the youth. Observations made during the youth admission also had a search performed by a staff the same sex as the youth. One

youth did not have the computer-generated admission wizard within the record; however, staff explained the Department's Juvenile Justice Information System (JJIS) was not working properly at the time of admission. The original hand-written admission wizard was provided for review.

2.02 Orientation	Satisfactory Compliance
Program orientation process shall occur within twenty-four hours of a youth being admitted into detention 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. *Facility 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;* 7. *Expectations for behavior and related consequences;* 8. *Possible new law violations for destruction of property; and* 9. *Youth rights.*	

The seven reviewed youth records contained signed orientation acknowledgement forms, indicating each youth received an orientation to the center within the twenty-four-hour time frame which addressed the rules and regulations of the center. The orientation advised the youth of the grievance procedures, visitation, schedule for telephone calls, Central Communications (CCC), how to access the Florida Abuse Hotline, youth rights, expectations of behavior and related consequences, possible new law violations for destruction of property, and availability of medical, mental health, and substance abuse services. Each form signed by the youth also had the youth's and staff's initials next to each topic explained during the orientation. The youth are provided handbooks for future reference on the topics covered. The staff show each youth a video regarding the Prison Rape Elimination Act (PREA) during the orientation process. The orientation observed during the annual compliance review included all of the required elements. The youth interviewed during the observed admission and orientation appeared comfortable and reported no issues with the process. Each of the seven interviewed youth reported they received an orientation to the center which included the rules and regulations, daily schedule, education services, visitation, abuse reporting, and the behavior management system.

2.03 Classification	Satisfactory Compliance

All youth admitted to the detention 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.

The center has a written policy and procedures outlining the assigning and classification of youth based on the youth's behavior and status, both observed and documented in the youth's history. Seven youth records were reviewed and found completed Vulnerability to Victimization and/or Sexually Aggressive Behavior (VSAB) and suicide risk screenings. All seven youth were considered with regard to safety and security based on sex, height, weight, age, and level of aggressiveness. The youth were screened for the nine special needs of mental illness, intellectual disabilities, physical disabilities, history of violent behavior, gang affiliation, criminal behavior, history of sexual offenses, the VSAB, and suicide risk. Two youth had alerts entered into the Department's Juvenile Justice Information System (JJIS); one for asthma and another for allergies which were not taken into account on the Medical and Mental Health (MH) Admission Screening document. The alerts, however, were clearly listed on both of the youth's Admission Wizard Intake Forms. Two of the seven youth required a single room based on the results of the VSAB, and a history of violent behavior was noted in five of the youth records reviewed. All seven youth had a suicide risk alert entered into JJIS.

2.04 Classification of Gang Members	Satisfactory Compliance

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 gang involvement is suspected, Detention 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 concerning the screening and procedures to identify street gang members or affiliates. Based on admission screening, none of the seven youth records reviewed were for youth identified as documented gang members and/or affiliates. One of the seven youth had a pre-existing alert for suspected gang membership which has yet to be verified by local law enforcement. This youth denied gang affiliation during the screening process upon his current admission to detention. Several youth detained in the center

during the annual compliance review period reflected a JJIS alert for suspected gang affiliation; however, none had been verified as a gang member by law enforcement. There were no additional applicable records for review.

2.05 Notification of Juvenile Probation Officer Circuit Gang Representative	Satisfactory Compliance
Each center shall identify the Juvenile Probation Officer designated as the Circuit Gang Representative to communicate suspected gang activity. *A referral on a youth for suspected gang involvement shall be shared, via email, with the Juvenile Probation Officer designated as the Circuit Gang Representative indicating suspicions of gang activity such as youth flashing gang signs, gang tattoos, gang-related drawings, or related activity.* *Detention staff should include in the email all pictures (when appropriate), copies of written statements, drawings, graffiti, and a description of what gang signs the youth was "flashing."*	

The center has not had any youth who met the criteria for gang membership since the last annual compliance review; however, the center provided information collected and shared between the center's designated gang representative and the local juvenile probation officer (JPO) designated as the gang liaison. Center staff were able to articulate their cooperation with local law enforcement with regard to identification of street gang member and affiliate youth.

2.06 Admission of Youth Personal Property	Satisfactory Compliance
The program 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 for admission of a youth's personal property. Seven youth records were reviewed, with five containing youth and staff signatures on the Property Receipt Form. Two Property Receipt Forms were missing the youth signatures. The center's superintendent was able to articulate the center's policy if a youth refused to sign the form, and further indicated the center has not had a refusal in a very long time. The center also has a policy and procedures in place for the handling of valuable property. Valuable property requires two staff, including a juvenile detention officer supervisor (JJDOS) to open the safe. Valuable property is kept in a clear tamper-proof bag, with youth's name, admission date, and Department identification number (DJJID), along with the itemized property listed, and the property inside the bag. The youth's clothes, shoes, and other personal property were locked and secured in a closet/locker room with each bag containing the youth's name, DJJID, and inventory list of the bags contents. The center maintains a drop safe logbook, which was observed and contained all required information. Each record had documentation signed by the youth regarding the procedure should property be unclaimed for thirty days post-release. The personal property process was observed upon admission and release during the annual compliance review. All seven interviewed youth indicated they signed for their property at admission.

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

The center has a procedure which safeguards each youth's personal property until it can be returned to the youth and/or parent/guardian. The process of both removal and addition of valuable property to the safe was observed during the annual compliance review. The entire process was announced and documented by master control in a logbook, as well as in a dedicated drop safe logbook. Video surveillance in the admission room clearly has the valuable property safe in view. The superintendent advised during an interview, an assistant detention superintendent (ADS) reviews the youth's property on a daily basis. While the center has no dedicated form for valuable property, the Property Receipt form clears indicates "safe" next to any items placed within the valuable property safe. There have been no Central Communications Center (CCC) reports concerning property for the last year.

2.08 Release	Satisfactory Compliance
When releasing youth from detention, 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 program 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 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 for the releasing of youth from the center promptly and accurately. Three closed records were reviewed for youth release. All three youth records had documentation indicating the juvenile justice detention officer supervisor (JJDOS) reviewed all of the paperwork and verified there was a court order and/or nothing which would have prevented the youth's release. All three youth were identified prior to release, and proper identification for the person the youth was being released to was obtained and documented. One of three youth records reviewed for release had an upcoming court date, which was provided the parent/guardian upon release. All parties signed the applicable release forms. A review of the Central Communications Center (CCC) reports for the annual compliance review period revealed there were no unauthorized releases. The release observed during the annual compliance review was of a youth being released to the custody of a residential program and found the release process was completed, as required.

2.09 Release of Youth Personal Property	Satisfactory Compliance
Upon the youth's release from detention and retrieval of personal property, the releasing officer, the youth, and the youth's parent or legal 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 for the retrieval of a youth's property upon release from secure detention, as well as reviewing and signing the Property Receipt form. All three records reviewed for release had a youth and parent/guardian signature for the release of property; however, one record was missing the youth's signature at admission. One release was observed during the annual compliance review and the youth was provided a property bag labeled "63," and youth promptly advised, "these are not my clothes." The staff immediately corrected the error, reviewed the inventory list, and found the correct bag which was also labeled "63." The superintendent responded in an interview stating all youth clothing is secured and the records are managed by the assistant detention superintendent (ADS). During the annual compliance review, previous letters sent to parents/guardians advising of unclaimed property were reviewed, as well as the dedicated safe and procedures for maintaining unclaimed property. Similar to the safeguards in place for handling valuable property, safeguards are in place for the handling of unclaimed property and monitoring safe access. The superintendent was able to articulate the process of handling unclaimed property.

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

The center maintains a written policy to ensure there are procedures in place to ensure medication and medical, mental health, and substance abuse information accompanies the youth upon their release from secure detention. Three closed records were reviewed for release compliance. Each of the records reviewed had the required documentation, to include signatures of all required parties, for the transferring of the medication from the center to the person the youth was being released to. One additional record was reviewed which demonstrated the appropriate handling and documentation of medication when a youth is transferred to another center. Medical and detention staff accurately explained the process in the policy were the individual acknowledges receipt of the medication by signing a receipt, which is placed in the youth's Individual Healthcare Record (IHCR). In an interview, the superintendent explained how medical and medication information is reviewed for all youth in secure detention during the weekly detention review.

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

The center has a written policy and procedures to ensure detention reviews are conducted to provide a systematic process, ensuring youth are held in secure detention for the shortest time possible. The policy also addresses detention reviews for youth placed on home detention, ensuring the youth's case proceeds expeditiously, and to share information regarding the youths' behavioral and/or physical issues, as needed. The center conducts weekly detention reviews each Wednesday to monitor each youth's case regarding changes in youth placement,

behavior, and alerts. A detention review meeting was observed during the annual compliance review. The review contained both secure detention and home detention youth and addressed any tasks required and who was to follow-up. Every youth with a detention status (including electronic monitoring) was reviewed. This accounted for a total of fifty-eight youth. The release dates and next court appearances (if applicable) were discussed and documented. The detention review observed had all parties present accounted for with a sign-in sheet, with one individual attending by telephone. A review of the detention reviews from the previous year displayed the same consistency in documentation of the participants. In an interview, the superintendent explained how the detention reviews are utilized to convey the youth's status to medical, mental health, education, and probation representatives. The superintendent or the designated detention review specialist conducts the weekly detention reviews.

2.12 Daily Activity Schedule	Satisfactory Compliance
Youth are provided the opportunity to participate in constructive activities that will benefit the youth and the program. 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 concerning daily activities to ensure the center keeps youth constructively involved. Two separate schedules of daily activities were reviewed; a weekly schedule and another for holidays and weekends. Also observed in numerous locations in the center were posting of the daily activities. These schedules included all required activities such as shower and hygiene times, meal times, visitation, and phone call times. Morning sick call is clearly posted on the schedule. Also included were education and life skills, including gender-specific programming, Eight to Great groups, and special projects. Reviewed logbooks reflected the participation of visitors in the visitation process. The seven youth interviewed all indicated the center has a daily schedule. Six of the seven interviewed staff reported gender-specific programming is listed as a part of the activity schedule.

2.13 Adherence to Daily Schedule	Satisfactory Compliance
Facility 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.*	

A review of the center's logbooks indicated participation in visitation, as well as daily activities. Observations found staff were documenting behavior management points during groups, education, and other daily activities. The various activities observed included indoor physical activity (the center has an indoor basketball court), school testing, multiple classes being taught, meal time, and sick call. All activities observed were in accordance with the daily activity schedule. Five of the seven youth interviewed reported the daily activity schedule is followed. Two youth reported the schedule is not followed due to their gym time being cut short. Six of the seven interviewed staff reported the daily activity schedule is followed. One staff reported, due to unforeseen safety and security issues (codes), sometimes the schedule is not followed.

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

The center has education access provided to detained youth though teachers of the Escambia County School District. Being the school is provided by the county, it is possible school could be cancelled when unforeseen emergencies or inclement weather, such as a hurricane or tornado, occur. Interviews with school staff reveal the youth attend education services five hours a day and school will have modified schedules if there are staffing issues. The education process does provide for 250 days of school (twenty-five hours a week, at minimum) of education access. Youth enrolled in the education program have the opportunity to earn credits and/or grades for the completion of education and training experience. A review of the logbooks and the schedule indicated some partial school days. There were continuous observations of classes being taught within the youth modules as a result of the high population. Teachers utilized a portable cart with all of their teaching supplies into each module while the youth used the tables as desks. The challenge which currently exists in the center is the mixing of alpha and bravo modules with only fifteen youth allowed in each class. All seven interviewed youth responded they are offered educational classes (including technical and career training), and they attend school Monday through Friday.

2.15 Career Education	Satisfactory Compliance
Staff shall develop and implement a career education competency development program.	

The center provides Type 1 career education programming, as seen in the center's use of Life Skills groups. Career education also includes communication, interpersonal, and decision-making skills though resources such as career awareness activities, journaling on social skills, and access to the Kuder career guidance provider, utilizing My Career Shines portal.

2.16 Behavior Management System	Satisfactory Compliance
The program provides a system of rewards, privileges, and consequences to encourage youth to fulfill the program's expectations. *Each facility shall implement and maintain a behavior management system to meet the needs of the youth and the facility. The system shall be approved by the regional director and 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, procedures, and a system of rewards, privileges, and consequences to encourage youth to fulfill the center's expectations. During the annual compliance review, numerous observations found the center has the rules and expectations of the youth posted throughout. Also displayed in numerous locations was the behavioral management system (BMS) which is utilized in the center. The standardized BMS has been approved by the regional director and is presented to the youth at intake and supplemented with postings throughout the center. During observations, staff were seen actively keeping track of the point system for the youth during activities. Every youth enters the center at a level two and

can move up to a level three or down to a level one depending on the youth's behavior. Points can be used twice a week to earn snack/candy rewards, extra phone time, and/or sibling visits. The posted BMS clearly differentiates youth basic rights and what are privileges. Documentation was reviewed which lists all of the privileges the youth can earn. The rewards are in compliance with the BMS outlined in the center's written policy. Three of the seven youth interviewed rated the BMS as "fair" while four of the youth rate it as "good." During an interview, the superintendent of the center described the BMS as a level system designed not to punish youth, but rather reward them for good behaviors. Five of the youth reported consequences were fair, one said it was not, and the remaining youth responded to never receiving consequences. All seven interviewed staff reported they felt the BMS was effective. Further, the staff reported youth are given an opportunity to explain their behavior and staff speak with youth about alternative acceptable behaviors.

2.17 Unauthorized Use of Punishment (Critical)	Satisfactory Compliance
The center's behavior management system restricts certain types of penalties on youth who demonstrate negative behaviors. *Group punishment shall not be used as a part of the facility's behavior management plan. 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 in detention facilities. All allegations of corporal punishment of any youth by facility 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's behavior management system (BMS) restricts certain types of penalties for youth who demonstrate negative behaviors, as presented in the center's written policy. The policy and procedures prohibit group punishment, as well as corporal punishment. Seven youth were interviewed in regard to the authorized use of punishment in the center. Each of the seven youth reported youth are not allowed to punish one another. Five youth stated they have been sent to their room as punishment, while two state they have not. The five youth further reported when sent to their rooms for punishment, the doors were shut and locked. One youth reported not receiving his medication while in confinement; however, a review of the youth's Medical Administration Record (MAR) did not reveal any instances of missed medication. Four of the seven youth reported they do not attend education classes while in confinement. Education staff reported when youth are placed in confinement, they do not attend classes, but assignments are delivered to the youth while in confinement. All seven youth reported handcuffs nor leg irons are not used to prevent a youth from hurting themselves. All seven interviewed staff members reported they have never observed another co-worker taking meals, snacks, sleep, education, or medical services away from a youth because they were acting out. Further, staff reported they have never observed another staff member encouraging one youth to beat up another youth.

2.18 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 did not have any grievances since the last annual compliance review. The center has a written policy and procedures regarding grievances. Observations during the annual compliance review found grievance procedures were explained to a youth at admission. A review of the grievance process is part of a youth's admission and orientation. The superintendent explained the center uses a creative "questionnaire" asking system for youth to ask staff questions and receive responses. This system was observed during the annual compliance review in every youth module next to the grievance procedures and forms. Seven youth were interviewed in regard to the grievance process. Five youth reported they have never filed a grievance. One youth reported the grievance process was very good and one reported the process was fair. All seven staff members interviewed were able to articulate the grievance process.

2.19 Trauma-Informed Care	Satisfactory Compliance

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

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

- *A recognition of the high prevalence of trauma*
- *Assessment for traumatic histories and symptoms*
- *Recognition of culture and practices that 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's practice for implementing trauma-informed care was reviewed. The center's practice included the following characteristics: recognition of trauma, assessment of trauma histories and symptoms, collaboration of caregivers, staff training, increased understanding of the function of behavior, and the use of objective and neutral language. Seven staff in-service training records were reviewed and found each staff completed trauma-informed care training. In an interview, the superintendent reported the center has added pictures and paintings in efforts to soften the appearance of the center, as well as conducting staff trainings designed to address the needs of youth dealing with stressful situations.

Standard 3: Mental Health and Substance Abuse Services

Overview

The Department has a contract with Maxim Healthcare Services, Inc., who subcontracts with Camelot Community Care, Inc., to provide mental health and substance abuse services at the center. The mental health and substance abuse department at the center is staffed with one licensed mental health professional who is a psychiatrist licensed pursuant to Chapter 459, two licensed mental health counselors (LMHC), under Chapter 491, and a licensed marriage & family therapist. One of the LMHCs is identified as the center's designated mental health clinician authority (DMHCA). The contract between the Department and Maxim Healthcare Services, Inc., does not include exhibit 2; the specific matrix for the center concerning mental health, substance abuse, and psychiatric services. The subcontract with Camelot Community Care, Inc. references a different contract between the Department and Maxim Healthcare Services, Inc., for the Central Region). The information contained therein does specifically address services to be provided for mental health and substance abuse at the center. Staffing coverage for mental health and substance abuse services at the center are available on-site seven days a week.

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

The center has identified a single licensed mental health professional, as the designated mental health clinician authority (DMHCA). A review of the center's logbook maintained within the medical department, demonstrated, at a minimum, the DMHCA is on-site weekly for a sufficient amount of time to ensure appropriate coordination and implementation of mental health and substance abuse services. The DMHCA is a full-time employee and is on-site forty hours a week. The DMHCA is a licensed mental health counselor (LMHC), under Chapter 491; which was verified through the Florida Department of Health and does not expire until March 31, 2019. The Department has a contract with Maxim Healthcare Services, Inc., who subcontracts with Camelot Community Care, Inc., to provide mental health and substance abuse services. A copy of the DMHCA's license and subcontract, was available on-site for review. The DMHCA was not certified as a Qualified Supervisor within three months of contract execution; contract was originally signed between the Department and Maxim Healthcare Services, Inc., on March 29, 2018, and subcontract signed between Maxim Healthcare Services, Inc., and Camelot Community Care, Inc., on May 3, 2018. The DMHCA reported she will be attending the Qualified Supervisor training on September 15, 2018.

An interview with the DMHCA revealed she and her team provide mental health and substance abuse screenings and assessments to all youth (male and female) admitted to the center. In addition, maintain accurate and thorough record keeping and/or documentation of mental health and substance abuse services and treatment planning. The mental health professionals also lead multidiscipline treatment team meetings which address the unique needs, strengths, and risk factors identified from assessments as needing mental health and or substance abuse services. The DMHCA states she is on-site Monday through Friday and on the weekends, as

needed. The DMHCA indicated, the center offers specialized services including comprehensive assessments, treatment plans, treatment plan reviews, and reviews all suicide assessments weekly at the treatment team meetings, as well as with the psychiatrist every week for those youth referred for psychiatric assessments. The youth who are receiving treatment and/or mental health services have their electronic charts audited weekly for provision of services. The DMHCA personally provides clinical services such as assessments for suicide risk, crisis assessments, comprehensive mental health assessments, and both individual and group counseling. The DMHCA communicates face-to-face every week with licensed mental health professionals. The DMHCA and psychiatrist meet once a week when he is present to discuss youth receiving psychiatric services and any other time by phone should he need to be consulted.

3.02 Licensed Mental Health and Substance Abuse Clinical Staff [Contract Provider] (Critical)	**Satisfactory Compliance**
The facility 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.	

There are four licensed mental health professionals (LMHP) providing mental health and substance services at the center, each staff are licensed under the appropriate Florida Statutes and have clear and active licensures. The psychiatrist is licensed pursuant to Chapter 459, F.S., and is board-certified in Child and Adolescent Psychiatry, which was verified through the Florida Department of Health and is good through January 31, 2019. Three of the LMHPs are licensed mental health counselors (LMHC). The second LMHC is licensed under Chapter 491; which was verified through the Florida Department of Health and expires March 31, 2019. The fourth staff, is a part time employee, who is a licensed marriage and family therapist, licensed under Chapter 491; which also expires March 31, 2019.

3.03 Non-Licensed Mental Health and Substance Abuse Clinical Staff [Contract Provider]	**Satisfactory Compliance**
The facility 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 provider has not had any non-licensed mental health and substance clinical staff employed at the center since the agreed upon contract between the Department and Maxim Healthcare Services, Inc., on March 29, 2018, and sub-contract signed between Maxim Healthcare Services, Inc., and Camelot Community Care, Inc., on May 3, 2018. The center and service provider are not licensed under Chapter 397.

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. *Detention center superintendent has established procedures for a thorough review of preliminary screening conducted by the Office of Probation and Community Intervention.*	

Seven youth records were reviewed for mental health and substance abuse admission screenings. The seven youth records contained screenings completed by probation staff including a Positive Achievement Change Tool (PACT) assessment, Suicide Risk Screening Instrument (SRSI), and a Massachusetts Youth Screening Instrument – Version 2 (MAYSI-2). There was documentation indicating each of the screenings were reviewed by center staff in each of the seven youth records reviewed. All of the youth records contained a completed SRSI, which were completed at intake. Each of the records reviewed had a SRSI and MAYSI-2 completed within the Department's Juvenile Justice Information System (JJIS). The seven youth records had appropriate nurse and/or mental health staff required sections of SRSI completed. The records had complete entries, which included a summary and recommendations in "Screening Results" sections. In all of the records reviewed, each youth had a "yes" response of the SRSI noted on the Department form MHSA 002. Each of the youth were placed on suicide precautions and a mental health referral was completed, which documented the youth's need for an Assessment of Suicide Risk (ASR). Each of the seven screenings reviewed were completed by trained staff. The results of the PACT, SRSI, and MAYSI-2 for each of the seven records reviewed, indicated a need for further assessment, and a referral was completed. In addition, when necessary, the superintendent was notified of the findings for each of the seven records reviewed. In all seven youth records reviewed, where the PACT Mental Health and Substance Abuse Report and Referral Form indicated a need for further assessment in the suicide category, each youth was subsequently placed on suicide precautions. Each of the seven youth records reviewed had a MAYSI-2 assessment, which indicated an elevated suicide risk; each youth was placed on suicide precautions and referred for an ASR. None of the youth required a referral for a comprehensive assessment upon admission. The superintendent was interviewed and reported all mental health, substance abuse, and suicide risk screenings are completed by the intake officers, assistant detention superintendent, detention screeners, and/or mental health staff.

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.	

Seven youth records were reviewed for mental health and substance abuse evaluation referrals. Four of the seven youth records reviewed were identified with mental health and substance abuse issues after admission and were referred for a comprehensive mental health and substance abuse evaluation. Two of the four referrals were generated for the local community provider and the remaining two youth had a mental health and substance abuse evaluation completed by the detention provider. Each of the four referrals were completed within thirty days of referral. Two of the remaining three youth had previously been referred for a comprehensive

evaluation based upon an earlier admission at the center. Both these comprehensive evaluations were reviewed, and the detention provider conducted an updated mental health and substance abuse evaluation. All the identified comprehensive mental health and substance abuse evaluations were completed on a comparable, Department approved instrument. The comprehensive evaluations were administered by a licensed mental health professional. The completed comprehensive evaluations considered the following while assessing each youth: identifying youth information, reason for evaluation, relevant background information (including home environment and family functioning, history of physical abuse, sexual abuse, neglect, witnessing violence and other forms of trauma, behavioral functioning, physical health mental health and substance abuse history, and educational functioning). In addition, behavioral observations, mental status examinations, discussion of findings, diagnostic impression formulation including diagnostic statistical manual diagnoses, and recommendations. The superintendent has a written facility operating procedure which addresses practices for a thorough review of the comprehensive evaluations forwarded to the center. The process has the mental health staff review each youth's intake packet. If the initial Positive Achievement Change Tool Assessment (PACT), Suicide Risk Screening Instrument (SRSI), and/or Massachusetts Youth Screening Instrument – Version 2 (MAYSI-2) indicate the need for further assessment, the juvenile probation officer (JPO) will refer the youth for a comprehensive assessment. The mental health staff tracks the requests for comprehensive assessments and requests the assessments from the JPO by e-mail and during the weekly detention review meeting. If a comprehensive assessment has not been received within twenty-one days, a licensed mental health professional will complete the assessment themselves. The assessment will be completed within thirty calendar days of youth's arrival at the detention center.

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

Six of the seven reviewed youth records required mental health and/or substance abuse treatment. Each of the identified youth requiring treatment were assigned to a mini-treatment team, consisting of mental health clinical staff, one staff from a different service area, the youth, and, when possible, the youth's parent/guardian. Six youth were determined to need mental health treatment, each of the youth received individual, group, or family counseling, provided according to the frequency required by the youth's individual treatment plan. Two youth were determined to be in need of substance abuse treatment, each of the youth received individual, group, or family counseling provided according to frequency required by the youth's individual treatment plan. For each of the identified youth requiring mental health treatment, an Authority for Evaluation and Treatment (AET) form covering mental health was obtained. For each of the identified youth requiring substance abuse treatment, a consent and information release concerning substance abuse was obtained. Treatment notes for each of the six identified youth were documented on Department form MHSA 018. Group therapy is limited to ten or fewer youth with mental health diagnoses for mental health treatment groups. Group therapy is limited

to fifteen or fewer youth with substance abuse diagnoses for substance abuse treatment groups.

In an interview, the designated mental health clinical authority (DMHCA) reported during the weekly supervision meetings, all of the progress notes, assessments, treatment plans, treatment plan reviews, and peer reviews of youth clinical charts are discussed. The DMHCA also reviews and counter-signs and dates all work to include the comprehensive mental health assessment, initial treatment plan, individual treatment plan, and treatment plan reviews which are completed by other licensed mental health professionals. In addition, the DMHCA regularly reviews progress notes to determine if youth are progressing with their treatment and if the youth are receiving treatment based on the actual treatment plan. Each youth and his/her progress or lack of progress is discussed with the mini-treatment team weekly. Seven youth were interviewed and four youth rated the mental health and substance abuse services they have received as good and three youth responded they were not receiving mental health and substance abuse services.

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 facility. *All youth who receive mental health and/or substance abuse treatment while in a detention facility 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 facility.*	

Six of the seven reviewed youth records required a treatment plan. Each of the initial treatment plans were in place within seven days of initiation of treatment and were developed on Department form MHSA 015. All six youth had a reason for referral for treatment. The treatment plan included an initial Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) or Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis and symptoms, as well as initial treatment methods and initial treatment goals. Six of the seven youth had psychiatric services included due to being on or prescribed psychotropic medication (which included frequency of monitoring). The initial treatment plans included the signature of the licensed mental health professional (LMHP) completing the plan. In addition, the signatures of each mini-treatment team member involved in development of initial treatment plan, along with the youth's, were documented.

There were four individualized treatment plans developed out of the six initial treatment plans reviewed. Two of the six youth recently had an initial treatment plan developed and the timeframe for development of an individualized treatment plan did not fall within the required thirty-one days. The remaining four youth had an individualized treatment plan developed by the thirty-first day of the youth's admission. Each of the individual treatment plans included the signature of the LMHP completing the plan. The treatment plan included an initial DSM-IV-TR or DSM-5 diagnosis and symptoms, symptoms which were treatment-focused, treatment goals, strengths/abilities, and preferences/needs. In addition, the four youth required psychiatric services, which including psychotropic medication and frequency of monitoring and pharmacological interventions. A review of each of the youth's progress notes, validated youth received treatment services, as stipulated on each of their treatment plans. Each of the

individual treatment plans were signed and dated by the youth, licensed mental health and substance abuse professionals, treatment team members, and the parent/guardian, when possible.

There were seven individual treatment plan reviews conducted for the four applicable youth reviewed. Each of the individual treatment plans were reviewed, at a minimum, every thirty-days by treatment team. Modifications to the youth's individual treatment plans were documented on the review form and clearly identified as such. The individual treatment plan reviews were signed and dated by the clinical staff, the youth, and a LMHP. During the annual compliance review, a mini-treatment team meeting was observed. The treatment team was comprised of medical, mental health, and center staff. The treatment team members discussed and reviewed those youth who had an individual treatment plan. The four youth who currently had an individual treatment plan, each were receiving psychiatric treatment services. The youth's treatment plans included treatment and services provided by a licensed psychiatrist. These youth's treatment plan included frequency of psychotropic medication monitoring and management, and treatment recommendations.

A total of seven youth records were reviewed for mental health and substance abuse treatment discharge summaries. Each of the three applicable youth records contained a mental health and substance abuse treatment discharge summary; Department form MHSA 011. The form was completed for each youth upon the youth's transition or discharge from the center. All three mental health and substance abuse treatment discharge summaries were provided to the juvenile probation officer (JPO), youth, and parent/guardian (as allowed).

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.	

Six of the seven youth records reviewed were applicable for psychiatric services, as each of the six youth were on psychotropic medication. The center provides psychiatric services to those youth identified in need. The psychiatrist is licensed pursuant to Chapter 459, F.S., who is board certified in Child and Adolescent Psychiatry; which was verified through the Florida Department of Health and expires January 31, 2019. Youth entering the center on psychotropic medication or are referred for psychiatric interview receive an initial diagnostic interview within fourteen days of the youth's admission to the center. The initial psychiatric interviews included all required elements. An in-depth depth psychiatric evaluation was conducted for six referred youth within thirty days of admission and included all required elements. Each of the psychiatric evaluations were signed by the psychiatrist conducting the assessment. When necessary, the psychiatric evaluation included page three of the Clinical Psychotropic Progress Note (CPPN) on Department form HS 006. The center did not, however, clearly identify "Psychiatric Evaluation" on each of the assessments. Each of the six psychiatric evaluations reflected the elements specified in Administrative Rule 63N-1, F.A.C. Each of the psychiatric evaluations included telephonic contact with the youth's parent/guardian to discuss psychotropic medication issuance. Each of the psychiatric evaluations also included the signature and date of the psychiatrist conducting the assessment. All six records reviewed for issuance of psychotropic medications, contained an Authority for Evaluation and Treatment (AET). Each of the reviewed records, regardless of psychotropic medication drug dosage change, found the

parental/guardian provided verbal consent. Documentation was found on page three of the CPPN.

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

The center has a written plan detailing suicide prevention procedures. The plan includes the following: identification and assessment of youth at risk of suicide, staff training (which included at least six hours of training annually on suicide prevention and implementation of suicide precautions. Also, includes quarterly mock suicide drills for all staff who encounter youth on each shift.). In addition, the center's suicide prevention procedures include all required elements, as referenced in Administrative Rule 63N-1(2)(e)3(l). The center's written suicide prevention procedures were approved by the superintendent and designated mental health clinician authority on August 6, 2018.

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.*	

Seven youth records were reviewed for suicide prevention services. Each of the seven youth were identified to be at risk of suicide during the admission screening to the center and were placed on precautionary observation, at a minimum of, constant supervision. All seven youth had a suicide risk referral. In addition, an alert was initiated and entered into the Department's Juvenile Justice Information System (JJJIS). The Assessment of Suicide Risk (ASR) documented the time and date of the assessment in real time. Each completed ASR indicated appropriate level of supervision. A suicide precaution observation log was completed in its entirety, which also included "safe housing areas." All seven ASRs involved a licensed mental health professional (LMHP). There were no youth released prior to receiving an ASR or released while on suicide precautions. Each ASR documented the superintendent or designee was notified immediately of the youth's suicide risk. A referral was made to the LMHP for each of the seven youth and placement on precautionary observation was authorized. Each of the seven youth had an ASR completed within twenty-four hours. None of the youth reviewed were identified as being in crisis. All seven ASRs were conducted by a LMHP and completed on the Department's form MHSA 004. Each of the seven ASRs conducted were discontinued on precautionary observation and placed on standard supervision. There was evidence within the center's logbook and on the ASR where administrative or supervisory staff provided instructions related to the suicide risk assessment findings. Appropriate entries within JJIS were found for each of the seven youth, when youth were removed from precautionary observation. There were no youth requiring secure observation.

The superintendent has an established review process for every serious suicide attempt or serious self-inflicted injury (requiring hospitalization or medical attention) and a mortality review for a completed suicide. The multidisciplinary review includes all required elements.

Six of the seven interviewed youth reported they had been placed on suicide precautions while at the center. Each of the applicable youth confirmed staff watched them the whole time they were on precautions. All seven interviewed staff reported they would notify the mental health authority and provide constant sight and sound supervision if a youth expressed suicidal thoughts. Six of the seven staff also added document supervision and notify supervisor. Three staff included search the youth and his/her room for sharp objects.

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 member assigned to observe the youth must provide the appropriate level of supervision and record observations of the youth's behavior at intervals of no more than thirty minutes.	

Seven youth records were reviewed for the use of suicide precaution observation (PO) logs. There were fourteen PO logs reviewed. All fourteen PO logs where documented on Department form MHSA 006, and were maintained for the duration the youth was on suicide precautions. Each of the fourteen PO logs documented the appropriate level of supervision and observations of the youth's behavior were documented in real time and did not exceed thirty-minute intervals. There were no warning signs observed. All fourteen suicide PO logs included safe housing requirements and were reviewed and signed by each shift supervisor and the licensed mental health professional. Five youth who had been placed on suicide precautions were interviewed and reported staff stayed with them at all times.

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.	

Seven staff training records were reviewed for completion of suicide prevention training. All seven staff received a minimum of six hours annual suicide prevention and implementation of suicide precautions training. Training consisted of two hours of training in the Department's Learning Management System (SkillPro) and four hours of instructor-led training.

The center completed twenty-eight mock suicide drills. The center met the minimum requirement and conducted one mock suicide drill for each quarter, on each shift, with each containing the required elements of a mock suicide drill. All forty-nine applicable staff participated in a mock suicide drill in the past six months. The center did not have a process in place for any staff who were not present during a quarterly mock suicide drill, which would afford them to have an opportunity to review each drill completed. The center will incorporate a review process for staff who were not present during a mock suicide drill. The process will be: All staff moving forward will review drills during briefing, if they were unable to participate in any drills. Six of the seven interviewed staff reported the suicide response kits are maintained in master control, five staff also included medical and on each of the mods, and two staff replied in the shift supervisor's office.

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

The center has a written mental health crisis intervention plan which details crisis intervention procedures. The written mental health crisis intervention plan includes the following procedures: notification and alert system, means of referral (which includes self-referral), communication, supervision, documentation, and review process. The center's written mental health crisis intervention plan was approved by the superintendent and designated mental health clinician authority on August 6, 2018.

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 facility, requires emergency care provided in accordance with the facility's emergency care plan. The Crisis Intervention Plan and Emergency Care Plan may be combined into an integrated Crisis Intervention and Emergency Services Plan which contains all the elements specified in Rule 63N-1, Florida Administrative Code.	

The center has a written emergency care plan which includes all required elements as specified in Rule 63N-1, F.A.C. The center's written emergency care plan was last updated and approved by the superintendent and designated mental health clinician authority on August 6, 2018. The written emergency care plan is located in the superintendent's office, on the center's K drive, and in the briefing room, and is accessible to all staff.

3.15 Crisis Assessments [Contract Provider] (Critical)	Satisfactory Compliance
A Crisis Assessment is a detailed evaluation of a youth demonstrating acute psychological distress (e.g., anxiety, fear, panic, paranoia, agitation, impulsivity, rage) conducted by a licensed mental health professional, or under the direct supervision of a licensed mental health professional, 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 had only one example of a youth requiring a crisis assessment during the annual compliance review period. The youth was administered a crisis assessment, which was completed on the Department's form MHSA 023, in the Office of Health Services (OHS) electronic medical records system. A mental health alert was entered into the Department's Juvenile Justice Information System (JJIS) for the youth requiring a crisis assessment. The crisis assessment was conducted by a licensed mental health professional and included all of the required elements. The center has an agreement with Lakeview Crisis Stabilization Unit and

Baptist Hospital, both located in Pensacola, Florida to provide mental health stabilization for youth.

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

The center had one example of a youth requiring a Baker Act and no youth requiring a Marchman Act during the annual compliance review period. Administrative staff were notified and involved when the Baker Act was utilized. Parents/guardians of the youth, along with the assigned juvenile probation officer (JPO), were also notified when the youth had an emergency. Upon return from the Baker Act facility, the youth was placed on constant supervision. A mental status examination was conducted by the center's licensed mental health professional. The youth was maintained on a minimum of constant supervision until properly transitioned to a lower level of supervision. The youth's supervision level was not lowered until the appropriate assessment was completed by the licensed mental health professional, who conferred with the superintendent. The applicable mental health alert was entered into the Department's Juvenile Justice Information System (JJIS). A review of the Baker Act documentation and the center's written facility operating procedures (FOP) demonstrated the center followed the proper procedures.

Standard 4: Health Services

Overview

The Department has a contract with Maxim Healthcare Services to provide medical services at the center. The center has an institutional pharmacy permit. Maxim Healthcare employs a medical doctor (MD) who serves as the designated health authority (DHA). The DHA is on-site once a week, for approximately two to four hours. The DHA also has a designee which is the advanced registered nurse practitioner (ARNP). The ARNP is on-site twice a week for approximately ten hours each visit. Medical services are provided seven days a week by the full-time registered nurse (RN), two licensed practical nurses (LPN), and a full-time medical clerk. The medical staff offers sick calls seven days a week to youth and other medical services as outlined in the contract.

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 facility.	

The center has a licensed physician who serves as the designated health authority (DHA). The DHA holds an unrestricted license and meets all of the requirements for independent and unsupervised practice in the state of Florida. A review of the sign-in logs confirmed the DHA is on-site two to four hours a week and is on-call twenty-four hours a day, seven days a week, when needed. The contract provider provides medical coverage when the DHA is on vacation or other scheduled absences. A review of the licenses for each medical staff was conducted, which include the DHA, advanced registered nurse practitioner (ARNP), registered nurse (RN) and the two licensed practical nurses (LPN) are all current. The DHA's interview explained the DHA's role is to oversee the clinic designee, perform clinical physical assessments, conduct periodic evaluations, create treatment plans, and approve medical facility operating procedures.

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

The center has facility operating procedures (FOP) for all health-related procedures utilized at the center. A review of the center's health-related policies, procedures, and treatment protocols found they properly outline the center's health care services. There designated health authority and superintendent signed and dated all treatment protocols with a revision date of July 5, 2018. Nursing staff also reviewed, signed, and dated the cover page on which all FOPs, treatment protocols, and other procedures were listed.

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.	

A review of seven youth individual healthcare records (IHCR) revealed each youth had a current Authority for Evaluation and Treatment (AET) filed. The IHCRs had either the original version or a copy of the AET with the word 'copy' stamped on the front. All AETs were obtained by the center before any medical services were provided.

4.04 Parental Notification [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.	

A review of seven individual healthcare records found four records were applicable for parental notifications. Parental notifications were sent out in three records for over-the-counter medications not covered in the Authorization for Evaluation and Treatment (AET) forms, significant changes to existing medications, off-site emergency care, hospitalizations, and off-site medical treatment. Notifications were made by telephone and witnessed. One record had parental notifications included even though there were no prescription changes or medical care conducted to require a notification. Written parental notices were sent out regardless of telephone notifications, and verbal notifications were followed-up with written parental notification to sign and return for all new medications given to youth. An interview with the registered nurse (RN) revealed parental notifications are ensured in the timely requirement by documenting contact in real time, communication with clinic staff, and keeping a "call back" log if unable to reach parents/guardians. The RN also reported both written and verbal parental notification is required when starting new medications, discontinuation of medication, youth injury or illness, and off-site care.

4.05 Notification – Clinical Psychotropic Progress Note (CPPN) [Contract Provider]	Satisfactory Compliance
The Department's requirement to inform the parent or guardian and obtain consent for the prescription of new psychotropic medications, discontinuances or psychotropic medication adjustments.	

A review of seven individual healthcare records found two were applicable for notification and consent for psychotropic medications. There was documentation of notification being sent by mail, to include the Clinical Psychotropic Progress Notes (CPPN) and explanatory information for initiation of psychotropic medication. Each CPPN was accompanied by a cover letter which was returned by the parent/guardian and was found in each of the youth's records.

4.06 Immunizations [Contract Provider]	Satisfactory Compliance
Each youth's immunization history and status shall be verified to meet state and Department requirements, and subsequently provide necessary immunizations/vaccinations (with parent/guardian consent).	

A review of seven youth individual healthcare records (IHCR) revealed each youth had up-to-date immunizations. Each of the youth's immunization records were pulled from the Florida Shots website. All immunizations were documented in the IHCR and did not require any other parental consent. An interview with the registered nurse (RN) confirmed the process of obtaining the immunization records.

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

A review of seven individual healthcare records found each youth received a healthcare admission screening which was entered in the Department's Juvenile Justice Information System (JJIS) on the date of admission. One youth record included a healthcare admission screening completed while JJIS was down, so the form did not have a date, but a print out of the form completed in JJIS included the date of admission. Each of the seven screenings were completed by a detention officer and six were reviewed with the youth by a licensed practical nurse or higher within twenty-four hours. The record of the admission while JJIS was down, had an admission date of July 27, 2018, with a review on September 11, 2018. An interview with the registered nurse (RN) confirmed youth are seen six to eight hours after admission, direct care staff complete the admission screening, and the review of the screening packets are reviewed and signed on the bottom, right corner of the form.

4.08 Medical Alerts [Contract Provider]	Satisfactory Compliance
The Department's requirement to alert staff of medical issues that may affect the security and safety of the youth in the facility.	

Seven youth individual health care records (IHCRs) were reviewed for medical alerts. All IHCRs had applicable characteristics for medical alerts which were entered into the Department's Juvenile Justice Information System (JJIS). Three youth had allergies, six had medication interactions, three youth had notes entered for chronic conditions, one youth had a physical impairment, and all seven had a medication side effect. The center has a Facility Operating Procedure (FOP) for identifying, notifying, and tracking youth who have an identified medical condition warranting notification. Seven staff were interviewed regarding notification of youth's medical alerts and all seven staff noted they were made aware of alerts from the alert form and shift meetings. Two staff responded they were made aware of alerts through logbook and other resources such as JJIS or staff meetings. One staff mentioned the alert board as a method for getting alerts.

4.09 Suicide Risk Screening Instrument [Contract Provider]	Non-Applicable
A Suicide Risk Screening Instrument shall be completed within twenty-four hours of admission and filed in the Individual Health Care Record.	

This indicator is considered non-applicable as the mental health staff review all Suicide Risk Screening Instruments.

4.10 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 facility.	

Seven youth individual health care records (IHCRs) were reviewed for youth orientation to healthcare services. Six of the seven reviewed IHCRs documented the youth had an orientation completed within twenty-four hours of admission. The remaining record had a date of admission for July 18, 2018, and the healthcare orientation was documented for July 22, 2018. Each of the youth's orientation to health care services included the sick call process, what constitutes an emergency, how medications are administered, notifying staff immediately if they are having side effects from medications, notifying staff about allergies and/or medical alert issues, notify staff of any chest pain, extreme shortness of breath, faintness while exercising, right to refuse care, what to do in the case of a sexual assault or attempted sexual assault, non-disciplinary role of the healthcare provider, and situations in which the healthcare staff shall notify security/facility administration.

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

Seven youth individual healthcare records were reviewed for notification of the designated health authority (DHA). The DHA was notified in all seven records and the twelve-hour notification to the DHA was in all four of the applicable records. Each of the four youth were referred to the DHA due to having known or suspected chronic conditions not requiring emergency treatment upon admission or were taking psychotropic medications. DHA notifications were documented within the youth's healthcare record under the chronological progress notes. An interview with the registered nurse (RN) revealed the DHA is notified by telephone within twenty-four hours of admission by the RN or license practical nurses (LPN) when a youth has a serious illness or chronic condition. The RN also reported DHA referrals are documented on the sick call forms, episodic care forms, emergency care notes, admission progress notes, and screening forms.

4.12 Healthcare Admission Rescreening [Contract Provider]	Satisfactory Compliance
A Healthcare Admission Rescreening is to be completed each time the physical custody of the youth changes and they are subsequently returned or readmitted to the facility.	

None of the seven records reviewed were applicable for a healthcare admission rescreening; however, the center provided the only two additional youth records applicable for healthcare rescreenings for review. The screenings were conducted by a juvenile justice detention officer and reviewed by licensed practical nurse or higher within twenty-four hours. Youth moving

between detention centers with an anticipated stay of twenty-four hours or more only require the medical and mental health admission screening to be completed again. The health-related history, comprehensive physical assessment, and other admission process screenings conducted by nursing/medical staff are not required when moving between centers.

4.13 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 a DJJ facility.	

A review of seven individual healthcare records found each contained an updated Health Related History (HRH) form which was completed within seven days of admission by a licensed nurse and reviewed by the designated health authority. Each HRH form was completed before, or at the same time as, the comprehensive physical assessment.

4.14 Comprehensive Physical Assessment [Contract Provider]	Satisfactory Compliance
The Comprehensive Physical Assessment (CPA) form shall be completed for all youth admitted in-to the physical custody of a DJJ facility.	

A review of seven individual healthcare records (IHCR) found six contained a current comprehensive physical assessment (CPA) completed within seven days of admission. The remaining record had a CPA completed nine days after admission. All seven of the CPAs were completed by the advanced registered nurse practitioner (ARNP). Five of the seven youth received a medical grade between two and five and were placed on the center's alert system. There was documentation in each of the IHCRs of the youth refusing the genital and gynecological exam portion of the CPA. The Department's Problem List was updated for each youth.

4.15 Female-Specific Screening/Examination [Contract Provider]	Satisfactory Compliance
The Department requires all adolescent girls receive gender-appropriate screenings, examinations, and tests to address their unique needs.	

Two of the seven individual healthcare records (IHCR) were applicable for female screenings and examinations. There was documentation indicating both youth provided verbal consent for qualitative urine pregnancy screenings. There was documentation which showed both youth were offered a gynecological examination. One youth accepted the gynecological exam done. An interview with medical staff revealed the gynecological exam is a standing order with the designated health authority. In interviews with youth, the two non-pregnant females reported they have not received prenatal, obstetrical, or gynecological services while at the center.

4.16 Tuberculosis Screening [Contract Provider]	Satisfactory Compliance
All youth are required to be screened for Tuberculosis (TB), and accurate documentation of results shall be maintained by each facility.	

A review of seven individual healthcare records found each youth had one verified tuberculosis screening test (TST) documented. Each of the youth received a Tier I tuberculosis test within seventy-two hours of admission. None of the youth needed further evaluation. The registered

nurse interview revealed youth are given a tuberculosis (TB) test within seven days of admission if there has not been a TB test documented within the last year.

4.17 Sexually Transmitted Infection Screening [Contract Provider]	Satisfactory Compliance
The facility shall ensure all youth are evaluated and treated (if necessary) for sexually transmitted infections (STIs).	

All seven youth records reviewed contained a sexually transmitted infection (STI) screening form and six of the seven youth reviewed admitted to being sexually active. One of the two female youth agreed to a gynecological evaluation on August 26, 2018 but had not had the exam at the time of the annual compliance review. Four of the seven youth consented to having STI testing done. All lab results for infectious and communicable disease were found in the lab results section of the individual healthcare record (IHCR). An interview with the registered nurse (RN) confirmed the STI screening forms are completed during intake, the youth's consent generates a referral to the designated health authority (DHA), and everything is documented on the STI and Health Related History forms.

4.18 HIV Testing [Contract Provider]	Satisfactory Compliance
The facility shall routinely offer counseling, testing, and referrals for medical treatment to all youth at risk for HIV infection.	

A review of seven youth individual healthcare records (IHCR) revealed each youth was offered counseling, testing, and a treatment for human immunodeficiency virus (HIV). Four of the seven youth records had documentation of consent for HIV testing. Pre- and post-test counseling was noted in two of the four youth who consented to testing. One of the four youth was on confinement when the HIV testing was conducted and was unable to be tested and another youth initially declined testing, so testing had not been done at the time of the review, from the youth's consent. An interview with healthcare staff revealed a person from the HIV/AIDS Foundation with the Department of Health conducts the testing and does pre- and post-counseling with the youth while waiting on the results. The three applicable records with HIV results were found in the IHCR in a sealed envelope, marked confidential. All seven interviewed youth reported they could ask to be tested for HIV/AIDS.

4.19 Sick Call Process – Requests/Complaints [Detention Staff/Contract Provider]	Satisfactory Compliance
All youth in the facility shall be able to make Sick Call requests and have their complaints treated appropriately through the Sick Call system.	

The center has a written policy and procedures for conducting sick calls. Three of the seven youth records reviewed had sick calls documented in the individual healthcare records (IHCR). There was no documentation of a youth presenting a similar sick call complaint three or more times within a two-week period or a complaint of any severe pains with which staff were unfamiliar in any of the seven records reviewed. Seven youth were interviewed as to how long the youth is seen when making a sick call. One youth reported immediately, four youth reported within one day, and two youth reported within two days.

4.20 Sick Call Process – Visits/Encounters [Contract Provider]	Satisfactory Compliance
The facility shall respond appropriately, in a timely manner, and document all Sick Call encounters as required by the Department.	

Licensed healthcare staff are the only staff responsible for conducting sick call. An interview with medical staff revealed the registered nurse (RN) usually handles sick calls for the morning, both RNs and license practical nurses (LPN) during the afternoon, and the LPN does sick calls in the evening and on weekends. Sick calls are usually conducted twice a day, Monday through Friday and on weekends. Each sick call reviewed by the RN was found documented on the individual healthcare record (IHCR) sick call index, progress notes, and sick call log book; however, one youth had a sick call not recorded on the sick call log book. This was due to the log sheet being printed before the late sick call. Youth signatures, showing their sick call was resolved, were found on the sick call log book. A sick call was observed during the annual compliance review. The youth placed the sick call at the morning medication pass at 8:00 a.m. and was seen around 11:00 a.m. The youth was escorted to the medical treatment room, to ensure privacy, by detention staff and stood outside the medical room while maintaining a visual of the youth. All vital signs, treatment, education and follow-up plans were documented, as required. Seven staff and youth were interviewed regarding who performs sick calls and all seven staff and youth reported the nurse. One youth reported a doctor as someone who will conduct sick calls.

4.21 Restricted Housing [Contract Provider]	Satisfactory Compliance
All youth in Restricted Housing/Confinement shall have timely access to medical care, as required by the Department.	

The center has a policy and procedures concerning restricted housing. A review of seven individual healthcare records (IHCR) found none of the records were applicable for detailed narratives entries in the IHCR. An interview with the nurse revealed youth are not usually held in restricted housing over twenty-four hours, which would require restricted housing documentation. A review of confinements during the annual compliance review period confirmed none were over twenty-four hours. An observation of the nurse visiting confined youth was made during the annual compliance review. The nurse provided medication to the youth in confinement and asked all youth if they had any health-related complaints. An interview with the registered nurse (RN) revealed the youth will initial all documents related to their medication administration after being released from confinement due to the youth not being allowed a pen.

4.22 Episodic/First Aid Care [Contract Provider]	Satisfactory Compliance
The facility shall have a comprehensive process for the provision of Episodic Care and First Aid.	

Three of the seven youth records reviewed were applicable for receiving episodic or first aid care. All three records included the date and time of episodic care, nature of the complaint, findings of person rendering care, and treatment rendered. Further information was documented, when applicable, in the progress notes including referral to off-site care, education/instruction to youth, plans for follow-up/future care, alert list updated, parental notification, and name, signature, and credentials of staff providing care. One youth was listed in the facility episodic care log book. In an interview with medical staff, the youth were not logged in the log book due to their conditions being resolved. Interview with the registered nurse

reported there are twelve first aid kits in the center and in each vehicle. Each first aid kit was found to be fully stocked with approved contents and inspected monthly.

4.23 Emergency Care [Contract Provider]	Satisfactory Compliance
The facility shall have established processes and procedures for either directly providing Emergency Care or facilitating an appropriate response to an emergency situation.	

A review of three pre-service and seven in-service staff training records found each staff had current certifications in first aid and basic cardiopulmonary resuscitation (CPR) with automated external defibrillator (AED) training. Each staff also received training in the use of an EpiPen auto injector. There was documentation of all licensed healthcare staff having current certifications in basic CPR with AED training. The center's AED is located in the main hall of the center which is accessible to all staff. Observations of the AED with the nurse was conducted during the annual compliance review. The AED is housed in a secure container with the instruction manual included and all months are listed for inspection with the registered nurse's (RN) initials. The RN conducted a self-test of the AED. The batteries were installed January 2018 and expire February 2023. The AED pads were installed January 2018 and expire May 2019. Both the batteries and pads were last re-installed September 4, 2018. A review of medical drills revealed medical drills were documented for every month, on every shift, through May 30, 2018. In reviewing the drills labelled 'medical,' there was no indication CPR or AED was used. It was determined which CPR/AED practices were conducted during the suicide drills, once every quarter with every shift. A drill was complete during the annual compliance review using CPR/AED to fulfill the quarterly requirement on every shift. An interview with the RN revealed a youth is placed on the off-site log and on the medical board for tracking. The DHA is contacted once a youth returns from the hospital or off-site appointment to obtain orders for discharge instructions. Seven youth were interviewed on how they would rate the medical care at the center. Two youth reported fair, two reported good, three reported very good. Staff were interviewed and asked if they felt they were able to call 9-1-1, if necessary, with all yes responses.

4.24 Off-Site Care/Referrals [Contract Provider]	Satisfactory Compliance
The facility 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.	

One of the seven youth records was applicable for off-site care or referrals. This record was the only record applicable for off-site care since the last annual compliance review. The Summary of Off-Site Care form was found in the youth's record. The was documentation of the designated health authority (DHA) being notified, reviewing, and signing/initialing all off-site care findings, instructions, and information. The youth did require follow-up for the off-site visit, a referral was entered, and there was evidence the referrals were tracked and youth received appropriate, timely follow-up care.

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

Six of the seven youth records reviewed were applicable for chronic conditions and evaluations. Each of the youth had a chronic condition and/or were receiving prescribed medication. Five of the youth were classified with a medical grade of two through five. Six of the youth were marked as chronic condition due to psychotropic medications and required evaluations. Three youth with chronic conditions only were placed on the chronic conditions list. All six youth received the required periodic evaluations. Interview with the registered nurse (RN) revealed the center monitors youth with chronic conditions with the chronic health conditions roster and chronic care tracking board.

4.26 Medication Management – Verification [Contract Provider]	Satisfactory Compliance
A youth's medication regimen shall be ascertained upon admission to the facility.	

Six of the seven youth reviewed were applicable for medication management. There was documentation in the youth records of licensed healthcare staff attempting to contact the community provider to determine the effectiveness of the current prescribed medication. There was documentation of the licensed nurse obtaining orders from the designated health authority (DHA) to resume current medications for youth. Interview with the registered nurse (RN) revealed medications are verified for youth upon admission by prescription labels and pharmacy.

4.27 Medication Management – Orders/Prescriptions [Contract Provider]	Satisfactory Compliance
All medications shall have a current, valid order and are given pursuant to a current prescription or Practitioner Order.	

All seven youth were applicable for medication management. A review of each youth's Medication Administration Record (MAR) found the MARs matched the medication list for youth who were taking medication at admission. All of the medications had a current, valid order and were given pursuant to a current prescription. There was documentation in the four applicable records of the designated health authority (DHA) reviewing the medications which were continued, discontinued, changed, or having new medications ordered. Three youth records included practitioner's orders or approved protocol for over-the-counter (OTC) medications not listed on the Authorization for Evaluation and Treatment (AET) form.

4.28 Medication Management – Storage [Contract Provider]	Satisfactory Compliance
All medications (e.g., prescriptions, over-the-counter, topical) are stored in separate, secure (locked) areas inaccessible to youth.	

A review of the medical department revealed each medication was identified and secured in a locked area designated for the storage of medications. All non-controlled medications are stored in a separate, secure, locked area inaccessible to youth. Medical staff and supervisors are the only staff which have access to the clinic and medication storage area. There are separate storage areas for different medication types: refrigerated medications are in a location separate

from food storage, non-controlled prescription medication, over-the-counter (OTC) medications, controlled medications (Narcotic, Psychotropic), secure storage of sharps, and clearly marked youth-specific sections. The center has a process for the destruction and disposal of expired or discontinued medications and bio-hazardous waste. There are no OTC medications stored on any of the living units or master control.

4.29 Medication Management – Medication and Sharps Inventory [Contract Provider]	Satisfactory Compliance
All medications and sharps shall be inventoried, as per Department requirements.	

The center keeps a perpetual inventory of all medications, as well as a weekly inventory of all sharps, prescribed medications, and over the counter (OTC) medications. An observation of a random selection of three different sharps, prescribed medications, and OTC medications was conducted to determine if counts and inventories matched. Each physical inventory was found to match the written inventory with no discrepancies. A review of the past six months of inventories also found no discrepancies.

4.30 Medication Management – Controlled Medications [Contract Provider]	Satisfactory Compliance
All controlled substances shall be inventoried, stored, and documented, as per Board of Pharmacy and Department requirements.	

All of the narcotics and other controlled medications were found to be stored in a medical cart behind two locks in the secure clinic. There was documentation of shift-to-shift counts conducted for all controlled substances. An interview with the registered nurse revealed controlled medications are counted four times a day. Each administered dosage was documented on the youth's individualized controlled medication inventory records received from the pharmacy. A random selection of three different controlled medications was conducted. All of the counts and inventories matched with no discrepancies.

4.31 Medication Management – Medication Administration Record [Contract Provider]	Satisfactory Compliance
The standard Department Medication Administration Record (MAR) shall be maintained at the facility for each youth who has a current, valid medication order.	

All seven individual healthcare records (IHCR) contained a Medication Administration Record (MAR). The MAR contained all of the required elements to include the youth's name, Department identification number, date of birth, allergies, precautions, medical grade, medical alerts, and a current picture of youth. A review of the MARs found documentation of medication start and stop dates. There was documentation of youth, as well as staff, initialing each administered medication entry on the MAR.

4.32 Medication Management – Medication Administration by Licensed Staff [Contract Provider]	Satisfactory Compliance
Medication Administration shall occur as scheduled in a comprehensive, accurate, and organized manner in the facility, only by a licensed nurse.	

A medication pass was observed during the annual compliance review. The working space where medication was distributed was found to be clean and organized. The youth were

escorted by detention staff to the clinic and approached the clinic door one by one. Youth stated their last name, first name, and date of birth. The medication was not pre-poured from original packaging and placed in another container prior to administration. One of the youth was observed to have parenteral medications and pricked his finger to test his blood sugar. The nurse gave the youth some water and the medications. The nurse checked to see if the youth swallowed the medication. Both the nurse and the youth would initial their medication administration record (MAR). Side effects were listed on the MAR. Youth and staff initialed when receiving meds. Refusals were clearly marked on the MAR.

4.33 Medication Management – Medication Provided by Non-Licensed Staff [Detention Staff/Contract Provider]	**Satisfactory Compliance**
Trained, non-healthcare staff may assist youth with self-administration of oral prescription medications or over-the-counter (OTC) medications, only when licensed nurses are not available on site. The nurse shall delegate the delivery, supervision, and oversight of youth during self-administration of medications.	

The center only allows trained non-healthcare staff to deliver medications to youth when licensed nurses are not on-site to administer oral prescription medications or over-the-counter (OTC) medications. The center has trained non-healthcare staff to only assist youth with the self-administration of oral prescribed medication(s). There was no observation of non-licensed healthcare staff administering medications. A review of the center's facility operating procedures (FOP) identified practices for non-licensed healthcare staff to administer medications. Staff and youth initialed, indicating the youth was seen.

4.34 Medication Management – Psychotropic Medication Monitoring [Contract Provider]	**Satisfactory Compliance**
The facility shall have a comprehensive process in place for the monitoring of psychotropic medications, to ensure youths' safety and as required by the Department.	

Six of the seven reviewed youth records indicated the youth was taking psychotropic medication. Each youth received an initial diagnostic psychiatric interview within fourteen days of admission. There was documentation of monitoring/review every thirty days by a psychiatrist for each of the youth receiving psychotropic medication, which contained all required information. An interview with the medical clerk revealed there were no standing orders for psychotropic medications, no emergency treatment orders for psychotropic medication, and no as-needed PRN orders for psychotropic medications. All applicable youth received an in-depth psychiatric evaluation or updated psychiatric evaluation within thirty days.

4.35 Infection Control – Surveillance, Screening, and Management [Contract Provider]	**Satisfactory Compliance**
The facility 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 center has an infection control policy and procedures which includes prevention, containment, treatment, and reporting requirements for several types and categories of diseases. These diseases include common infectious diseases of childhood, self-limiting episodic contagious illnesses, viral or bacterial infectious diseases tuberculosis, hepatitis (A, B, C), HIV, infectious diseases caused by blood borne pathogens, other outbreaks or epidemics caused by any other infectious agent, whether spread directly or indirectly, outbreaks of

pediculosis (lice) and/or scabies, methicillin-resistant staphylococcus aureus (MRSA) and other emerging antibiotic-resistant micro-organisms, food-borne illnesses such as those cause by E. Coli, bio-terrorist agents (e.g., anthrax, small pox), and chemical exposures in the workplace. There were not any instances in which the local county health department, Centers for Disease Control and Prevention, and/or the Central Communications Center (CCC) should have been notified of an infectious disease. Interview with the registered nurse (RN) revealed the Hepatitis B Immunization is available to staff.

4.36 Infection Control – Education [Contract Provider]	Satisfactory Compliance
The facility's comprehensive Infection Control education plan shall include pre-service and in-service training for all staff, and youth infection control education, as per Centers for Disease Control and Prevention (CDC) guidelines.	

Each of the seven reviewed youth records indicated each of the youth received infection control training within seven days of admission. A review of pre-service and in-service training records revealed staff received training regarding infection control. Interview with the registered nurse (RN) reported the clinic manager conducts infection control training to staff.

4.37 Infection Control – Exposure Control Plan [Contract Provider]	Satisfactory Compliance
The facility's exposure control plan shall meet the requirements of OSHA standards (29 CFR 1910), with maintenance and documentation of the plan, as per the requirements of the Department.	

A review of the exposure control plan revealed it was written in accordance with OSHA standards. The plan included risk assessments and methods of compliance. The plan was reviewed and signed annually by the superintendent or designee. Interview with the registered nurse (RN) revealed the exposure control plan is located in the medical clinic.

4.38 Prenatal Care – Physical Care of Pregnant Youth [Contract Provider]	Satisfactory Compliance
The facility shall provide prenatal care at recommended intervals. High-risk pregnant youth will be provided additional testing and services, as recommended.	

None of the selected youth records were applicable for this indicator. One applicable youth was reviewed. According to an interview with the medical clerk, prenatal care begins immediately upon determination of the youth's pregnancy. There was documentation of daily monitoring for danger signs of pregnancy complications. There was also a documented plan for post-birth psychological and physical care.

4.39 Prenatal Care – Nutrition and Education of Youth [Contract Provider]	Satisfactory Compliance
The facility shall provide nutritious foods in sufficient quantities meeting the standards of the minimum daily allowances for pregnant youth. Each pregnant adolescent shall receive prenatal, postpartum, and parenting education including topics directly related to healthcare issues and medical risk for pregnant adolescents.	

The two selected youth, who were females, were interviewed and stated they have received prenatal, obstetrical, or gynecological services, when needed, at the center. There was

documentation in each of their records indicating the licensed healthcare staff provided routine monitoring of the youth's nutritional and weight status weekly. Each pregnant youth receives education on the topics including alcohol and drug usage, smoking, nutrition, sexually transmitted diseases, contraception, prenatal care, birthing process, postpartum care, basic baby care (feeding, diapering, bathing), child/infant development, and parenting skills.

4.40 Prenatal Staff Education [Contract Provider]	Satisfactory Compliance
All non-healthcare staff involved in the supervision or treatment of pregnant youth shall receive appropriate education.	

A review of seven staff training records to include pre-service and in-service training revealed each staff received education on female healthcare by a licensed nurse. The in-service training included training on monitoring, observation, and emergency care of pregnant youth.

Standard 5: Safety and Security

Overview

The center is a sixty bed, hardware secure facility which provides supervision of youth twenty-four hours a day, seven days a week who are detained pending adjudication, disposition, or placement in a commitment program. Ten-minute checks are conducted visually, documented on paper, and with an electronic wand system. The center has a total of fifty-five cameras which are all in working order. The center maintains four vehicles which are utilized for the transportation of youth. All staff and youth movement is monitored and authorized by the master control operator. The master control operator is also responsible for the securing and issuance of keys and radios, maintains a logbook in order to document movement and other pertinent issues which occur during the day-today operations of the center. Staff participate in a variety of drills to include escape, fire, and Continuity of Operation Plan (COOP), medical and mental health drills. Drills are facilitated by supervisory staff.

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 facility 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 facility to another in accordance with Florida Administrative Code.*	

The center has a written policy and procedures addressing the safety of staff and youth at the center. Observations each day of the annual compliance review revealed staff were aware of the location of the youth assigned to them at all times. On the first day of the annual compliance review, youth were observed in the classroom, during line movements to and from the gymnasium, and in the cafeteria during lunch. During the second day of the annual compliance review, youth were observed during the lunch meal. On the third day, youth were observed on the modules. On the fourth day of the annual compliance review, youth were again observed on the modules. Youth movement was also observed in master control on video surveillance and the master control operator authorized all movement of youth. At no time during the annual compliance review did youth movement occur until cleared by master control. A review of the logbooks revealed documentation of all movement. Seven staff were interviewed and reported counts were conducted at the following times: any time there is movement, beginning of shift, middle of shift, end of shift, three times a day, and in an emergency situation. Further, six of

seven staff members reported they felt there have been 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 real-time observation 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 addressing room check and supervision levels. The center has a fifty-five video surveillance cameras which were all operational at the time of the annual compliance review. Video surveillance footage is stored for thirty days. Ten minute checks from three different days, on each of the three shifts were reviewed. Ten-minute checks were observed being conducted in the required frequency and in real time. Staff members were observed stopping and looking in each youth room while conducting checks. Staff utilize an electronic room check system (security check wand) during the night hours and use a written ten-minute observation sheet during the day. All seven interviewed staff reported room checks are conducted every ten minutes.

5.03 Census, Counts, and Tracking	Satisfactory Compliance

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

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

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

The center has a written policy and procedures addressing head counts. According to the written policy and procedures, head counts are taken, called into master control, and documented, at a minimum, at the beginning and ending of each shift, any emergency to

include power outages, evacuations, code called outside the secure walls, prior to routine movements, population changes, and at least once, randomly on each shift. A review of master control logbooks and module logbooks for the previous six months revealed counts were conducted, as required. Seven staff were interviewed and reported counts were conducted at the following times: any time there is movement, beginning of shift, middle of shift, end of shift, three times a day, and in an emergency situation.

5.04 Logbook Maintenance	Satisfactory Compliance
The program 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 program maintains a chronological record of events, incidents, and activities in logbooks. The center has separate logbooks in master control, each living unit, visitors, and contracted staff. A review of the logbooks for the previous six months was conducted during the annual compliance review. Logbooks are bound with numbered pages and dates are documented at the top of each page. All observed entries were made in real time; no military time was used. Each entry had the staff's name, youth involved, a brief description of events, and the initials of the staff making the entry. Alerts were observed to be documented and highlighted in the logbooks. Errors were struck through with a single line, dated and initialed by the person correcting it. The logbooks were observed to include all required information. The center does not utilize an electronic logbook.

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 to ensure logbooks are maintained to document all events which occur at the center in the event other sources of information are lost or destroyed. A review of the center's logbooks for the previous six months revealed the

superintendent or designee reviews all logbooks on a weekly basis and the juvenile justice detention center officer supervisor (JJDO) reviews the logbook maintained in master control when assuming center responsibility. Additionally, the JJDOS reviews the logbooks in each living area daily. The juvenile justice detention officer (JJDO) reviews the logbook maintained in the living areas when accepting responsibility for living area at shift change. Documentation further revealed the superintendent or assistant superintendent tour the youth living area at least once during each shift and documents their visit in each area's logbook. According to the superintendent interview, management reviews the logbooks multiple times a week.

5.06 Key Control	Satisfactory Compliance
Each facility 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 2016-2017 Detention indicators.)*	

The center has a written policy and procedures to ensure the proper usage, storage, and general security of any center key is maintained in the facility. Facility keys were observed to be secured and maintained in a secure metal storage box station in master control. All keys were secured in an area inaccessible from all youths. Each key ring was identified to the number of keys on the ring. The keys also matched the key log in master control. All visitor keys and staff personal keys were also secured within master control on a separate board. The master control operator provides the staff their personal keys upon leaving the facility for lunch or at the end of the shift. The master control operator also signs all staff keys and radios back in at the end of the shift. Keys inventories were reviewed and observed to be completed as required. Seven staff were interviewed and asked to explain the facility daily process for tracking keys. Seven staff members reported the keys were issued by master control at the beginning of each shift. Once the shift is done, all keys will be returned, and all staff are responsible for turning their keys into master control. The center has not had any reports of lost or missing keys for the past six months, this was confirmed by the superintendent and a review of the logbook and incident reports. Further, each of the seven staff were able to identify different types of restricted keys. According to the superintendent interview, permanent keys are issues to the superintendent, assistant superintendent, staff assistants, maintenance, food service, and the facility training coordinator.

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

The center ensures any vehicle used by the program to transport youth is properly maintained and maintains documentation on the use and maintenance of each vehicle. No youth or staff are permitted to use tobacco products. Center vehicles are locked when not in use. The center has four vehicles which are used for transportation. All four vehicles were secured when not in use, all seat belts were in working condition, and no contraband was found in the vehicles. All vehicles were checked and had all required equipment, including fire extinguishers, window punch, and seat belt cutter. All vehicles were equipped with emergency road side equipment and flash lights which were all working properly. Youth transport was observed during the annual compliance review. There were two officers at all times when transporting youths, one driver and one staff riding in the back of the vehicle with the youth for safety and security purposes. All vehicle logbooks and keys are checked out in master control, along with a cell phone. A vehicle inspection was observed to be completed prior to the transport, all youth were searched before entering the vehicle and after the transport. Staff were observed searching the vehicle for contraband prior to the transport as required. The transporters and youth were secured in their seat belt before departing the facility and called into master control prior to departure. All weekly vehicle checklists were in compliance and completed for the past six months, vehicle inspection reports were in compliance for the last six months. Documentation further revealed the annual maintenance inspections have been completed as required.

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

The center has a written policy and procedures for tool inventory and tool management. The center ensures all tools and equipment related to maintenance are properly maintained, stored, and inventoried. The center's perpetual tool inventory was reviewed and completed, as required. Documentation revealed the inventory was conducted monthly and signed by the maintenance staff, along with the superintendent. No tools were missing from the inventory form. The tools were all marked as property of the Department. The tool control room was secure, locked, and no youth had access to this area. Vendors sign in to the center, as well as document items they are bringing in to the center. Venders are escorted at all times when in the secure area of the center. Further, venders sign out upon exiting and verify they removed all items they brought into the center. The superintendent indicated no lost or stolen tools during this annual compliance review period and this was verified by a review of the logbook and incident reports. Seven staff were interviewed in regard to what type of tools are the youth allowed to use: two staff reported none, five staff reported which youth use mops and brooms while cleaning on the module, and three staff indicated youth use scrub brushes while cleaning. Seven youth were interviewed in regard to their use of tools. One youth reported they did not use any tools, six youth reported they use mops and brooms while cleaning, and one youth indicated they used a scrub brush while cleaning.

5.09 Kitchen Tools	Satisfactory Compliance
Kitchen knives and other hazardous kitchen sharps are stored in a locked cabinet, drawer, or toolbox containing an inventory list. *All storage areas, including cabinets and drawers, are secured when not in use.* *Kitchen staff conducts an itemized inventory of all equipment, including kitchen knives and other hazardous kitchen implements, upon reporting for duty.* *All equipment is accounted for prior to the departure of the kitchen staff. Any discrepancy must be reported to the Superintendent or designee.*	

The center has a written policy and procedures addressing kitchen tools. Kitchen knives and other hazardous kitchen sharps are stored in a locked cabinet, drawer, or toolbox containing an inventory list. All storage areas, including cabinets and drawers, are secured when not in use. Kitchen staff conducts an itemized inventory of all equipment, including kitchen knives and other hazardous kitchen implements, upon reporting for duty. All equipment is accounted for prior to the departure of the kitchen staff. Any discrepancy is reported to the superintendent or designee. An inventory form found in the kitchen reflected all tools and sharps were accounted for. An interview with the center's food service manager revealed no youth have access to the kitchen or access to any kitchen tools. In the event a kitchen tool is missing, this will be reported to the superintendent and any other inventory problems or anything missing will also be reported to the superintendent. Documentation revealed all kitchen inventory secure utensil inventory forms were in compliance and signed off by the kitchen manager for all shifts.

5.10 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.*	

Youth are not allowed to use or access any tools, including kitchen or medical equipment. Youth are allowed use cleaning items such as mops, brooms, buckets, and other common household items under the direct supervision of staff. Observations were made during the annual compliance review of a youth cleaning with another staff present. The youth was using a mop, broom, and buckets; no other chemicals or tools were used. The storage area where the center keeps the mops, buckets, and brooms was observed. The storage area was a secure closet in which youth do not have access. The unit logbook revealed documentation of cleaning start and stop times while youth are on the module. Seven youth were interviewed in regard to their use of tools and cleaning items. Two youth reported they do not use any type of cleaning agents. Four youth stated they use cleaning agents which staff spray for them and they wipe. One youth reported youth spray cleaning agents. Seven staff were interviewed in regard to what type of tools are the youth allowed to use: two staff reported none, five staff reported which youth use mops and brooms while cleaning on the module, and three staff indicated youth use scrub brushes while cleaning.

5.11 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 procedures addressing toxic, poisonous, and flammable materials. Toxic materials are inventoried and secured when not in use. The center's safety plan was available for review. All flammable, toxic, caustic, and poisonous items are inventoried and secured when not in use and the Material Safety Data Sheets (MSDS) were maintained by the center. Toxic or caustic materials are not allowed to enter into the facility unless an MSDS is on file in the MSDS logbook and posted near items. A master copy of the MSDS log book is maintained in an accessible binder for all personnel to review at any time. All of these items were observed in a secure stored area, where no youth could have any access to them. The MSDS binder was posted near the chemicals and toxic material in a secure area of the facility. All items were reviewed and matched the inventory forms.

5.12 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.*	

Flammable toxic, caustic, and poisonous fluids and other dangerous substances are only drawn or acquired by authorized personnel. The superintendent, assistant superintendent, maintenance staff, and supervisors are the only authorized personnel within the center who can access these items. Youth are not permitted to use, handle, or clean-up dangerous or hazardous chemicals or respond to chemical spills. Youth are not permitted to clean, handle, or dispose of any other person's bio hazardous material, bodily fluids or human waste. All flammable, toxic, caustic, and poisonous items were observed stored in a secure area where no youth had access. No youth were observed using any tools or cleaning agent items during the annual compliance review. Seven youth were interviewed and two reported they do not use any type of cleaning agents. Four youth stated they use cleaning agents which staff spray for them and they wipe. One youth reported youth spray cleaning agents. Seven of seven staff members

interviewed reported youth are not allowed to clean with substances which are toxic, flammable, or poisonous.

5.13 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 addressing the disposal of flammable, toxic, caustic, and poisonous items. The maintenance mechanic and other trained staff who have the safety equipment for diluting, handling, and disposing of hazardous waste and or solid waste are be responsible for disposing of hazardous items and toxic material in accordance with Occupational Safety and Health Administration (OSHA) Standard 29 CFR 1910.1030 (amended 1-12004). The kitchen manager and maintenance staff reported there has been no disposal of any flammable toxic, or caustic and poisonous items in the last six months. The kitchen manager further reported no grease has been disposed of due to the center only baking youth food. The maintenance staff reported if any light bulbs need to be disposed of, maintenance staff will contact the county to pick them up from the center. Biohazard waste is collected in the medical clinic and is disposed of on a monthly basis. A review of the Central Communications Center (CCC) reports for the previous six months revealed there has been no incident of any spills.

5.14 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.	

Confinement at the center is only used 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 other or self. Confinement rooms windows and cameras were observed to be free of obstruction. The confinement rooms contained no non-fixed items. Five instances of confinement under twenty-four hours were reviewed. In each instance rooms were searched prior to placement, the confinement report was completed within one hour, and the juvenile justice detention officer supervisor (JJDOS) reviewed the report within two hours. Documentation reflected the JJDOS spoke with the youth every three hours. In applicable instances, the superintendent or designee documented the need for continued confinement. In all five cases the superintendent or designee reviewed the confinement report within forty-eight hours and confinements were reported to education staff for tracking of assignments.

5.15 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.*	

Confinement beyond twenty-four hours is approved by the superintendent or designee. Reasons for extended confinement will be clearly documented on the confinement report. The youth's behavior is monitored and documented by the juvenile justice detention officer supervisor (JJDOS) every three hours. In the event it is necessary to extend the confinement period beyond twenty-four hours, permission is needed from the regional director. There have been no instances of confinement over twenty-four hours since the last annual compliance review period.

5.16 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's Continuity of Operations Plan (COOP) was available for review to include attached annexes. COOP drills are required to be conducted twice annually. The center has conducted three COOP drills since the last annual compliance review. COOP drills were conducted on December 28, 2017, April 30, 2018, and May 3, 2018. The drills were observed to be documented in the logbooks and all shifts were captured in the drills. Seven staff were interviewed and reported they have participated in the following drills: weather, major disturbance, bomb threats, hostage situations, chemical spills, flooding, terrorism, escape, and fire.

5.17 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's escape prevention plan was available for review. The center conducts mock escape drills quarterly and on each shift. Drill documentation was available for review, as well as the logbook to verify the center is conducting escape drills, as required. Documentation supported all staff participated as required. Seven staff were interviewed in regard to their participation in drills. Four of seven staff reported they have participated in an escape drill.

5.18 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.*	

Management has implemented a disaster preparedness plan and fire prevention plan. Monthly fire drills are documented and conducted under varied conditions on each shift. The facility has a fire evacuation and prevention plan throughout the facility. Fire drills were reviewed for past six months, copies made of dates documented, shifts were in compliance with having fire drills monthly, and documentation supported all staff participated as required. The master control logbook had fire drills documented for all shifts. Three of seven youth interviewed reported they had been instructed on what to do in case of a fire. Seven of seven staff members interviewed reported they had participated in a fire drill.

Program Name: Escambia Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: Escambia County / Circuit 1
Review Date(s): September 11-14, 2018

MQI Program Code: 2
Contract Number: N/A
Number of Beds: 60
Lead Reviewer Code: 168

Overall Rating Summary

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