STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Escambia Regional Juvenile Detention Center

Department of Juvenile Justice

(State-Operated)
1800 Saint Mary Avenue
Pensacola, Florida 32514

Review Date(s): August 27-30,2019

Promoting Continuous Improvement and Accountability
in Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Juan Youman, Office of Program Accountability, Lead Reviewer (Standard 1)
Warren Garrison, Office of Program Accountability, Regional Monitor (Standard 5)
Patrick McKinstry, Office of Program Accountability, Regional Monitor (Standard 3)
Craig Swain, Office of Program Accountability, Regional Monitor (Standard 4)
Micah Youmas, Leon Regional Juvenile Detention Center, Juvenile Justice Detention Officer Supervisor (Standard 2)

Program Name: Escambia Regional Juvenile Detention Center
Provider Name: N/A
Location: Escambia County / Circuit 1
Review Date(s): August 27-30, 2019

MQI Program Code: 2
Contract Number: N/A
Number of Beds: 50
Lead Reviewer Code: 141

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

Overall Rating Summary

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

Standard 1: Management Accountability
Detention Rating Profile

Indicator Ratings

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

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

Standard 2: Youth Management
Detention Rating Profile

Indicator Ratings

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

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

Indicator Ratings

Standard 3 - Mental Health and Substance Abuse Services		
3.01	Designated Mental Health Clinician Authority (DMHCA)	Satisfactory
3.02	Licensed MH/SA Clinical Staff *	Non-Applicable
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 *	Non-Applicable

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Standard 4: Health Services
Detention Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Detention Rating Profile

Indicator Ratings

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

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Program Overview

The Escambia Regional Juvenile Detention Center is a state-owned detention facility, operated by the Department, located in Pensacola, Florida. The center is co-located with the Escambia Juvenile Courthouse, Juvenile Assessment Center, and the intake and screening probation unit. The center serves youth in Escambia and Santa Rosa Counties in Circuit 1. Male and female youth who are detained pending adjudication, disposition, or placement in a residential commitment program are housed in the sixty-bed center. Youth are provided services which include youth orientation, behavior management, safety and emergency procedures, transportation, mental health, and healthcare services. The center's educational services are provided by the Escambia County School Board. The center's management team includes the superintendent, two assistant superintendents, one field training coordinator, one administrative assistant, one staff assistant, seven juvenile justice detention officer (JJDO) supervisors, and forty-four JJDOs. Mental health and healthcare services are provided through the contracted provider, Maxim Healthcare Services Inc. Mental health services are provided by one licensed and two non-licensed mental health staff. Clinical services provided by the center include mental health and substance abuse evaluations, mental health treatment planning, individual, group, and family therapy, mental health crisis intervention services, on-site psychiatric services, and availability for substance abuse services for youth with co-occurring disorders. Medical services are provided by one designated health authority (DHA), one advanced registered nurse practitioner (ARNP), one registered nurse (RN), and one part-time licensed practical nurse (LPN). The medical clinic maintains nursing coverage every day. Food services are provided by Department staff and include menus, meal planning, meal schedules, special diets, nutritional analysis, daily allowance, food preparation, health certifications, food product standards, sanitation, and cleaning. Staff are responsible for the custody and control of youth in their care, providing youth supervision twenty-four hours a day, seven days a week. The center has three living modules which are divided by males and females. There are forty-three security cameras at the center, of which forty-two were operational at the time of the annual compliance review. The center was found to be clean and free of graffiti. At the time of the annual compliance review, the center had five vacancies, which included one supervisor, one JJDO II, and three JJDO I.

Standard 1: Management Accountability

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

A review of the employee and volunteer roster at the center revealed the center hired a total of nineteen staff and thirteen volunteers since the last annual compliance review. Each staff and volunteer received a background screening prior to their hire or start day. A pre-employment assessment passing score was found in each employment record. The Annual Affidavit of Compliance with Level 2 Screening Standards was completed and sent to the Department's Background Screening Unit by the January 31st deadline.

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.	

A review of the employee and volunteer roster at the center found three staff were eligible for a five-year background rescreening. There was documentation of each rescreening being submitted to the Background Screening Unit/Clearinghouse at least ten business days prior to the five-year anniversary date.

1.03 Staff Code of Conduct	Satisfactory Compliance

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

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

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

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

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

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

A review of fourteen staff personnel records found each staff signed a code of conduct. The was no documentation of any staff receiving disciplinary actions for violations of the code of conduct. A review of the incident reports revealed there were no substantiated allegations of improper conduct by staff during the past six months. The center has a process in place for allowing youth to call the Florida Abuse Hotline or the Central Communications Center (CCC) to report suspected abuse. Eight staff interviews revealed the supervisor and superintendent will be notified of each called made and the calls are documented in logbooks. Staff revealed youth are allowed to make the call. Of the eight staff interviewed three stated they have never observed a coworker using profanity when speaking to youth, three staff stated once, and two staff stated occasionally. Eight staff reported they have never observed a co-worker using threats, intimation, humiliation, etc. when interacting with youth. Four staff stated the working conditions at the center were very good. The other staff reported working conditions at the center were good. Seven youth were interviewed and five stated they never had to report abuse and two stated they have never been stopped form reporting abuse to the Florida Abuse Hotline. Six of the seven youth interviewed revealed staff are respectful with talking to youth. Four youth interviewed stated they heard a staff use curse words when speaking to youth, one youth stated never, and the other two youth stated often. Six youth stated they had never heard staff threaten youth and one stated occasionally. Two of the seven youth interviewed stated they did not feel safe at the center. One youth felt there were a lot of germs around. The youth felt the center staff could be better at making sure the facility is cleaner. The youth did not want to file a grievance or call the Florida Abuse Hotline about the state of the facility. The other youth stated staff have threaten them approximately twice a week. The youth also stated their mother contacted the center and their juvenile probation officer and filed a grievance in regard to staff behavior. The youth feels staff are not looking out for youth's best interest. The youth did not want to call the Florida Abuse Hotline. The superintendent was notified of the results of the interview.

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

The center had a total of eleven incidents reported to the Central Communications Center (CCC) since the last annual compliance review. Five incident reports were reviewed. Each of the incidents were reported within the required time frame of two hours and documented in the center's logbook. An interview with the superintendent revealed all youth have the right to contact the Florida Abuse Hotline at any time. Whenever a reportable incident occurs, the center's highest-ranking staff will notify the CCC within two hours of the incident, or within two hours of becoming aware of the incident. If staff observe abuse, as mandatory reporters, they are obliged to report any instances of abuse.

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

A random selection of seven Protective Action Response reports were reviewed. Each of the reports were completed by the end of the staff member's workday and included statements from all staff involved. Each of the reports were reviewed by a supervisor and a PAR instructor to determine if use of force was consistent with policy. A post-PAR interview was conducted with the youth by the supervisor less than thirty-minutes after each incident. There was documentation indicating the superintendent/designee reviewed the report, after all other reviews, and made comments, if appropriate, within seventy-two hours. During the annual compliance review period the center's PAR Rate was 3.83 which is below the statewide average of 11.75. An interview with the superintendent revealed all administrators and staff are trained annually in PAR. PAR reports are generated anytime an officer places their hands on a youth with the exception of sole use of the Straight Arm Escort, close or extended. Eight staff interviews revealed staff try to talk to youth prior to using physical restraints (PAR) or mechanical restraints.

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

Seven staff training records were reviewed for pre-service/certification training. Each of the staff were certified within 180 days of their hire date. The training records revealed all the staff completed all required pre-service trainings to include Protective Action Response (PAR), cardiopulmonary resuscitation (CPR)/automated external defibrillator (AED), first aid; mental health services, substance abuse services, suicide recognition, prevention and intervention, safety, security, and supervision, to include emergency plans and procedures, and Department of Juvenile Justice Detention Facility Operations prior to any contact with youth. The staff were

also trained in essential skills, orientation, information security awareness, legal, DJJ: The Organization, gang awareness, interpersonal/communication skills, detainee behavior and consequences, and active shooter training. All trainings were documented in the Department's Learning Management System (SkillPro). All the staff received training at the academy as well.

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

Seven staff training records were reviewed for in-service training. Each staff completed the required number of hours of training. These training included Protective Action Response (PAR) update, cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), professionalism and ethics, and active shooter training. Each of the staff completed six hours of suicide prevention training. Three of the training records selected were supervisors, who each completed at least eight hours of supervisory training. All three supervisors received training in medication administration and utilizing an epinephrine auto injector. All trainings were documented in the Department's Learning Management System (SkillPro). The program has an annual in-service training calendar, which is updated as changes occur.

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

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

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

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

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

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

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

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

A copy of the center's alert list found in the Department's Juvenile Justice Information System (JJIS) was reviewed. There was documentation in the center's logbooks and internal alerts identifying youth with medical, mental health, suicide, gang, and security issues. All medical alerts were removed by medical staff. Mental health alerts were closed by mental health staff. Information regarding youth alerts is available to all staff during pre-shift meetings which was observed during the annual compliance review. Each staff also received a copy of the alerts to have with them during the shift. Seven staff interviews revealed staff are informed of alerts specific to youth during shift debriefings and by reviewing the logbook, JJIS, and alert forms. The staff interviews also revealed management informs staff about issues within the center through staff debriefings, memos, emails, and trainings. Seven youth records were reviewed for alerts. Each of the seven youth had a least one alert entered into the system while at the center. Each of the alerts were documented in the logbook. It was noted three of the youth had a chronic condition. All of the alerts removed were removed by the appropriate staff.

Standard 2: Assessment and Performance Plan

2.01 Admission	Satisfactory Compliance

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

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

The center has a written policy and procedures to ensure youth are admitted to the center in accordance with Florida Administrative Code. Seven youth records were reviewed and all seven contained documentation of an arrest affidavit/custody order, Detention Risk Assessment Instrument, Suicide Risk Screening Instrument, frisk, strip, and/or electronic search by an officer of the same gender, offered a telephone call and meal, and medical, mental health, and substance abuse screenings. During the annual compliance review, a youth admission was observed. The youth was provided a meal and given a telephone call to his parents/guardians.

2.02 Orientation	Satisfactory Compliance

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

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

Seven records were reviewed, and documentation revealed all of the youth completed their orientation within twenty-four hours of admission. All seven youth signed an orientation acknowledgment sheet, which was maintained in each youth's record. The orientation explained the center's rules and regulations, youth rights, visitation, telephone calls, grievance procedures, access to medical, mental health, and substance abuse services, access to the Florida Abuse Hotline and Central Communications Center, behavior expectations and related consequences, and possible new law violations for destruction of property. The center's orientation contains all elements outlined in the center's policy. The Department's PREA video, was observed being watched by youth during the intake process. Seven youth were

interviewed, and six of seven youth reported someone provide them with information about the center's rules and regulations, daily schedule, education services, visitation, abuse reporting, and the behavior management system. The other youth stated no one provide them with information about the center.

2.03 Classification	Satisfactory Compliance
All youth admitted to the center shall be classified to provide the highest level of safety and security. Considerations shall include, at a minimum: *1. Physical characteristics (e.g. sex, height and weight);* *2. Age and level of aggressiveness;* *3. Special needs (mental illness, developmental disabilities, and physical disabilities);* *4. History of violent behavior;* *5. Gang affiliation;* *6. Criminal behavior;* *7. History of sexual offenses;* *8. Vulnerability to victimization; and* *9. Suicide risk identified or suspected.* *Youth shall be assigned to a room based on their classification and are reclassified if changes in behavior or status are observed. Youth with a history of committing sexual offenses or a victim of a sexual offense are not to be placed in a room with any other youth. Youth with a history of violent behavior shall be assigned to rooms where it is least likely they will be able to jeopardize safety and security.* *All newly admitted youth are screened to determine if he or she is a criminal street gang member or is affiliated with any criminal street gang. In the event hang involvement is suspected, center staff should enter the "other suspected gang affiliation" alert into JJIS along with as much detailed information within the alert note as possible.*	

The center has a written policy and procedures to ensure youth are classified to provide the highest level of safety and security. Seven youth records were reviewed and each youth was classified after considering the youth's history and status. Other potential safety and security concerns taken into consideration are sex of the youth, height, weight, age, level of aggressiveness, mental illness, intellectual disabilities, physical disabilities, history of violent behavior, gang affiliation, and criminal behavior. All seven records also considered history of sexual offenses, vulnerability to victimization and sexually aggressive, medical, suicide risk identified or suspected, escape, and security. When making room assignments, all seven youth were assigned to a room based on their classification, history of sexual offenses, and, if necessary, youth were reclassified if changes in behavior or status were observed. During the classification process, alerts were entered in the Department's Juvenile Justice Information System (JJIS). The center uses the youth's face sheet, Vulnerability to Victimization and Sexually Aggressive behavior (VSAB), and/or Massachusetts Youth Screening Instrument - Version 2 (MAYSI-2) when classifying the youth.

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

The center has a written policy and procedures in place regarding the notification of the juvenile probation officer (JPO) designated as the circuit's gang liaison of suspected gang activity. A review of seven youth records found none were applicable. Three additional youth records were reviewed. There was documentation found in each of the three applicable records indicating the gang liaison was notified. During the annual compliance review, the center did not have any youth with any gang association or suspicion of gang activity. An interview with the staff identified to serve as the gang representative for the center verified the process.

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

Seven youth records were reviewed for admission of youth with personal property. All seven records had the youth and staff's signature on all admission paperwork, as well as a letter of acknowledgement regarding unclaimed property, signed by the youth. Three of the seven records documented a safe drop. All three youth had money and personal items of value verified and secured in a clear tamper-proof property bag, which included the date, youth's name, Department identification number (DJJID), and a list of items in the bag. The bound logbook for the drop safe documented the date, time, youth's name, DJJID printed name of the officer who secured the property, and officer's initials. All seven youth's other personal property, including clothing were placed in an assigned bag in a different area, as documented on the property receipt form. This form was placed in each of the youth's records. A valuable property receipt form was in the three applicable active records. Seven interviewed youth revealed staff checked their personal property and had them to sign a form stating the personal property was correct.

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

The center's drop safe is located in a secured room which is under video surveillance. This room and safe were observed during the annual compliance review. The bags are clear, tamper-proof, and contain a completed inventory form. The bound logbook is stored next to the safe. Administration and supervisors are the only staff who have access to the youth personal property. In the past six months, there were no Central Communications Center reports

regarding youth property. An interview with the superintendent revealed youth personal property is stored in the property room and only the administration staff and supervisors have access to the property room. The superintendent stated, in regard to the disposal of property not claimed, is if the youth or parent/guardian cannot be located, the superintendent or designee will ensure all money and property is counted and inventoried. A money order will be sent to the Regional Fiscal Manager. The Regional Fiscal Manager will then forward the money order to the Headquarters' designee. The center keeps a record for any property disposed of or cash forwarded to headquarters.

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

Three closed youth records were reviewed for release. All three youth records had documentation indicating the juvenile justice detention officer supervisor (JJDOS) reviewed all the paperwork and verified there was not a court order and/or any other legal reasons which would have prevented the youth's release. All three youth were identified as the correct youth to be released prior to release. Identification was obtained for two of the three adults the youth were released to, with a copy placed in the youth records. For the remaining youth, the person picking up the youth presented their identification but refused to give their identification to staff to copy; however, the person was employed by the Department of Children and Families Services. All parties signed the applicable release forms. A review of Central Communications Center (CCC) reports for the annual compliance review period revealed there were no unauthorized releases. All release procedures were completed, as required. The annual compliance review team was unable to observe a release during the review.

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

The center has a written policy and procedures for the retrieval of a youth's personal property upon release from the center, as well as reviewing and signing the Property Receipt form. Two of the three closed records reviewed for release had a youth and parent/guardian signatures for the release of property. The other record had a signature from a Department of Children and

Family Services staff. 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. Like 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.

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

The center has a written policy and procedures 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 involving medication. 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. Medical and detention staff accurately explained the process in the policy indicating 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.

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

The center has a written policy and procedures to ensure 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 the sharing of information regarding the youths' behavioral and/or physical issues, as needed. The center conducts weekly detention reviews every 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. During the meeting, youth in secure detention were reviewed and any tasks required and who was to follow-up were addressed. 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 participating by telephone. A review of documentation from detention reviews during the previous year displayed the same consistency in documentation of the participants. In an interview, the superintendent explained 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. The superintendent interview revealed the following staff attend the weekly case reviews for secured detention: superintendent, detention review specialist, chief probation officer, commitment manager, and a representative from education, medical, mental health, and the Department of Children and Families.

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

The center has a policy and procedures in place regarding the center's daily activity schedule. During the tour of the center, the activity schedule was found posted in each living unit visible to youth. The schedule indicated times the youth are to participate in school activities, conduct personal hygiene/showers, have meals/snacks, attend visitation, recreation activity, and participation in small group discussions or social activities. The schedule also reflected when educational programming is offered, times of phone calls and letter writing are permitted, bed times for youth with higher levels in the behavior management system, and when to conduct unit/facility cleaning. Seven interviewed staff revealed the daily scheduled is followed. Seven staff were interviewed regarding restorative justice activities. Five youth indicated the center provides restorative justice activities. Each of the seven interviewed staff indicated the center offers gender-specific programming as part of the daily schedule. All seven youth also reported the center does have a daily activity schedule.

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

The center has a daily activity schedule in place to document the activities of the center. The center has a weekly schedule for normal business days and a weekend/holiday schedule. A review of the center's logbook indicated adherence to the daily activity schedule with a few exceptions to include shortness of staff and youth behavior. Observations of the daily schedule during the annual compliance review week found staff adhering to the daily schedule as written. Seven youth were interviewed, and all youth indicated the daily schedule is followed. Eight staff were interviewed, and each reported the daily schedule is followed.

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

All youth at the center are given access to education. School starts at 8:30 a.m. and ends at 2:32 p.m. A review of the education schedule revealed the youth are provided education 250 days a year distributed over twelve months, with a minimum of twenty-five hours of instruction each week. Teachers are also given days for training and planning throughout the school year. Youth enrolled in educational programs at the center have an opportunity to earn course credit for completion of the education and training experience. A review of master control logbooks dated April to August 2019 found there were no missed school days. Eight staff interviewed revealed there was minimal interference of educational instruction. Seven interviewed youth

stated the center offers educational (school or career/technical instruction) classes and youth attend school Monday through Friday. All youth stated they attend the following classes at the center: life skills, math, science, history, reading, social studies, and career choices. The superintendent revealed there is minimal interference of education instruction.

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

Interviews with education staff revealed the center is providing the requirements for Type one programming to include life skill groups activities and instructions. The youth learn communication, impersonal skill and decision-making skills in the Leadership Development Course.

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

The center has policy and procedures in place addressing the behavior management system (BMS). The rules and expectations are posted throughout the living units. The center also has a reward system which is based on points for good behavior and the loss of points and level drops for inappropriate behavior. Eight interviewed staff indicated they believe the center's BMS is effective. Each of the staff felt youth are given an opportunity to explain their behavior and they speak with the youth about alternative acceptable behaviors.

Staff interviews indicated only points and level drops can be taken away as consequences. Seven youth were interviewed and two stated they felt the BMS was very good, two youth stated the system was good, two stated the system was fair and one youth stated it was poor. Five of the youth said the consequences were fair, one said they were not fair, and one never received any consequences. Seven interviewed staff revealed supervisors provide feedback to staff regarding the implementation of the behavior management system on a weekly and as need basis.

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

The center's behavior management system (BMS) addresses rewards and consequences for positive and negative behaviors. The BMS implemented at the center does not allow for group punishment or corporal punishment of youth. Eight staff stated they never observed staff encouraging youth to punish another youth. All eight staff reported consequences for inappropriate behavior does not include the loss of meals, snack, sleep, or school. Seven youth interviewed stated snacks, points, level, clothing/bedding and school are taken away as consequences. Seven youth reported they are not allowed to punish other youth. Five youth reported they are sent to their room for punishment with the door shut and locked. Six of the seven youth revealed they have never witnessed handcuffs or leg irons used on out of control youth to prevent them from hurting themselves or others.

2.17 Grievances	Satisfactory Compliance
The grievance procedures establish each youth's right to grieve and ensure all youth are treated fairly, respectfully, without discrimination, and their rights are protected. The process includes: *1. Informal phase, wherein the JJDO attempts to resolve the complaint or condition with the youth using effective communication skills;* *2. Formal phase, wherein the youth submits a written grievance resulting in a response from a JJDO Supervisor by the end of the shift (if possible), or otherwise within twenty-four hours; and* *3. Appeal phase, wherein the youth may appeal the outcome of the formal phase to the superintendent or designee.*	

The center has a policy and procedures in place which gives each youth a right to grieve if they feel they were not treated fairly. Upon admission, each youth is informed of the grievance process. The center's grievance process has three phases which includes an informal, formal, and appeal phase. The grievance policy revealed the informal phase occurs wherein the juvenile justice detention officer (JJDO) attempts to resolve the issue with the youth. The youth submits, in writing, the grievance to the JJDO for handling and submission into the Detention Facility Management System. If the youth is not satisfied with the outcome with the JJDO assigned, the grievance will move to the formal phase where the shift supervisor has until the end of the shift or within twenty-four hours to resolve the complaint with the youth. If the youth is still dissatisfied with the outcome of findings by the shift supervisor, the grievance then moves to the appeal phase. This phase is where the superintendent or designee must review and attempt

to resolve the complaint within seventy-two hours of receipt, excluding weekends and holidays. The center did not have any grievances during the annual compliance review period. An interview with the superintendent revealed they knew the grievance process and time frames. Seven youth were interviewed, and all reported they never filed a grievance and could not rate the grievance process.

2.18 Trauma-Informed Care	Satisfactory Compliance

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

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

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

A tour of during the annual compliance review found the center has a soft room. The facility was found to be painted in soothing colors. A review of seven training records revealed six of the staff received in-service training in trauma-informed care. An interview with the superintendent revealed the implemented trauma-informed practices includes softer colorful structural/paintings, soft rooms, fun activities for youth and staff, and projects for youth to work on.

Standard 3: Mental Health and Substance Abuse Services

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

The center has a single licensed mental health professional, identified as the designated mental health clinician authority (DMHCA). The DMHCA is a licensed mental health counselor (LMHC), under Chapter 491. The LMHC is a full-time employee and is on-site forty hours a week. The Department has a contract with Maxim Healthcare Services, Inc., to provide mental health and substance abuse services. A copy of the LMHC's licensure and contract was available while on-site during the annual compliance review.

An interview with the DMHCA was conducted and confirmed his credentials as a LMHC. In addition, the medical license is clear and active within the State of Florida. The DMHCA confirmed he was on-site at the center five days a week for forty hours each week. Additionally, the DMHCA supervises two non-licensed clinicians for the planning and delivery of mental health services. The DMHCA meets with staff daily, either in person, or by email or telephone. The DMHCA meets with the psychiatrist weekly.

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

The center does not employ any other licensed clinical staff other than the designated mental health clinician authority (DMHCA); therefore, this indicator shall be rated non-applicable.

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

The center is licensed under Chapter 397; which will expire April 1, 2020. The clinical supervisor assures the two non-licensed staff working under his supervision are performing services they are qualified to provide based on education, training, and experience. Both non-licensed mental health clinical staff hold a master's-level degree from an accredited university or college; one has a master's in social work and the other has a master's in the field of counseling. Each of the non-licensed mental health clinical staff are registered interns; one is a registered clinical social worker and the other is a registered mental health counselor. Each of the non-licensed clinical mental health staff is an employee of a facility licensed under Chapter 397, Florida Statutes, and

hold, at a minimum, a bachelor's degree from an accredited university or college with a major in psychology, social work, counseling, or related human services field. Both non-licensed mental health clinical staff conduct Assessments of Suicide Risk (ASR) and have received twenty hours training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. Each of the staff have training which includes administration of, at a minimum, five ASRs or crisis assessments conducted on site in the physical presence of a licensed mental health professional and documented on non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form; both staff completed training on March 20, 2019. Each of the non-licensed mental health and substance abuse clinical staff received on-site face-to-face direct supervision by the licensed clinical supervisor(s), at least one hour a week. These face-to-face supervisions were conducted both individually and in a group format. Documentation of direct supervision was recorded on the Department's form, Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log.

As evident through on-site youth record review, the licensed mental health professional providing direct supervision is responsible for reviewing and signing Comprehensive Mental Health Evaluations, Updated Comprehensive Mental Health Evaluations, Initial Mental Health Treatment Plans and Individualized Mental Health Treatment Plans. Each of these when prepared by the non-licensed mental health clinical staff, were reviewed by the licensed mental health professional within ten calendar days of administration of the instrument. In addition, the licensed mental health professional providing direct supervision conducted reviews for each ASR and Follow-Up ASR (FASR), Crisis assessment, and Follow-Up Crisis Assessment conducted by the non-licensed mental health clinical staff within twenty-four hours of the referral for assessment. Each of the ASRs, FASRs, Crisis Assessments, or Follow-Up Crisis Assessments conducted by the non-licensed mental health clinical staff was signed by the licensed mental health professional the next scheduled time he was on-site. The qualified professional providing direct supervision to both of the substance abuse clinical staff, also reviewed and signed any Comprehensive Substance Abuse Evaluations, Updated Comprehensive Substance Abuse Evaluations, Initial Substance Abuse Treatment Plans and Individualized Substance Abuse Treatment Plans when prepared by the two non-licensed substance abuse clinical staff person within ten calendar days. The non-licensed mental health and substance abuse clinical staffing is in accordance with current contract and Florida Administrative Rule 63N-1.

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

Seven youth records were reviewed for mental health and substance abuse admission screenings. The Suicide Risk Screening Instrument (SRSI) and a Massachusetts Youth Screening Instrument – Version 2 (MAYSI-2) assessments were completed by probation staff. There was documentation to support a review for each of these instruments completed by detention staff for all seven youth records reviewed. Each of the seven youth records contained a completed SRSI which was completed during the youth's intake. The SRSI and MAYSI-2 were

documented within the Department's Juvenile Justice Information System (JJIS). Each of the youth records indicated a nurse and/or mental health staff completed the applicable sections of the SRSI as required. There were complete entries, including a summary and recommendations in the "Screening Results" sections. Six of the seven records found the youth had a yes response on the SRSI. Each of these six youth were appropriately placed on suicide precautions and a mental health referral was completed. All seven screenings were completed by trained staff. Six of the records showed the results of the SRSI and MAYSI-2 indicated a need for further assessment. A referral was made for each of the applicable six records. As required, the superintendent was notified of the screening instrument findings. Six records found the MAYSI-2 assessment indicated elevated suicide risk subscales. Subsequently, each youth was placed on suicide precautions and referred for an Assessment of Suicide Risk (ASR). None of the youth required a referral for a comprehensive assessment.

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

Seven youth records were reviewed, of which five were applicable for mental health and substance abuse evaluations. Each of the five youth records reviewed were identified after admission and referred to the detention provider. Each of the referrals resulted in completion of a new mental health and or substance abuse evaluation, which was completed by the detention provider. Each of the five mental health and or substance abuse evaluations were completed within thirty days of referral. None of the youth reviewed, required a comprehensive assessment through a community provider.

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

Seven youth records were reviewed for mental health and substance abuse treatment. Five out of the seven youth reviewed, required mental health and or substance abuse treatment. Each of the five-youth requiring treatment, were assigned to a mini-treatment team. Each of the mini-treatment teams consisted of a mental health clinical staff, a staff from a different service area, the youth, and when possible, youth's parent/guardian. The five applicable youth who were determined to be in need of mental health treatment, were in receipt of individual, group, and or family counseling. Treatment was provided according to the frequency required by the youth's plan. The five applicable youth were determined to be in need of substance abuse treatment. Each of these youth received individual, group, and/or family counseling according to frequency required by the youth's plan. Each of the five youth requiring mental health treatment had a proper consent for treatment; an Authority for Evaluation and Treatment (AET) found in their

records. Each of the five youth requiring substance abuse treatment had a consent and information release on file, related to substance abuse. Treatment notes for the five identified youth were found documented on the Department's form Counseling/Therapy Progress Note. Mental health staff have adequate access to youth in order to provide treatment services. 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.

The designated mental health clinical authority (DMHCA) reported individualized and group counseling are provided at the center. Both these methods are for mental health and or substance abuse issues. One of the seven interviewed youth reported mental health and substance abuse services are very good, five youth responded good, and one youth responded very poor. The youth reporting service as poor, further stated, she is not getting the prescription psychotropic medication she takes at home. A follow-up conversation occurred with the nurse in the medical department pertaining to this youth's concerns. Documentation showed this same youth was asked by nursing staff on August 8th and August 9th, 2019 by the advanced registered nurse practitioner (ARNP); both times the youth denied taking any medications.

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

Seven youth records were reviewed for treatment planning. Five of the seven youth records reviewed were applicable for treatment plans. Each of the five applicable youth had an initial treatment plan in place within seven days of initiation of treatment. Each of the initial treatment plans were developed on the Department's form Initial Mental Health/Substance Abuse Treatment Plan. The five youth had a documented reason of referral for treatment, along with an initial Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) and Diagnostic Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis.
The treatment plans included initial treatment methods, along with initial treatment goals. Three of the five youth required psychiatric services. Each of the five initial treatment plans included the signature of the licensed mental health and substance abuse professional. In addition, the signatures were documented for the youth and the mini-treatment team members involved in development of initial treatment plan.

A total of five youth records were applicable out of the seven for completion of an individualized treatment plan. Three of the five youth were applicable for an individualized treatment plan being completed within the thirty-first day of the youth's admission. The remaining two youth were recently admitted to the center, and a plan was not yet required to be developed. Each of the three applicable individualized treatment plans included the signature of the licensed mental health professional within ten days of completion. The three treatment plans included an initial

DSM-IV-TR or DSM-5 diagnosis. Each of the treatment plans also included symptoms which were treatment-focused, treatment goals, strengths/abilities, and preferences/needs. Only one of the three applicable youth required psychiatric services. The psychiatric services included psychotropic medication and frequency of monitoring, along with pharmacological interventions. A review of each of the three applicable youth progress notes, validated youth received treatment services as stipulated on the treatment plan. The three individualized treatment plans reviewed were signed and dated by the youth, mental health and substance abuse professionals, treatment team members, and the parent/guardian, (when possible). There were no individualized treatment plans which required a review to be completed within a thirty-day timeframe. One youth was applicable for psychiatric treatment services. The youth's treatment plan included treatment and services provided by a licensed psychiatrist.

Three closed youth records were reviewed for mental health and substance abuse treatment discharge summaries. The three youth records contained mental health and substance abuse treatment discharge summaries, which were completed upon each youth's transition or discharge from the center. Each of the mental health and substance abuse treatment discharge summaries were provided to the juvenile probation officer (JPO), parent/guardian (as allowed), and the youth.

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

The center employs a psychiatrist, who is licensed pursuant to Chapter 459, Florida Statutes, and is certified in child and adolescent psychiatry, from the American Board of Psychiatry and Neurology. The provider does not employ a licensed and certified psychiatric advanced registered nurse practitioner (ARNP) or an advanced practice registered nurse (APRN), under Chapter 464, Florida Statute.

Three of the seven youth records reviewed were applicable for psychiatric services. Each of the three applicable youth entering the center were referred for an initial diagnostic interview and seen within fourteen days of admission. The initial psychiatric interview included the reason for the referral, history (medical, mental health and substance abuse history), mental status examination, Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR) or Diagnostic Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis and symptoms, treatment recommendations, prescribed medication, explanation of the need for psychotropic medication, and frequency of medication monitoring/management. Each of the three youth in receipt of psychotropic medication had documented monitoring for Tardive Dyskinesia monthly, as required. Additionally, each youth record contained an Authority for Evaluation and Treatment (AET). None of the three reviewed records required a new psychotropic medication, discontinuation, or dosage of medication to be significantly change. None of the youth reviewed for psychotropic medication were in foster care. One youth had reached the age of eighteen and was responsible for authoring his health care and authorizing release of his healthcare records. None of the youth records required an in-depth psychiatric evaluation.

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

The center has a written plan detailing suicide prevention procedures and practices. The written suicide prevention plan includes a way for staff to identify and provide an assessment of youth at risk of suicide. The plan also includes staff training, mock suicide drills, suicide precautions, levels of supervision, referrals, communication, notification, documentation, immediate staff response, and a review process; as referenced in the Department's Rule.

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

Six out of the seven youth records reviewed identified to be at risk during admission screening. Subsequently, each of the six youth were placed on precautionary observation (constant supervision). An alert was initiated for each of the six youth and entered into the Department's Juvenile Justice Information System (JJIS). Each of the youth had a suicide risk assessment referral. For each of the six youth, an Assessment of Suicide Risk (ASR) documented the assessment in real time. The completed ASR indicated the level of supervision for each youth. All six youth reviewed were placed on standard supervision at the time the ASR was administered. A total of eleven suicide precautionary observation logs were generated between the six youth records reviewed. Two of the eleven precautionary observation logs were not completed in their entirety; one log was missing the mental health professional's signature and documentation to support "safe housing areas." The other log was also missing documentation to support "safe housing areas" and documentation (check mark) to identify which type alert the youth was on. The remaining nine precautionary observation logs contained all necessary requirements. None of the youth reviewed were released prior to receiving an ASR or released while on suicide precautions. Each ASR documented a consultation with the designated mental health clinical authority (DMHCA) or licensed mental health professional. In addition, the superintendent or designee was notified immediately of the youth's suicide risk. Subsequently, precautionary observation was authorized. An ASR for each of the youth was completed within twenty-four hours. None of the youth were identified as having been in crisis. All six youth placed on precautionary observation were placed on standard supervision at time of the assessment. All six ASRs were conducted by a non-licensed clinical staff under the supervision of a licensed mental health professional. Each of the non-licensed licensed clinical staff were in receipt of twenty hours of ASR training. There was evidence within the logbook and on the ASR where administrative or supervisory staff provided instructions related to the suicide risk assessment findings, to include beginning and ending times for any youth placed on suicide precautions. Alerts within JJIS were found for each of the six youth. 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 included, circumstances surrounding the event, written procedures relevant to the incident, relevant training received by involved staff, pertinent medical and mental health services involving the victim, possible precipitating factors, and recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and/or operational procedures. Seven youth were interviewed and stated they have never been placed on suicide watch while at this center. Seven staff were interviewed and were able to identify what practices staff are responsible for, if a youth expresses suicidal thoughts.

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

Six out of seven reviewed youth records were applicable for the use of suicide precautionary observation logs. A total of eleven suicide precautionary observation logs were generated between the six youth records reviewed. Each of the eleven precautionary observation logs were documented on Department form Suicide Precaution Observation Logs, which was maintained for the duration the youth is on suicide precautions. Each of the eleven precautionary observation logs documented the appropriate level of supervision and observations of the youth’s behavior. The documentation is in real time and did not to exceed thirty-minute intervals. There were no warning signs observed. Each of the precautionary observation logs were reviewed and signed by each shift supervisor. One precautionary observation log out of eleven was missing the mental health clinical staff signature. Two out of eleven precautionary observation logs were missing documentation to support “safe housing areas.” Four youth were interviewed face-to-face separately and asked, while you were on suicide precautions, were staff with you at all times; each youth replied yes.

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

Seven staff in-service training records were reviewed for completion of suicide prevention training. Each of the 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. Training at the center included a total of eighteen mock suicide drills. Each of the drills were held no less than quarterly on each of the three shifts. The mock suicide drills included all staff who come in contact with youth, which included kitchen and maintenance staff. A review of the mock suicide drills demonstrated each of the reviewed staff participated in quarterly drills. In addition, fifty percent of staff with direct contact, on a day-to-day basis, with youth, participated in at least one mock drill, which included the use of cardio pulmonary resuscitation (CPR) annually. Staff members who are not present during a quarterly drill have the opportunity to review drill scenarios and procedures during shift briefings. Seven staff were interviewed and were able to identify locations within the detention center where the "Knife for Life", wire cutters, and needle nose pliers (Suicide Response Kit) are kept.

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

The center has a written mental health crisis intervention plan which details crisis intervention procedures and practices. The written crisis intervention plan includes the following procedures: notification and alert system, means of referral (includes youth self-referral), communication, supervision, documentation, and review process.

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

The center has a written emergency care plan which included the following: immediate staff response, notifications, communication, and supervision. In addition, the emergency care plan included process for authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment under Chapter 394, Florida Statute (Baker Act), transport for emergency substance abuse assessment and treatment under Chapter 397, Florida Statute (Marchman Act). The emergency care plan also included procedures for documentation, training, and a review process. The center's written emergency care plan was last updated and approved August 6, 2018. The location of the written emergency care plan is located in the superintendent's office and accessible to all staff.

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

The center has not had any youth requiring a crisis assessment during the annual compliance review period. An informal interview was conducted with the center's designated mental health clinician authority (DMHCA); he confirmed there has been no youth requiring a crisis assessment since the last annual compliance review. The center would utilize the Department's

form Crisis Assessment, if necessary, located within the Office of Health Services (OHS) electronic medical records system.

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

The center has not had any Baker or Marchman Acts during the annual compliance review period, therefore, this indicator shall be rated “non-applicable.”

Standard 4: Health Services

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

Maxim Healthcare Services, Inc. is contractually required to provide comprehensive medical services at the center. The center has a board-certified physician who has a clear and active license and meets all the requirements to serve as a medical doctor/designated health authority (DHA). The physician's specialty is pediatrics. The DHA is responsible for the overall clinical direction, policies, and protocols for the medical services provided. The advanced registered nurse practitioner (ARNP) holds a clear and active license to practice in the State of Florida. A review of sign-in logs for the six months prior to the annual compliance review, confirmed the DHA was on-site weekly for at least two hours. The hours are posted on the door of the medical clinic, visible for all to see. The DHA is responsible for making the necessary arrangements for a qualified doctor to cover the center during vacations or extended absences. The advanced registered nurse practitioner (ARNP) provided services on-site, a minimum of twenty-four hours a week. The ARNP works in collaboration with the DHA, who signed the nurse practitioner protocol/collaborative practice agreement on August 31, 2018. A check of all licensed medical staff confirmed all had current State of Florida medical licenses, verified by the Department of Health.

An interview with the DHA confirmed the DHA conducts physical evaluations, diagnoses health problems, prescribes treatment, educates and counsels patients concerning medical conditions, makes referrals for off-site care, and reviews protocols to make the necessary changes. The DHA is also available twenty-four hours a day, seven days a week by phone to address all concerns the center has.

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 utilizes facility operating procedures (FOP) and treatment protocols for all health-related concerns. The FOPs were found to be well organized in a three-ring binder. All FOPs and treatment protocols contained the signatures of the designated health authority (DHA) and the superintendent. On August 25, 2019, an annual FOPs and treatment protocols review was conducted by the DHA and the superintendent. Documentation confirmed all medical staff received a comprehensive clinical orientation to the Department's healthcare policies and procedures, which was provided by the registered nurse. Documentation confirmed nursing staff completed the annual review of FOPs and signed the cover page.

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 healthcare records confirmed each youth had a signed Authority for Evaluation and Treatment (AET). All AETs were received prior to the youth receiving medical treatment. One AET was stamped "copy" and the remaining six were originals. Two were limited AETs.

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

A review of seven youth individual healthcare records (IHCR) found none were applicable for a parent/guardian notification. Three additional youth records were reviewed and found each youth was placed on general medications. Each instance documented telephone calls, or attempted telephone contacts, and verbal approvals which were witnessed. In addition, the parental notifications were sent to the parent/guardian using the Department approved health services forms for parental notifications.

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

Seven youth individual healthcare records (IHCR) were reviewed for screenings upon admission for healthcare concerns. Each of the seven reviewed IHCRs contained a Medical and Mental Health Screening Form completed, on the date of admission, by a juvenile justice detention officer (JJDO) or JJDO supervisor (JJDOS) and reviewed by a registered nurse (RN), or licensed practical nurse (LPN) within twenty-four hours. Three of the seven youth were applicable for a qualitative urine pregnancy screening at the time of admission. In each instance the youth consented, was tested, and the results were documented in the youth's IHCR. An interview with the nursing staff confirmed youth are normally seen by nursing staff within twelve hours, but no longer than twenty-four hours of admission and admission screenings are completed by nursing staff.

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

The center maintains a written policy and procedures which requires healthcare staff to orient each youth to the center within twenty-four hours of admission. Seven individual healthcare records (IHCR) were reviewed for completion of orientation. In all seven IHCR reviewed, documentation revealed each youth participated in orientation to the general process of healthcare. Two youth received their orientation outside of the twenty-four-hour requirement but within forty-eight hours. The remaining five youth received their orientation within the required

twenty-four hours. Youth orientation to healthcare services addressed all of the required topics, including sick call, the right to refuse care, and what to do in the case of a sexual assault or attempted sexual assault, the role of healthcare staff at the center and to notify staff immediately if they are having side effects from medications, allergies and/or medical alert issues, and/or when experiencing chest pain, extreme shortness of breath, or faintness while exercising.

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

The center maintains a written policy and procedures which requires the designated health authority (DHA)/designee to be notified when any youth admitted to the center requires emergency care or routine notification in accordance with the Department's requirement. Seven youth individual healthcare records (IHCR) were reviewed. None of the youth required emergency care upon admission.

Three youth were identified as possessing a medical concern, chronic condition, or taking psychotropic medications. Each of the three IHCRs indicated the DHA and the advanced registered nurse practitioner (ARNP) was notified within twelve hours and referred for appropriate follow-up service. One of the three applicable youth was taking psychotropic medication upon admission and documentation showed the DHA was notified, as required. An interview with the nurse confirmed the DHA is notified of chronic illnesses after completion of the intake. The DHA is notified by phone.

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

Seven youth individual healthcare records (IHCR) were reviewed. Each record had a completed Health Related History (HRH) form within seven days of admission to the center by a licensed nurse. Four were new HRH forms, the remaining three were updated forms. Documentation provided revealed the designated health authority (DHA) or designee reviewed the HRH forms. Each HRH form was completed prior to completing the Comprehensive Physical Assessment (CPA).

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

A review of seven youth individual healthcare records (IHCR) revealed a Comprehensive Physical Assessment (CPA) was completed for each youth. Each CPA was reviewed and initialed by the physician. Each CPA was completed within seven days of admission by a medical doctor or the advance registered nurse practitioner (ARNP). Four of the seven youth CPAs were new, the remaining three were updated due to the youth having a valid CPA on file. In seven youth records, the youth "voiced no concerns" related to their private parts; in addition, they all refused the genitalia/Tanner Exam. Each of the seven youth records documented the refusal for the Tanner Exam. A review of the Department's Problem List indicated it was

updated for each youth, as required. The center has a written policy and procedures outlining all youth are required to be screened for tuberculosis (TB). A review of seven youth IHCRs reflected each youth had a minimum of one verified tuberculosis skin test (TST) documented in each youth's IHCR. Each of IHCRs documented Tier One TB screenings were completed within seventy-two hours of admission. There were no further evaluations or treatments needed. The information was documented on each youth's Infectious and Communicable Disease (ICD) form and on the CPA. An interview with the nurse revealed youth are evaluated to determine the probability of exposure.

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

The center has a policy and procedures regarding the completion of sexually transmitted infection (STI) screenings. Seven individual healthcare records (IHCR) were reviewed, of which three youth reported being sexually active. The center screens each youth for STIs and attempted to make accommodations for all youth interested in submitting to STI test and human immunodeficiency virus (HIV). One of the seven youth submitted to the STI evaluation. The results were documented on the communicable disease form. The youth's test results were noted on the Department's Infectious and Communicable Disease (ICD) form filed in the youth's IHCR, if applicable. The remaining six youth refused testing.

Seven youth records were reviewed, of which five refused human immunodeficiency virus (HIV) testing and treatment. A copy of the refusal was filed in the youth's IHCR, of the two youth who consented to HIV testing, one later refused, and the remaining youth is scheduled for pre-test counseling on August 30, 2019. The certified registered nurse is providing all HIV services at the center. Seven youth interviewed and confirmed they can request HIV testing.

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

The program has a policy and procedures in place to conduct sick call for all youth in the center experiencing illness. All youth in the center can make sick call requests and have their complaints treated appropriately through the sick call process. Sick calls are conducted daily, as needed, by a licensed medical staff. Medical staff reserve time Monday through Friday from 11:00 a.m. to 12:00 a.m. and 5:00 p.m. to 6:00 p.m. and Saturday and Sunday from 10:00 a.m. to 11:00 a.m. to address sick calls. Sick call request forms and narrative progress notes conform to the professional standard to include all elements of the subjective, objective, assessment, and plan (SOAP) format. There were no youth complaints of any severe pain with which medical staff was unfamiliar with. Documentation confirmed when youth are in restricted housing, medical staff provided the necessary medical attention based on the youth's needs. The center documented the sick calls in three ring binders. Eight staff were interviewed concerning sick calls and all reported the nurse and doctor respond to sick calls and two staff also stated staff respond to the sick calls. Seven youth were interviewed, three reported seeing within one day of requesting a sick call. One youth reported being seen within three days, and

three youth reported never requesting a sick call. Four also reported nurse and staff conduct sick calls, three reported the medical staff.

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

The center has an established policy and procedures for the provision of episodic care, first aid, and emergency care. A review of seven youth individual healthcare records (IHCR)revealed one was applicable; therefore, two additional applicable youth records were reviewed. A review of three applicable youth IHCRs found each contained appropriate documentation of the episodic care events. Each youth was seen by medical staff. The center maintained an Episodic Care Log to document the provision of episodic care and first aid treatment. A review episodic care documentation found subjective, objective, assessment, and plan (SOAP) elements. A review of the logs indicated episodic care was administered by the nursing staff.

The center has a total of five first aid kits. All five were inspected and contained all the approved content, as required, all contents were up-to-date, and all first aid kits were resealed with a tamper tag. The program also has two automated external defibrillators (AEDs), both were tested and were functional during the annual compliance review. The pads and batteries were installed on August 20, 2018 and will expire on March 28, 2021. Documentation and interviews confirmed the nursing staff review inventory and restock all first aid kits monthly and document the review on a log located on each first aid kit. First aid kits were located throughout the center. A review of the center medical drills confirmed the center conducts mock emergency medical drills at least quarterly on each shift. Eight staff were interviewed and all reported they were able to call 9-1-1 if they feel necessary.

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

The center has a written policy and procedures to provide timely referrals and coordination of medical services for youth requiring off-site care. A review of seven youth individual health care records (IHCR) revealed one was applicable; therefore, two additional applicable youth records were reviewed. The reviewed documents confirmed the center provides for timely referrals and coordination of off-site healthcare medical services. Information was documented on the episodic care log. The IHCRs contained a summary of off-site care form and discharge instruction documents, when applicable. Reviewed documentation confirmed the designated health authority (DHA) was notified of the emergency event and the youth followed-up with the DHA in all three instances.

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

The center has a written policy and procedures for the delivery of treatment to youth identified as having a chronic medical condition. A review of seven youth individual healthcare records

(IHCR) found three youth were identified with a chronic medical condition and/or taking prescribed medications. The center maintained a chronic conditions roster to document the youth identified with certain medical conditions. An interview with the registered nurse confirmed periodic evaluations are conducted in some cases weekly and others monthly as needed based on the conditions. Documentation of the chronic condition log was provided. At the time of the annual compliance review, two of the youth's first evaluations were scheduled the first week of September 2019 and the remaining youth's first evaluation was completed on August 27, 2019. There was no lapses in treatment and their Problem Lists were updated.

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

The center has a written policy and procedures to ensure medication is received, stored, inventoried and provided in a safe and effective manner. A review of seven youth individual healthcare records (IHCR) found three youth were prescribed medication prior to their admission to the center. In each of the three IHCR, the medication was brought to the center by the parent/guardian, verified, and the youth was continued on medications. The center used the standard Department Medication Administration Record/Electronic Medical Record (EMR), to document consumption and refusal of medications. The MAR documented all of the required information including medication start and stop dates, and staff and youth initials of medication received. There were no lapses or errors in medication administration. The medical staff document weekly side effects monitoring on the MARs.

A medication pass was observed during the annual compliance review after the youth gave verbal consent for the observation. The registered nurse (RN) verified the Six Rights of Medication Delivery/administration (Right youth, right medication, right dose, right route, right time, and right documentation). After the RN gave the youth the medication, the RN verified the youth consumed the medication by checking his mouth. The center has trained non-healthcare staff to assist in the delivery of medications, only when licensed staff are not on-site. There were no refusals; however, the center's practice is to clearly document refusals on the MAR and Refusal Form, when applicable. Eight staff were interviewed, and all reported they do not give any medications to youth. Seven youth were interviewed, two stated they received medication from the doctor and four reported receiving medication from the nurse.

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

The center maintains a written policy and procedures ensuring medical equipment classified as medications/sharps secured and inventoried by using a routine perpetual inventory. The medical staff ensure all medication and sharps are stored and locked in designated areas inaccessible to youth. Medications are stored in a locked medication cart, cabinets, and in the locked refrigerator all of which are situated in the medical clinic which is always locked and inaccessible to youth. All medications are stored separately. All controlled medications were stored behind two locks. There was documentation of shift-to-shift counts being conducted. A

shift-to-shift inventory count of all controlled substances was documented on the youth's individualized Controlled Medication Inventory Record.

A review of the center's inventory was conducted; documentation showed the center secured, locked, and inventoried all medications and medical equipment such as sharps by using a routine perpetual inventory descending count as each sharp is utilized and disposed. A random inventory of three different sharps, three prescribed medications, and three over-the-counter (OTC) medications revealed each count was accurate and documented by licensed nursing staff correctly. A review of the past six months of medications revealed all counts and inventories matched medications on-site. The number of pills, tablets, or dosages remaining after each administered dosage was documented on the youth's individualized Controlled Medication Inventory Record. Reporting criteria and procedures for inventory discrepancies shall be in place. The center contracts with Diamond Pharmacy Services for the delivery of medication and the return of unused medication.

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

The center has a written policy ensuring all staff and youth receive education on infection control. A review of the center's plan was conducted and confirmed the plan included all of the required elements. Seven reviewed youth individual healthcare records (IHCR) confirmed each youth received infection control training within seven days of admission. Training included guidelines for hand-washing techniques, universal/precautions, prevention/transmission of communicable diseases, prevention of blood borne pathogens, and guidelines for infection control. A copy of the Health Education Record form was maintained in each reviewed IHCR. All trainings and education were provided in accordance with the Centers for Disease Control and Prevention guidelines. A review of seven staff training records confirmed each staff received pre-service and in-service infection control training.

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

The center has a written policy and procedures which ensure access to prenatal care for all pregnant youth and health education is provided to both youth and staff. A review of the staff's training roster verified the center's registered nurse provided training/education to staff involved in the supervision or treatment of pregnant youth. The training/education addressed the monitoring, observation and care of pregnant youth. A review of three applicable youth records confirmed once a youth is determined to be pregnant, prenatal care begins immediately. One youth was in the center for three days, another youth was in the center for seventeen days, and the remaining youth was in the center for two months. Each of the three pregnant youth received education regarding alcohol and drug use, smoking, nutrition, sexually transmitted diseases, contraception, prenatal care and the birthing process, postpartum care, basic child care, child/infant development and parenting skills. Documentation showed each youth received

a plan of care through post-birth to include psychological and physical care. Each youth was provided extra foods, prenatal vitamins, an extra mattress for comfort, weekly monitoring, and doctor visits. Only one youth was applicable for medical evaluations every thirty days and received the required monitoring. The remaining youth were not in the center long enough to receive the monitoring. However, the center provided daily and routine monitoring of danger signs nutritional and weigh status by licensed medical staff.

Standard 5: Safety and Security

5.01 Active Supervision of Youth (Critical)	Satisfactory Compliance
Staff are aware of the location of youth assigned to their supervision at all times. Staff monitor the movement of youth in their direct care from one location to another. *Youth are in sight of at least one juvenile justice detention officer (JJDO) at all times (with the exception of sleeping hours or time secured in rooms).* *Officers are responsible for the care of youth at all times. At no time shall another youth be allowed to exercise control over or provide discipline or care of any type to another youth.* *When a youth leaves the group or program area of the center for any reason, all staff assigned to supervise the youth are informed.* *Master Control authorizes all movement of youth prior to the actual movement, and no movement occurs until cleared by Master Control.* *Staff moves youth from one area of the center to another in accordance with Florida Administrative Code.*	

An observation of staff during daily activities was conducted during the annual compliance review. Activities included recreation, as the female youth were outside playing kickball, breaks, as all the youth were in their assigned living units, line movements, lunch, basketball inside the gym, and education. There were a total of six female youth being actively supervised by a minimum two female staff during each day of the annual compliance review. A minimum of five staff were observed supervising the male youth. In cases when a youth left a group or a program area, staff were assigned to supervise the youth and notification was sent to all staff including the staff assigned to master control by utilizing two-way radios. No movement occurred prior to the staff assigned to master control authorizing it. All movement was in accordance with the Florida Administrative Code. At no time were staff observed allowing youth to exercise control over or provide discipline or care of any type to another youth. A review of the logbooks determined the counts were conducted at the beginning and end of each shift. There is a total of three shifts as the first shift. A census sheet is utilized and a white board in each living area as a method of tracking the youth and the center’s log book. A random sample of eight staff were interviewed and they reported staffing was adequate.

5.02 Ten-Minute Checks (Critical)	Satisfactory Compliance

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

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

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

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

The center has forty-three cameras, of which forty-two are operational. Video recordings are stored for thirty days. An observation the video for the center for ten-minute visual observations determined staff conducted the required visual observations. Observations included staff visual observations during sleep time. Staff were observed conducting visual observations of the youth in a manner ensuring the safety and security of each youth, as staff paused to look inside the secure room and leaned towards the window. Staff were in the direct line of sight as needed and documented in real time. At no time was the officer unable to see the youth. An observation of the center's cameras was conducted. An observation of two different shifts from a sample of videos, six different days and times determined compliance. Visual Observation sheets are utilized by detention officers when conducting checks, as the checks were conducted within the required frequency. The center utilizes wands and visual observation sheets. A random sample of eight staff were interviewed and they reported 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).

Daily observations determined census counts of the youth were taken. The officers, in collaboration with master control, document the head counts at the beginning and end of each shift, emergencies, routine group movement, population change, and random head counts. This

is accomplished by the officers utilizing two-way radios. A review of the center's logbooks determined headcounts, youth movements, and daily census were documented, as required. A random sample of eight staff were interviewed and they reported emergency counts are conducted when a youth is missing, not visible, or after a major disturbance. Documentation did not include youth not physically present. A random sample of eight staff were interviewed and they reported counts are conducted at beginning and end of each shift. If the count isn't correct, staff reported they inform master control to ask for a recount count.

5.04 Logbook Maintenance	**Satisfactory Compliance**

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

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

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

A log book is utilized in each living unit and master control. The log books maintain a chronological record of events, incidents, and activities. The books are bound with number pages. Each entry included dates, times, names of staff, youth involvement, brief descriptions of events, and the name of the staff making the entry. Medical, special needs, and mental health alerts or issues were highlighted. Logbook entries were reviewed for each living unit for the past six months. The center utilizes military time on some occasions. Entries were made in ink and the logbooks were bound with sequential pages. The master control logbook documented all the required entries.

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.

Logbook entries were reviewed for each living unit for the past six months. The center utilizes three living areas, B one, B two and three, and G one. The males utilize B one and B two and the females utilize G one. Documentation determines the superintendent and the captains review the log books weekly. Those entries were documented in blue ink. The juvenile justice

detention officer supervisors (JJDOS) reviewed the facility logbook maintained at master control for each shift daily.

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

An observation of the center's key control procedures was conducted. Each key was placed on a tamper-resistant key ring. The center's emergency keys were maintained within master control. Only the superintendent, captains, supervisors, and the maintenance staff have access to the center's emergency keys, as the superintendent reported and observations confirmed. The observations conducted determined the emergency keys provide the action of going out and leaving out through the exteriors doors, providing access to evacuation areas. The supervisors for each of the three shifts maintain the inventory for all keys. The center documents the shift, the ring number, the number of keys on each ring, capability of each key, and who the key is issued to. It also documents the date and time the key was issued and returned. Seven staff records were reviewed, and each staff had key control training. An observation of staff during daily activities was conducted. Observations confirmed officers were responsible for the security of their issued keys and accounted for their issued keys during their work schedule. The key identified also matched the key they signed out. The issued keys were always on the staff. Youth were not observed to have control of the keys at any time during the annual compliance review. There were no accounts of the center's keys leaving the grounds during the scope of the annual compliance review period. Each day of the review the review team's personal keys were observed to be secured in master control prior to entering the facility. The center's policy delineates the proper key control requirements and training for staff. The policy requires staff to report all missing or lost keys immediately upon gaining knowledge. Eight interviewed staff reported the center's daily process for tracking keys include using the key log, a chit, and utilizing master control to properly secure and store personal and visitors' keys. Staff also reported the center's practice is to keep inventory of keys, prohibit youth from accessing keys, replacing damage keys, and searching the facility and youth for any reported missing keys.

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

The center has a total of seven vehicles. Interviews with the maintenance staff revealed the vehicles are inspected prior to use by the detention officers and when items are found or suspected to be out of compliance, staff must have approval of transportation. The center did not have any instances vehicles being out of compliance. Documentation indicated each of the seven vehicles were searched before and after each transport. The officer completed the searches. Documentation reviewed for the past six months included the maintenance staff conducting weekly visual checks and monthly vehicle checks to include all appropriate requirements. An observation of staff before and after transportation was not available during the annual compliance review. Documentation determined a copy of the current transportation procedures were in each of the vehicles. Each of the vehicles were observed to be free of contraband, a secure screen, had enough gasoline, vehicle logs, gas credit card, and vehicle registration. After transports, documentation determined the staff searched the vehicle for contraband and remaining youth. Invoices included annual safety inspections and any deficiencies were corrected prior to use.

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

The center utilizes a locked storage room located inside the center's main hallway leading to the gym. The kitchen also maintains sharp tools in a locked cabinet attached to the wall. Each tool was inspected monthly. The results of these inspections are reviewed by the superintendent. There was no evidence of broken tools upon observation.

The center maintains a perpetual inventory of all tools, and the superintendent reviewed each tool. Kitchen staff inventoried each tool daily during shift change. There was no evidence of discrepancies upon observation. There have not been any documented instances of lost tools by the center. Tools and equipment with the potential to cause death or serious injury are maintained in locked secure areas inaccessible to youth. The maintenance tools are marked with an identification code. The issuance and return of tools were documented. Interviews with the maintenance staff and superintendent determined it's the program practice to allow the superintendent and captains to have access to maintenance tools. Maintenance staff reported missing tools are documented and reported to the superintendent. The kitchen tools are separate and stored securely. The issuance of kitchen tools and returns of tools are documented daily. An observation of the center's policy on maintenance and kitchen tools determined staff adhere to the required procedures for tool inventory and management. Each tool room was secure and inaccessible to youth. All tools were accountant for by the maintenance staff. Maintenance and kitchen staff did maintain documentations for the issuance and return of tools.

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

The center utilizes three living areas, B one, B two and three, and G one. Each mod was observed to be clean. Seven youth and eight staff youth were interviewed, and each reported using mops and brooms and scrub brushes. Youth were forbidden to use any other tool. Youth are under strict supervision while handling mops and brooms.

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

The center utilizes two storage units for flammable, toxic, caustic, and poisonous items located in two storage units inaccessible to youth. A key lock is used to secure the storage closets. Maintenance, kitchen staff, and captains have access to the storage units. The center's safety plan includes inventory and secure storage. Each inventoried item matched the on-site inventory. All flammable, toxic, caustic, and poisonous items were stored in the secure area inaccessible to youth. A review of the center's safety plan determined procedures to address a chemical spill or injury while handling dangerous materials. The Material Safety Data Sheets (MSDS) to the flammable, toxic, caustic, and poisonous materials and items determined there is an MSDS for all materials.

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

Flammable, toxic, caustic, and poisonous fluids and other dangerous substances were stored in secure areas inaccessible to youth. The center utilizes two storage closets for flammable, toxic, caustic, and poisonous located within the center and in the kitchen's storage, inaccessible to youth. Eight interviewed staff and seven youth each reported youth are not allowed to clean with flammable, toxic, caustic, and poisonous fluids and other dangerous substances.

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

Observations determined flammable, toxic, caustic, and poisonous fluids and other dangerous substances are stored in secure areas inaccessible to youth located outside in two storage units in front of the sally port entrance and in the kitchen's designated storage area. A review of the center's facilities operatizing procedures determined all hazardous items and toxic materials are disposed of in accordance with Occupational Safety and Health Administration (OSHA) Standard. There were no signs of kitchen waste being disposed of inappropriately as observations revealed. An interview with maintenance personnel determined it's the practice of the facility to dispose of flammable, toxic, caustic, and poisonous items and materials in accordance of OSHA as Escambia County is utilized as the county owns the building.

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

The center utilizes three living areas for confinement. The rooms on each mod were free of obstruction. Seven confinements under twenty-four hours were reviewed. Each room utilized did not have any safety hazards. Each of the seven youth had a confinement report. Documentation showed each confinement room was searched by an officer. The confinement report was completed in the facility's management system (FMS). The juvenile justice detention officer supervisor (JJDOS) documented if there were any special needs for each of the seven youth reviewed. The confinement report was evaluated and the JJDOS documented the youth's status every three hours for each of the seven youth. The superintendent reviewed each of the reviewed confinement reports within forty-eight hours. The JJDOS reviewed each confinement within two hours. All instances of continued confinement were stated clearly in the confinement report. The need for confinement was documented every three hours.

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

The center utilizes three living areas for confinement. The rooms on each mod were free of obstruction. The center did not have any reports of confinement over twenty-four hours.

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

The center utilizes a binder to maintain the Continuity of Operations Planning (COOP) drills. The center had documentation of completing a COOP drill prior to June 1, 2019. The center completed all required COOP drills, within the last year, covering sever weather, major disturbances, hostage, chemical spills, and flooding scenarios. Drills were also located in the center's log books. Eight staff were interviewed and eight reported participation in a weather scenario COOP drill, five reported major disturbances, six bomb threats, five bomb threats, eight terrorism, and eight fire drills.

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

A review of the center's escape prevention plan determined the center has a process to maintain safety and security in the event the center needs to respond quickly and appropriately. The plan delineated appropriate levels of supervision, staff vigilance, and proper building maintenance in escape drills. A review of the center's escape prevention plan determined the center included the Department's policies and procedures. Seven staff records were reviewed, and each received escape prevention training. The center utilizes a binder to maintain the

escape drills. The center has three shifts. The center conducted and documented quarterly mock escape drills for each shift, each quarter. Eight staff were interviewed, and each staff reported they had training of escape prevention annually. Drills were also located in the center's log books. Each of the staff also reported participating in escape drills.

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

A review of the center's fire prevention plan determined the center has implemented a disaster preparedness plan. The center utilizes a binder to maintain the fire drills. Drills were found to be conducted monthly, facility wide, on each shift. The center had documentation of conducting monthly fire drills. Dills were also located in the center's log books. Eight staff were interviewed and each of the staff reported participation fire drills.