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:

Lea Herring, Office of Accountability and Program Support, Lead Reviewer (Standard 1)
Jill Foy, Office of Accountability and Program Support, Regional Monitor (Standard 2)
Tara Frazier, Office of Accountability and Program Support, Regional Monitor (Youth and Staff Interviews)
Patrick M McKinstry, Office of Accountability and Program Support, Regional Monitor (Standard 3)
James Ken Phillips, Office of Accountability and Program Support, Regional Monitor (Standard 5)
Craig Swain, Office of Accountability and Program Support, Regional Monitor (Standard 4)

Program Name: Escambia Regional Juvenile Detention Center MQI Program Code: 2
Provider Name: DJJ Contract Number: N/A
Location: Escambia County / Circuit 1 Number of Beds: 50
Review Date(s): October 20-23, 2020 Lead Reviewer Code: 127

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
5.08 Key Control	
5.18 Escape Drills	

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	Grievances	Satisfactory
1.09	Entering Alerts(JJIS) and Sharing of Alert Information *	Satisfactory

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

Standard 2: Youth Management
Detention Rating Profile

Indicator Ratings

Standard 2 - Assessment and Performance Plan		
2.01	Admission	Satisfactory
2.02	Orientation	Satisfactory
2.03	Classification	Satisfactory
2.04	Notification of JPO Circuit Gang Rep	Satisfactory
2.05	Admission of Youth Personal Property	Satisfactory
2.06	Storage of Youth Personal Property	Satisfactory
2.07	Release	Satisfactory
2.08	Release of Youth Personal Property	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	Trauma-Informed Care	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).

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

The center has a daily activity schedule for Monday through Friday and a daily activity schedule for the weekends on Saturday and Sunday. A review of the center's logbooks for the previous six months reflected adherence to the daily activity schedule. The few exceptions noted were during times of quarantine due to the COVID-19 pandemic, in which youth did not move to the classrooms and schoolwork was completed on the dorms. Also, noted were instances of all youth visiting medical for temperature checks. In addition, observations made throughout the week of the annual compliance review reflected adherence to the daily schedule. Five interviewed youth reported the center has an activity schedule and the schedule is followed daily. Five interviewed staff reported the daily activity 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. A review of the center's instructional schedule indicated school starts at 8:30 a.m. and ends at 2:32 p.m. A review of the education schedule and school district calendar revealed youth are provided with education 250-days a year distributed over twelve months, with a minimum of twenty-five hours of instruction per week. Teachers are also given three 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 the master control logbooks reflected there were no missed school days. An interview with the lead educator and five youth revealed there is minimal interference of educational instruction. Four interviewed youth stated they attend life skills, math, science, history, reading, social studies, and career choices at the center. One youth has graduated but chose to continue to attend school in order to earn the student of the week award. The superintendent reported there is no interference in 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.	

The center is providing Type One programming to include life skills group activities and instruction. The center also uses My Career Shines, job applications, and mock interviews. The career education programming includes communication, interpersonal skills, and decision-making skills. In addition, the youth take a career interest inventory.

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

The center has incorporated trauma-informed practices into current operations to deliver services and to provide care to youth in custody. The center has a soft room and painted using soothing colors. A review of ten staff training records, five in-service and five pre-service reflected all ten staff completed the Trauma Informed Care training. According to the superintendent, soft colors and age appropriate artwork have been placed throughout the center. In addition, the superintendent reported staff are trained on practicing trauma-informed care in Phase One training, in-service training, and implementation of the statewide behavior management system (BMS).

Standard 3: Mental Health and Substance Abuse Services

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

The center has identified a single licensed mental health professional as the designated mental health clinical authority (DMHCA). The DMHCA is a licensed mental health counselor (LMHC) under Chapter 491. The DMHCA licensure is clear and active, which expires on March 31, 2021. The DMHCA is a full-time employee and is on-site forty hours per week. The DMHCA functions include appropriate coordination and implementation of mental health and substance abuse services, which are taking place at the center. The center has designated two additional back-up DMHCA's; both are licensed under Chapter 491. Each of the back-up DMHCA licensures are clear and active expiring on March 31, 2021. The contract held between the Department and Camelot Community Care, Inc., was reviewed and outlined the DMHCA duties and responsibilities.

The DMHCA was interviewed and able to describe their role in the coordination and implementation of mental health and substance abuse services at the center. The DMHCA is responsible for overseeing the mental health department which entails reviewing, completing, and signing the necessary documents such as the Assessments of Suicide Risk (ASR), Suicide Risk Screening Instrument (SRSI), treatment plans, and progress notes within the designated time frame. Services provide include but are not limited to mental health counseling and substance abuse counseling (individual and group bases). The center maintains a running tracking log to determine due dates for treatment plans as well as the daily tracking log of the services provided.

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 have any other licensed clinical staff other than the DMHCA; therefore, this indicator shall be rated as 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 service provider is licensed under Chapter 397, in order to provide substance abuse services. The service provider's licensure for the center expires on April 1, 2021. Review of documentation while on-site, supports the clinical supervisor assures the non-licensed clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience. The one non-licensed mental health clinical staff person holds a master's-level degree from an accredited university in the field of psychology. The non-licensed substance abuse clinical staff person can provide substance abuse services within the center as an employee of this service provider who is licensed under Chapter 397. The non-licensed mental health clinical staff person conducted Assessments of Suicide Risk (ASR) and was in receipt of twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. The training included administration of, at a minimum, five assessments of suicide risk or crisis assessments conducted on-site in the physical presence of a licensed mental health professional and documented on the non-licensed mental health clinical staff person's training ASR form. The non-licensed mental health clinical staff person's training was completed on November 17, 2019. In addition, the one non-licensed mental health and substance abuse clinical staff has received at least one hour per week of on-site face-to-face direct supervision by the licensed clinical supervisor. Documentation of supervision notes were observed for the past six months. Documentation of direct supervision was observed and recorded on the Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log form.

A review of five youth records revealed the licensed mental health professional (LMHP) providing direct supervision reviewed the assessments which were conducted by the non-licensed mental health clinical staff within twenty-four hours of the referral for assessment. Each of the completed assessments which were conducted by the non-licensed mental health clinical staff were signed by the LMHP the next scheduled time the LMHP was on-site. In addition, the qualified professional providing direct supervision to substance abuse clinical staff also reviewed and signed the necessary evaluations and treatment plans prepared by the 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 the Florida Administrative Code and the current contract between the Department and Camelot Community Care, Inc.

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

A sample of five youth records were reviewed for mental health and substance abuse admission screening. The screening instruments completed by the juvenile assessment screener staff, were the Suicide Risk Screening Instrument (SRSI) and the Massachusetts Youth Screening Instrument – Version 2 (MAYSI-2). On-site documentation reviewed, also supported each of these instruments were completed by detention staff. The five reviewed SRSI were each completed during the youth's intake. The five reviewed SRSI and MAYSI-were completed using the Department's Juvenile Justice Information System (JJIS). The nurse and/or mental health staff completed the required sections of the SRSI. There were completed entries observed in each of the five youth records reviewed which included the summary and recommendations in the "screening results" sections. Four of the five youth records reviewed were applicable and contained a "Yes" response on the SRSI. Each of the four youth were appropriately placed on suicide precautions and a mental health referral was completed.

In each of the four applicable records, results of the SRSI and MAYSI-2 indicated a need for further assessment. As indicated by the screenings conducted, further assessment was required for four of the five youth records reviewed. In each of the four applicable cases, a referral was generated for each of the youth. Notification was made to the superintendent, or designee, for each of the four screening instrument findings. In the four applicable youth records reviewed, a MAYSI-2 assessment indicated an elevated suicide risk subscales. The four youth were placed on suicide precautions and referred for an Assessment of Suicide Risk (ASR). One of the five youth records reviewed, required a referral for a comprehensive assessment. An interview with the superintendent revealed, detention staff, nursing, and mental health clinical staff complete the mental health, substance abuse, and suicide risk screenings.

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

A sample of five youth records were reviewed and three were applicable for needing a mental health and substance abuse evaluation. Each of the three applicable youth contained a new comprehensive mental health or substance abuse evaluation. Each of the evaluations were completed by Camelot Community Care, Inc. within thirty days. The three completed comprehensive mental health and/or substance abuse evaluations consisted of the substance abuse and mental health (SAMH) evaluation. Each of the evaluations were completed within the Department's Office of Health Services (OHS) Electronic Medical Record (EMR) module. None of the reviewed youth records required a comprehensive assessment through a community provider.

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

A sample of five youth records were reviewed for treatment which three were applicable. One of the three youth were applicable for an initial treatment plan. The initial treatment plan was developed on the Initial Mental Health/Substance Abuse Treatment Plan form. The reason for referral for treatment was noted, along with the initial Diagnostic Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis and symptoms. The initial treatment included counseling, treatment goals, and psychiatric services. The initial treatment plan contained appropriate signatures from the mental health professional, youth, and mini-treatment team members involved in development of the plan. Two of the three youth required an individual treatment plan. The remaining youth recently received an initial treatment plan, whereas the individual treatment plan was not required at time of the annual compliance review. The remaining two youth had individualized treatment plans which were developed within thirty-one days of the youth's admission to the center. Both treatment plans were signed by the licensed mental health professional; however, one of the two plans did not contain a signature date. Each of the individualized treatment plans included DSM-5 diagnosis and symptoms. In addition, both plans included treatment goals, strengths/abilities, and preferences/needs.

A review of the youth's progress notes validated each youth were in receipt of treatment services as stipulated on their treatment plans. Each of the individualized treatment plans contained dates and signature of youth, mental health professional, treatment team members, and parent/guardian. One youth required a thirty-day individual treatment plan review. The one youth individual treatment plan review was conducted timely and completed on the Individualized Mental Health/Substance Abuse Treatment Plan Review form. The individual treatment plan was reviewed every thirty days by the treatment team and modifications were documented on the review form. The one youth individual treatment plan review was signed and dated by the clinical staff, youth, and licensed mental health professional. A sample of three youth records were reviewed for mental health and substance abuse treatment discharge. Each of the reviewed records contained a Mental Health/Substance Abuse Treatment Discharge Summary form which was completed upon the youth's discharge. In addition, the Mental Health/Substance Abuse Treatment Discharge Summary form was documented and provided to the juvenile probation officer (JPO), parent/guardian, and the youth.

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

A sample of five youth records were reviewed for mental health and/or substance abuse treatment which three were applicable. Each of the three applicable youth requiring treatment were assigned to a mini-treatment team. Each of the three youth were determined to be in need of mental health treatment which included either individual, group, and/or family counseling. Two of the three youth reviewed were applicable for inclusion of substance abuse treatment. Proper consent for mental health treatment was found for each of the three youth receiving mental health treatment. Proper consent and information release were found for each of the two youth receiving substance abuse treatment. Treatment notes and Counseling/Therapy Progress Notes were found for each of the three youth. An informal interview was held with the mental health professionals, who verified they have adequate access to youth in order to provide treatment. Mental health and substance abuse treatment services are typically provided to youth after school hours, or as needed, when identified by staff or youth. Group therapy is limited to ten or fewer youth with mental health diagnoses and fifteen or fewer youth with substance abuse diagnoses. Video observation of groups being conducted at the center, along with logbook verified the mental health professionals are conducting the services and the delivery time frames were being met.

An interview with the designated mental health clinician authority (DMHCA) was conducted and was able to describe the type of specialized services offered at the center. The DMHCA indicated the center does not offer any specialized services at this time. The DMHCA stated, the center offers clinical services which are comprised of individual and group mental health and substance abuse counseling, crisis interventions, and emergency services. Five youth were interviewed on how they would rate the mental health and substance abuse services they are receiving. One youth responded fair, three youth responded good, and one youth responded very good. There were no additional comments provided.

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.	

A sample of five youth records were reviewed for psychiatric services and four were applicable for an initial psychiatric interview. Each of the reviewed youth's initial psychiatric interview included a reason for referral, history, mental status examination, Diagnostic Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis and symptoms, and treatment recommendations. One of the youth was currently taking or prescribed medications at time of the initial psychiatric interview. The youth had an explanation of the need for psychiatric medication and frequency of monitoring and management of taking medications. One of the five

reviewed youth were applicable for an in-depth psychiatric evaluation within thirty days of referral or admission. The in-depth psychiatric evaluation contained the reasons and factors leading to the referral. In addition, history, mental status examination, and identification of factors which may account for influences or ameliorate the youth's difficulties. The in-depth psychiatric evaluation also included diagnostic formulation, treatment recommendations, prescribed medications, and signature of the practitioner conducting the evaluation. The Clinical Psychotropic Progress Note (CPPN), page three was completed due to changes to the youth's psychotropic medication regimen. The psychiatric evaluation included identifying data, diagnosis, target symptoms of each medication, side effects, youth's adherence, contact with parent/guardian, and signature and date of psychiatrist. A consent for psychotropic medication was documented within the youth's health record. There was no noted need for tele-medicine or tele-psychiatry required according to the contract. The provider, Camelot Community Care, Inc., employs a psychiatrist, who is licensed pursuant to Chapter 459, Florida Statutes. The psychiatrist has a clear and active license which expires on January 1, 2021. The provider does not employ a licensed certified psychiatric advanced practice registered nurse (APRN). The provider has a back-up psychiatrist, who is licensed under Chapter 459, Florida Statutes with a clear and active license which expires March 31, 2022.

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 detention center has a written plan detailing suicide prevention procedures which was reviewed and signed by designated mental health clinician authority (DMHCA) on August 19, 2020 and by the superintendent on August 10, 2020. The written suicide prevention plan includes identification and assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and review process.

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

A sample of five youth records were reviewed for suicide prevention services which four were applicable. Each of the four reviewed youth were on determined to be at risk and placed on precautionary observation during the admission screening. The four youth had a Juvenile Justice Information System (JJIS) alert initiated upon identification of suicide precautions. A suicide risk assessment referral was found for each of the four youth identified in need. The Assessment of Suicide Risk (ASR) was conducted and completed in real time. Each youth had suicide precaution observation logs completed during the youth's time on supervision. One

youth had one documented time period of three minutes over the required thirty-minute observation time frame. All other time entries on each of the precautionary observation logs contained the required thirty-minute intervals. In each of the four youth records, qualified mental health professionals were involved. None of the reviewed youth were released prior to receiving an ASR or released while on suicide precautions.

The staff conducting the ASR documented a consultation with the designated mental health clinician authority (DMHCA). In each of the four reviewed youth records, the superintendent or designee was notified of the youth's suicide risk. The four youth had a completed ASR conducted within twenty-four hours of the referral. Each of the four youth were placed on standard supervision as a result of the ASR. The completed ASR were conducted by the non-licensed mental health professional. The non-licensed mental health professional completed appropriate twenty hours of ASR training on November 17, 2019. There was evidence in the center's logbook and suicide risk assessment where administrative or supervisory staff were provided instructions related to the youth's precaution decisions. A review of JJIS demonstrated alerts were appropriately entered/removed as needed. There were no occasions of youth requiring to be placed into secure observation.

The superintendent has an established review process for every serious suicide attempt or serious self-inflicted injury and a mortality review for a completed suicide. The multidisciplinary review included circumstances surrounding the event, written facility operating procedures relevant to the incident, 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. The center has a suicide response kit which includes a knife-for-life, a separate set of wire cutters, and needle nose pliers.

Five youth were interviewed and three stated they have been placed on suicide precautions while at the center. The remaining two youth stated they had not been placed on suicide precautions. Further review of documentation revealed, one of the two youth had been on precautionary observation at intake. Two of the youth while on suicide precautions, confirmed staff was present at all times, the one remaining youth stated no staff was on the unit but not at the door. A follow-up interview was conducted with three of the youth, the fourth youth who had been on precautionary observation; however, was released earlier in the week of the annual compliance review. A follow up interview with each of the three youth confirmed staff was them at all times while on suicide precaution. The one youth who previously reported no, stated staff was on the unit but not at the door, indicated their misunderstanding of the question and confirmed staff were present while on suicide precautions. Five youth were interviewed and were able to identify processes they 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.	

A sample of five youth records were reviewed for suicide precaution observation logs which four youth were applicable. There was a total of eight suicide precaution observation logs reviewed between the four youth records reviewed. Each of the suicide precaution observation logs were maintained for the duration the youth was on suicide precautions. The four youth had the

appropriate level of supervision and observation of behavior documented in real time. One youth had one documented time period of three minutes over the required thirty-minute observation time frame. All other time entries on each of the eight reviewed precautionary observation logs contained the required thirty-minute intervals. Each suicide precaution observation logs were reviewed and signed by each shift supervisor. Each suicide precaution observation logs were reviewed and signed by the mental health clinical staff. Completed suicide precaution observation logs each documented safe housing requirements. During an interview with five staff, each were able to identify the location of the suicide response kit within the center.

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.	

A review of five staff pre-service training and five in-service training records were reviewed for completion of suicide prevention training. Each of the reviewed staff received a minimum of six hours annual suicide prevention and implementation of suicide precautions training. Training at the center included a total of twelve mock suicide drills; four mock suicide drills per shift. The mock suicide drills were held no less than quarterly on each of the center's three shifts. The mock drills included all staff who come in contact with youth including kitchen and maintenance staff. Documentation of the mock suicide drills demonstrated staff participated in quarterly drills with a minimum of one quarterly drill semi-annually. Documentation demonstrated the direct care staff participated in at least one mock drill which included the use of cardio-pulmonary resuscitation (CPR), annually. Staff members not present during a quarterly drill have the opportunity to review each mock drill scenario and procedures during shift briefings.

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

The center has a written mental health crisis intervention plan which details crisis intervention procedures. The written mental health crisis intervention plan was reviewed and signed by designated mental health clinician authority (DMHCA) on August 19, 2020 and by the superintendent on August 10, 2020. The written mental health crisis intervention plan included notification and alert system, means of referral (including self-referral), communication, supervision, documentation, and a 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 center, requires emergency care to be provided in accordance with the center's Emergency Care Plan. The Crisis Intervention Plan and Emergency Care Plan may be combined into an integrated crisis intervention and emergency services plan which contains all the elements specified in Rule 63N-1, Florida Administrative Code.	

The center has a written emergency care plan which included immediate staff response, notification, communication, and supervision. The written emergency care plan included process for authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment under Chapter 394, Florida Statute (Baker Act), and transport for emergency substance abuse assessment and treatment under Chapter 397, Florida Statute (Marchman Act). The written emergency care plan also included procedures for documentation, training, and a review process. The center's written emergency care plan was last reviewed and signed by designated mental health clinician authority (DMHCA) on August 19, 2020 and by the superintendent on August 10, 2020. The location of the written emergency care plan is located on the center's K drive in the conference room and in the supervisor's office. The emergency care plan is accessible to all staff.

3.15 Crisis Assessments [Contract Provider] (Critical)	Satisfactory Compliance
A Crisis Assessment is a detailed evaluation of a youth demonstrating acute psychological distress (e.g., anxiety, fear, panic, paranoia, agitation, impulsivity, rage) conducted by a licensed mental health professional (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 had one youth requiring a Crisis Assessment during the annual compliance review period. The reviewed Crisis Assessment included reason, mental status, danger to self or others, initial clinical impressions, supervision recommendations, treatment recommendations, recommendations for follow-up, and notification to parent/guardian of follow-up treatment. A mental health alert was entered into the Department's Juvenile Justice Information System (JJIS). The Crisis Assessment was completed by the on-site licensed mental health professional. The reviewed Crisis Assessment was conducted immediately based upon the needs of the youth. There was no indication or allegation of the youth being a victim of a Prison Rape Elimination Act (PREA) event.

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

A sample of three youth records were reviewed for Baker or Marchman Acts during the annual compliance review period. Each of the three youth were placed on suicide precautions upon re-admission from the Baker Act. A mental health referral was completed in each of the three youth for a mental status examination. The mental status examination was completed by the licensed mental health professional on-site. Each of the three youth were maintained at a minimum of constant supervision until they were properly transitioned to a lower level of supervision. Each youth's level of supervision was not lowered until the appropriate assessment was conducted and a mental health staff conferred with the center's superintendent or designee. Each of the three youth returning from Baker Act were placed on constant supervision upon return. Each of the three youth had a suicide risk alert entered into the Department's Juvenile Justice Information System (JJIS). The discontinuation of the three youths suicide risk alert was based upon an Assessment of Suicide Risk (ASR) conducted by the on-site mental health professional.

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.	

Camelot Community Care, Inc., is contractually required to provide comprehensive medical services to youth in 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 in family practice. The DHA is responsible for the overall clinical activities, policies, and protocols for the medical services provided. The center also utilizes the services of an advanced practice registered nurse (APRN) who 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 with the exception of two weeks. During the DHA absence, the center utilized coverage provided by another medical doctor through Teladoc Medical Services and the APRN provided assistance. The DHA is responsible for making the necessary arrangements for a qualified doctor to cover the center during vacations or extended absences. The APRN provided services on-site, a minimum of twenty-four hours a week. The hours are posted on the door of the medical clinic and visible for all to see. The APRN works in collaboration with the DHA who signed the nurse practitioner protocol/collaborative practice agreement on October 19, 2019. All medical staff licenses were displayed on the medical wall and each licensed medical staff licenses were found to be current. An interview with the DHA confirmed the DHA conducts conduct physicals, see youth for initial and follow-up chronic care evaluations, evaluate youth referred from sick call, assist with policy and procedure development, collaborate with APRN, and is available for on-call service for clinic staff.

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 July 1, 2020, the FOPs and treatment protocols were evaluated and 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 the 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.	

An evaluation of five youth individual healthcare records confirmed each youth had a signed Authority for Evaluation and Treatment (AET). Four of the five AETs were stamped "copy" the remaining. Each youth had a signed AET prior to receiving any medical service. According to the nurse interview, the youth's parent/guardian is contacted and advised to sign or update the AET. If a parent/guardian cannot be reached, a limited AET is obtained from the superintendent or assistant superintendent. In addition, weekly emails are sent to the juvenile probation officers to advise youth needing an AET on file.

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.	

An evaluation of five youth individual healthcare records (IHCRs) found three were applicable for a parent/guardian notification. The three applicable youth records were evaluated and found each youth was placed on general medications. Each IHCR contained documentation a parental notice was sent. 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.	

Five youth individual healthcare records (IHCRs) were evaluated for screenings upon admission for healthcare concerns. Each of the five evaluated IHCRs contained a Medical and Mental Health Screening form completed on the date of admission by a juvenile justice detention officer (JJDO) and evaluated by a registered nurse (RN) or licensed practical nurse (LPN) within twenty-four hours. Documentation confirmed the designated health authority (DHA) was notified upon entry of all youth. One of the five youth was applicable for a qualitative urine pregnancy screening at the time of admission. The youth consented and was tested and the results were documented in the youth's IHCR. According to the nurse interview, the DHA is notified within twenty-four hours by the RN or LPN once a youth is identified as having a chronic condition.

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

Five youth individual healthcare records (IHCRs) were evaluated for completion of youth orientation. In all five IHCR evaluated, documentation revealed each youth received orientation to health care services. Youth orientation to healthcare services addressed all of the required topics, including access to medical care, sick call, what constitutes an emergency, medication

process, the right to refuse care, what to do in the case of a sexual assault or attempted sexual assault, and the non-disciplinary role of healthcare staff at the center.

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.	

Five youth individual healthcare records (IHCRs) were evaluated concerning the designated health authority (DHA) or designee notification when any youth admitted to the center who requires emergency care or routine notification in accordance with the Department's requirement. Two youth required routine notification in accordance with Department's requirements upon admission. One additional IHCR was obtained. 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 practice registered nurse (APRN) was notified within twelve hours and referred for appropriate follow-up service. Two of the three applicable youth were taking psychotropic medication upon admission. The remaining youth was identified with a medical concern and documentation confirmed the DHA and the psychiatrist was notified, as required. An interview with the nurse confirmed the DHA was notified of chronic illnesses within twenty-four hours of completing the intake.

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

Five youth individual healthcare records (IHCRs) were evaluated for Health-Related History (HRH). Each record had a completed/updated HRH form within seven days of admission to the center by a licensed nurse. Two were new HRH forms and the remaining three were updated forms. Each HRH was completed on the Department's form. Provided documentation revealed the designated health authority (DHA) or designee evaluated 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 into the physical custody of the center.	

An evaluation of five youth individual healthcare records (IHCRs) revealed a Comprehensive Physical Assessment (CPA) were completed for each youth. Each CPA was evaluated and initialed by the physician. Each CPA was completed within seven days of admission by a medical doctor or the advance practice registered nurse (APRN). Three of the five youth CPAs were new and the remaining two were updated due to the youth having a valid CPA on file. In four youth IHCRs, the youth "voiced no concerns" related to their private parts and each youth refused the genitalia/Tanner Exam which "no complaints" were documented on the CPA. The remaining youth was transferred from another center Four of five youth IHCRs documented the refusal for the exam. The remaining youth was transferred from another center. An evaluation of the Department's Problem List indicated was updated for each youth, as required.

An evaluation of five 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 (STI) and HIV risk factors.	

Five youth individual healthcare records (IHCRs) were evaluated of youth reported being sexually active. The center screens each youth for sexually transmitted infections (STI) and attempted to make accommodations for all youth interested in submitting to a STI test and human immunodeficiency virus (HIV). Four youth submitted to the STI evaluation. At the time of the annual compliance review, only one youth had the results of the test in their IHCR. The remaining youth results were pending. When applicable, results were documented on the Department's Infectious Communicable Disease form. The youth's test results were noted on the Department's ICD form filed in the youth's IHCR, if applicable.

Five youth IHCRs were evaluated and three IHCRs contained documentation the youth refused human immunodeficiency virus (HIV) testing and treatment. One additional applicable IHCR was evaluated. Three IHCRs documented consent to HIV testing and received pre-test and post-test counseling. The remaining youth was released from the center prior to being tested. The results of the two youth were filled in a confidential manner and documentation supported the results were evaluated by a practitioner. The center's registered nurse is certified to provide all HIV counseling services. Five interviewed youth confirmed they can request a 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.	

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. The center's sick call hours are Monday through Friday at 11:00 a. m. and 5:00 p.m. and on weekends at 10:00 a.m. Five youth individual healthcare records (IHCRs) were evaluated and two were applicable for sick call submissions. One addition applicable record was evaluated. Documentation confirmed each youth was seen by medical staff within twenty-four hours of submitting the request. None of the evaluated youth presented a sick call with a similar complaint three or more times within a two-week period. There were no youth complaints of severe pain which medical staff was unfamiliar with. The center documented the sick calls in three ring binders. According to the nurse, there were no instances of restricted housing to review. Five youth were interviewed on how quickly they are seen upon making a sick call request. One youth reported immediately, two youth reported within one day, one youth reported within two days, and the remaining youth reported more than three days. All five youth reported the nurse conduct sick calls.

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. An evaluation of five youth individual healthcare records (IHCRs) revealed one was applicable; therefore, two additional applicable youth records were evaluated. An evaluation 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. An evaluation episodic care documentation found to conform to the professional standards. An evaluation of the logs indicated episodic care was administered by the nursing staff.

According to the nurse, the center has a total of eighteen first aid kits. One is located in medical, two in master control, one in the front lobby, one by the time clock, one at the end of the hallway of medical, one on the girls mod, one in the entryway to the boys mod, one on the boys mod, two located in the school hallway, one in the kitchen, one in the principal's office, and five assigned for the transport vans.

Three first aid kits are placed in areas frequently utilized by youth. The evaluated first aid kits were inspected and contained all the approved content, as required. All content was up-to-date and each first aid kits was resealed with a tamper tag. The program also has two automated external defibrillators (AEDs) which both were tested and were functional during the annual compliance review.

The batteries were installed on September 28, 2018 and will expire in the year 2023. The AED pads expires on March 28, 2021. Documentation confirmed the nursing staff reviews inventory and restock all first aid kits monthly and document the review on a log located on each first aid kit. Five staff were interviewed and each reported they are able to call 9-1-1, if necessary. First aid kits are located throughout the center. An evaluation of the center’s medical drills confirmed the center conducts mock emergency medical drills at least quarterly on each shift.

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. An evaluation of five youth individual health care records (IHCRs) revealed none were applicable; therefore, three additional applicable youth IHCRs were evaluated. The evaluated IHCRs confirmed the center provided 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. Evaluated documentation confirmed the designated health authority (DHA) was notified of the event and the youth followed-up with the DHA in all three instances. In all three instances follow-up appointments were required; however, the youth were released from the center prior to their scheduled appointment.

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.	

An evaluation of five youth individual healthcare records (IHCRs) found one youth was identified with a chronic medical condition and/or taking prescribed medications. Two additional applicable youth IHCRs were evaluated. The center maintained a chronic conditions roster to document the youth identified with medical conditions. Each youth is also classified using a numerical medical grade. Each IHCR contained documentation the youth were receiving treatment for a physical health condition and periodic evaluations were scheduled on the nursing staff calendar. None of the evaluations exceeded a three month interval. Each evaluation was documented in the youth's IHCR. When applicable, treatment order were clearly distinguishable for clinical staff. There were no lapses in treatment and the Problem Lists was updated. The Department's Problem List was updated, as required. According to the designated health authority (DHA), all periodic evaluations are conducted no less than once every three months.

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

An evaluation of five youth individual healthcare records (IHCRs) found three youth were prescribed medication prior to their admission to the center. In each of the three IHCRs, the medication was verified and the youth was continued on medications. All medication has a current, valid order and the IHCR documented the prescription and practitioner's orders. The center used the standard Department's Medication Administration Record (MAR) to document consumption and refusal of medications. The MAR documented all of the required information including the medication start and stop dates and the staff and youth initials of medication received. The medical staff documented weekly side effects monitoring on the MARs. Youth and staff initial the MARs acknowledging medications was provided. There were no lapses or errors in the medication administration with the exception of one youth refusing medication during one medication pass. The center has trained non-healthcare staff to assist in the delivery of medications when licensed staff is not on-site.

Two youth were applicable for psychotropic medication upon admission, both IHCRs documented the psychiatrist was notified upon admission. Each youth received their psychiatric interview within fourteen days of admission and was continued on medication. A medication pass was observed during the annual compliance review, the registered nurse (RN) verified the six rights of medication delivery/administration. After the RN administered the medication to the youth, the RN verified the youth consumed/applied the medication by checking the youth mouth and provided the youth with a small sum of water. Five staff were interviewed and four reported they do not administer any medications to youth. The remaining staff reported the provide medication to youth. Five youth were interviewed and four reported medications are provided by the nurse. The remaining youth reported not taking any medications.

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

The center maintains a written policy and procedures ensuring medical equipment classified as medications/sharps is secured and inventoried by using a routine perpetual inventory. The medical staff ensures all medication and sharps are stored and locked in designated areas inaccessible to youth. Observation of the medications confirmed, 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 locked and inaccessible to youth. All medications are stored separately. All controlled medications are stored in the medication cart behind two locks. A shift-to-shift inventory count of all controlled substances was documented on the youth's Individualized Controlled Medication Inventory Record.

There was documentation of shift-to-shift counts being conducted. An evaluation of the center's inventory was conducted. Documentation confirmed the center inventoried all medications and medical equipment such as sharps by using a routine perpetual inventory descending count as each sharp is utilized and disposed, when applicable. A random inventory of three different sharps, two prescribed medications, and three over-the-counter (OTC) medications revealed each count was accurate and documented by licensed nursing staff correctly. An evaluation 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. According to the nurse, if there is a discrepancy with the counts, a recount of the medications will be conducted and the Department's Central Communications Center will be notified, if necessary. The center contracts with Diamond Pharmacy Services for the delivery of medication and the return of unused medication. During an interview with the nurse, unused medications are sent back to Diamond pharmacy for a credit. Controlled medication is stored in a double lock box until destroyed by the consulting pharmacy with a RX destroyer. The medication destroyed is recorded on the destruction log.

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

An evaluation of the center's infection control plan was conducted and confirmed the plan included all of the required elements. Five youth individual healthcare records (IHCRs) was evaluated and 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 evaluated IHCR. All trainings and education were provided in accordance with the Centers

for Disease Control and Prevention (CDC) guidelines. An evaluation of five 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. An evaluation 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. The center was able to provide one applicable youth for prenatal care. The documentation confirmed once the youth was confirmed to be pregnant, prenatal care began immediately. The youth received education regarding alcohol and drug use, smoking, nutrition, sexually transmitted diseases, contraception, prenatal care and the birthing process, postpartum care, basic childcare, child/infant development, and parenting skills. Documentation revealed the youth received a plan of care through post-birth to include psychological and physical care. In addition, the youth was provided extra foods, prenatal vitamins, an extra mattress for comfort, weekly monitoring, and doctor visits while in the center. The youth was not in the center long enough to receive a focused medical evaluation every thirty days due to being released shortly after admission.

Standard 5: Safety and Security

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

Observations were made of youth movement and supervision during the week of the annual compliance review. Youth were observed being accounted for at all times. At no time were youth seen unaccompanied by staff. Interaction between youth and the center's staff was observed to be positive. A review of the logbooks indicated youth movement and counts were being conducted consistently. During daily observations, the center was adhering to the weekday activity schedule. Youth were seen supervised during dayroom activities, mealtimes, counseling sessions, and educational classes. Five staff were interviewed and each agreed the center has enough staff to provide for the safety and security of the youth and other staff members.

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

The center's behavior management system (BMS) was clearly identified within the written facility operating procedures. Postings of the BMS were seen in all youth living areas and hallways. The BMS has been approved by the detention regional director. The system includes rewards for positive behavior and consequences for inappropriate behaviors. Daily activities were observed which determined the proper implementation of the BMS. The youth daily points earned are captured within a BMS logbook which is located in each living unit. The points earned will allow youth to move up a level system, earning additional privileges as they increase

their level. Incentives earned may include special meals, tokens to purchase items in the store, additional minutes on telephone calls, and later bedtimes. The center's assistant superintendent maintains an incentive calendar which posts rewards for each week. The center's superintendent was interviewed concerning the BMS and stated it is a standardized system which will enhance safety and security as it relates to youth behavior and promotes the health and well-being of youth by providing an environment which fosters social, emotional, intellectual, and physical development.

The system is a three-level system which tracks youth behavior. The superintendent was able to outline and summarize the center's BMS. Five youth were interviewed concerning the BMS. Three youth rated the system as good, one rated the system as fair, and one rated the system as poor. Youth were able to summarize the level system and explain the rewards given. Seven interviewed staff were able to summarize the center's BMS, as well as describe rewards and consequences given at the center. All five interviewed staff reported the BMS was effective. All five stated staff speak with youth to discuss consequences being imposed and give youth the opportunity to explain their behavior. Four of five staff expressed supervisors provide to feedback regarding their implementation of the BMS. Two staff reported the feedback is given weekly and two staff reported it is given as needed. One staff stated they have not received feedback from supervisors.

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

The center's behavior management system (BMS) was identified within the written facility operating procedures. The center's BMS was seen posted in all youth living areas and hallways. The BMS was approved by the detention regional director. The system includes rewards for positive behavior and consequences for inappropriate behaviors. Five youth were interviewed concerning the center's implementation of the BMS and consequences given. Three youth stated consequences received were fair, one youth stated the consequences received were not fair, and one youth stated never receiving consequences. All five youth stated youth are not allowed to punish one another. One youth reported being sent to their room for punishment, while the four remaining youth reported they have not. The youth who reported having received consequences for behavioral issues indicated the consequences received affected only their level. Five interviewed staff reported the items which can be taken away form a youth as a consequence for a behavior may only affect the youth's level or points within the level system. All five staff denied observing a co-worker take meals, snacks, clothing, education, or medical care as a consequence. All five staff denied observing a staff encouraging youth to fight another youth.

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

The center's superintendent reports having a total of fifty-seven cameras, which fifty-one were operational. The superintendent reported a work order has been issued to repair the cameras currently not operational. In addition, the superintendent stated the center have a renovation plan in effect to change out the current digital video recording system. A sample of six ten-minute video checks were observed during the annual compliance review. The sample size included observations of checks being conducted on both second and third shifts in all youth living units and on weekends and weekdays. Checks were also seen being completed by different staff members.

The center utilizes the electric wand system in which staff touch the wand to the door when conducting the checks. The electronic wand system captures the time and date as to when the check was conducted. The corresponding wand logs were observed with the sample of video checks conducted to confirm the practice was being completed consistently. Video observations made found in each of the six samples, the staff were all seen stopping and checking the youth within their rooms. None of the checks observed were conducted outside the ten-minute required time frame. Five interviewed staff reported checks are to be completed every ten-minutes. The center's superintendent was interviewed and stated staff shall visually observe youth on standard supervision every ten-minutes while they are in their sleeping quarters. Staff are to conduct observations in a manner ensuring the safety and security of each youth and document each check in real time electronically or manually.

5.05 Census, Counts, and Tracking	Satisfactory Compliance

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

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

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

A review of master control and mod logbooks provided for the scope of the annual compliance review found evidence counts were being conducted formally three times on each shift. Formal counts are held at the beginning, middle, and end of the shifts. The master control operator was observed performing a formal count during the annual compliance review. In addition to these counts, the number of youths are accounted for and documented in the logbook prior to movement from one location of the center to another. Drills were also observed to be documented within the logbooks. The master control operator was interviewed and explained the count process. The operator also stated staff are not including youth in their count who are not physically present with the staff person at the time of the count. Five interviewed staff all were able to summarize the count process. Staff also indicated if a count is not cleared, youth movement is ceased and a recount will be conducted. In addition, the staff reported emergency counts may be completed when a youth is believed to be missing, when visibility is hindered, or after a major disturbance.

5.06 Logbook Maintenance	Satisfactory Compliance

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

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

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

The center maintains a master control logbook as well as logbooks for each youth living area. A review of master control and mod logbooks provided for the scope of the annual compliance review was completed. In addition, the master control operator has a logbook assigned for

contracted staff, visitors, and individuals from the Department of Children and Families to sign-in and sign-out when visiting. Logbooks are bound with numbered pages. No pages were observed missing or falling apart. The date is documented at the top of each page. Entries observed include the time of the event with the name of the staff and youth involved, as well as a brief description of the event and the initials of the staff making the entry. Entries impacting the security of the center are highlighted in yellow. Errors are struck through with a single line, dated, and initialed by the person correcting the error. The master control logbook includes documentation of admissions and releases, youth movement, presence of law enforcement, emergency situations, Protective Action Response incidents, population counts, youth on special supervision, and youth placed in confinement. Emergency drills were also observed documented within the master control logbook. However, fire drills were not observed to be documented consistently for the scope of the annual compliance review.

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

The center maintains a master control logbook as well as logbooks for each youth living area. A review of master control and mod logbooks provided for the scope of the annual compliance review was completed. The superintendent was interviewed and stated the superintendent or designee reviews all logbooks on a weekly basis. This was not consistent for the master control logbooks; however, a review of the mod logbooks found this to be consistent in practice. There was evidence the juvenile justice detention officer supervisor or officer in charge, reviewed the logbooks maintained in each living area daily. There was also evidence the logbooks were signed indicating the supervisor accepted responsibility for the living areas assigned at shift change. There was evidence in the unit logbooks, the superintendent or designee toured the youth living areas during visits made to those areas.

5.08 Key Control	Limited Compliance
Each center is responsible for maintaining inventory and control of all facility keys. *All keys shall be placed on a tamper-resistant key ring designed to inhibit the removal of keys.* *Emergency key rings shall be maintained separately from other facility keys, in master control, in a secure location designated by the Superintendent. These keys shall be notched or otherwise identifiable by touch.* *The key(s) on these rings shall provide egress through facility exterior doors providing access to evacuation areas.* *A key inventory shall be maintained by the Superintendent or designee at all times.* *(For the entire indicator statement, please reference the Monitoring and Quality Improvement FY 2020-2021 Detention indicators.)*	

The center has a written policy and procedures which outlines the key control process. The procedures also include the processes for addressing missing or lost keys, as well as the reporting and replacement of damaged keys. A review of the Central Communications Center reports for the scope of the annual compliance review as well as an interview with the center's superintendent, found no documentation or incident involving a missing or lost facility key. All keys were observed to be secured and inaccessible to youth. During the annual compliance review, personal keys were observed to be taken up by the master control officer prior to a staff or a visitor entering the secure areas. The personal keys were secured in a lock box in master control. Emergency keys and restricted keys such as for school, medical, mental health, and vehicles were seen secured in master control. Direct-care keys were observed in a secure box within the shift briefing room. All keys were maintained on a temper resistant ring with a chit which had the assigned key number engraved and the total number of keys on the ring. The keys were also placed on a colored key ring hub system as required according to policy.

Issuance of keys were seen documented on a shift report which included the date and time of issuance and names of staff issuing and receiving the keys. Three direct care staff displayed their assigned keys for the shift. Each staff key ring chit matched the number of keys assigned on the tamper resistant ring. A sampling of seven keys located in the secure locker were reviewed which determined all keys matched the appropriate number of keys indicated on the chit and in the corresponding key location within the secured locker. Although the keys identified for sampling was the proper key location and number of keys was completed, the center did not have an updated master key inventory on hand at the time of the annual compliance review.

According to the center's policy, the key inventory must be maintained by the superintendent or designee at all times. The superintendent was interviewed and was able to summarize the key control process. The master control operator also was interviewed and explained the process for collecting visitors and staff personal keys, as well as issuance of staff keys when entering the restricted area. Five interviewed staff were able to identify which keys were considered as restricted, such as keys for medical records, youth property, kitchen, and mental health and case management records. All interviewed staff were able to summarize the key control process.

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

The center had four vehicles used to transport youth. The maintenance mechanic was interviewed and stated the center has a total of six vehicles; however, two of the center's vehicles have not been used to transport youth during the scope of the annual compliance review. The two vehicles are in the process to be surplused by the Department. A review of all vehicles found each to be secured when not in use. Each of the vehicles had the appropriate number of seatbelts. The vehicles were overall clean and contained an approved fire extinguisher. A vehicle log is maintained by the maintenance mechanic which confirmed each vehicle had weekly visual checks to include a check of the water coolant, lights, oil, emergency equipment, brakes, horn, interior/exterior, and cleanliness. In addition, monthly checks were also evidence for each vehicle to inspect tires, batteries, windshield wipers, windows, mirrors, and overall damage. Inspection forms are documented on the mandatory inspection form and copies maintained by the maintenance mechanic. Each vehicle had evidence of an updated annual inspection completed by a certified mechanic. Prior to a youth transport, staff are required to obtain the vehicle keys from master control and obtain a vehicle bag which consists of an approved first aid kit, a seat belt cutter, flashlight, and window punch. The bags are stored in master control. There were appropriate bags for each assigned vehicle. Vehicle logs were reviewed and contained documentation of acknowledgement the vehicle was used, the destination, number of youth and staff names, and time the transport began and ended. A transport was unable to be observed during the annual compliance review. Informal interviews were conducted with two youth and two staff to confirm both youth and staff wear seatbelts when being transported.

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

The center has a written policy and procedures which addresses tool inventory and management. Inspections of the maintenance tool rooms, kitchen tool, knife storage, and mop and broom closets found each area to be secured and inaccessible to youth. Maintenance tools were marked with an engraved identification code which were identified as Department property. Maintenance tool inventory sheets were reviewed to confirm the maintenance mechanic conducts monthly inventory of all tools. The superintendent reviews and signs the inventory forms as required. A sampling of ten percent of the tools stored was conducted to ensure the tools were in place as designated in which all tools were accounted for. The maintenance mechanic did not have a sign-in or sign-out inventory log for the tools removed out of the area. During the annual compliance review, the maintenance mechanic created a tool log which documented tools removed from the maintenance office and returned. Examples of this practice were observed during the review. An inspection of the kitchen area found all kitchen tools and knives were securely stored behind two locked doors. The food service director was interviewed and stated the knives are inventoried on each shift. Inventory forms were reviewed to confirm this practice. Inventory forms were compared with the items in the secure cabinet and found all to be accounted for. The maintenance mechanic and food service director reported not having any issue with missing tools or knives. In the event a tool is missing, the center is locked

down and the superintendent is immediately notified. In the event a vendor arrives on-site, the maintenance mechanic accompanies the vendor during the work project. The center currently reports there are no vocational work projects where youth utilize any tools other than brooms or mops. The superintendent was interviewed and stated only maintenance and kitchen staff, repair service personnel, and service vendors have access to tools. Youth may only use cleaning items such as mops, brooms, buckets, and household items under direct supervision.

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

Detention youth are not permitted to utilize tools including kitchen and medical equipment. Youth may only use cleaning items such as mops and brooms and other household items under direct staff supervision. Youth were unable to be observed performing cleaning duties during the annual compliance review. Five interviewed staff reported youth are only authorized to use scrub brushes, mops, and brooms. All five staff reported they would notify a supervisor in the event a tool was broken or missing. Five interviewed youth also reported only using items such as mops and brooms.

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

The center's Continuity of Operations Plan (COOP) addresses the center's safety plan. All flammable, toxic, caustic, and poisonous items were stored in areas inaccessible to youth. Chemicals and cleaning agents were stored in three separate locations, one which included the kitchen closet. The maintenance mechanic conducts monthly inventory of the items and the kitchen staff conducts the inventory for the items stored in the kitchen are. A comparison of the inventory form with the items found each to be accounted for. All items were reviewed for having a corresponding Safety Data Sheet (SDS). Each had the SDS with the exception of a bottle of 'foaming cleaner' which was in the kitchen. The food service director reported this item was no longer used and removed the item for disposal. In addition, a bottle of lighter fluid was discovered in the outside locked storage shed. The maintenance mechanic removed the item

from the area for disposal. Due to the COVID-19 pandemic, hand sanitizer is accessible in the dayroom areas for both youth and staff. During the annual compliance review, the SDS were attached next to the hand sanitizer for easier access.

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

The center has a written policy and procedures concerning access and authorization for flammable, toxic, and poisonous items. The policy indicates only authorized personnel are permitted to have access to these items. Observations during the annual compliance review found all chemicals were secured and inaccessible to youth. There were no youth observed handling any chemicals. Five interviewed youth all reported they do not directly handle chemicals. Five interviewed staff stated youth are not permitted to clean with substances which are flammable, toxic, or poisonous.

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

The center has a written policy and procedures outlining the disposal of flammable, toxic, caustic, and poisonous items. A review of the Central Communications Center (CCC) information and an interview with administration revealed the center has not had any instances of chemical spills nor have they disposed of any flammable or toxic items within the previous six months. The maintenance mechanic was interviewed and stated kitchen grease is disposed of in a grease vat. Final disposal of the grease is disposed of by the county whom leases the facility building to the Department. The maintenance mechanic reported chemicals are disposed of in accordance with the Safety Data Sheets (SDS) requirements.

An interview with medical staff was conducted. The medical department reported they have a contractual agreement with Steri-Cycle who comes on-site to pick up and dispose of any biohazardous waste. The waste is stored in containers and the company disposes of waste when notified by the center's medical staff. The medical department maintains a disposal log which confirmed documentation of this practice.

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

A review of the facility management system (FMS) found documentation of confinement reports for under twenty-four hours. A sample of fourteen confinement reports were reviewed for

completion requirements. According to interviews with center administration, all youth are provided educational materials as applicable when in confinement. All fourteen confinements reviewed had documentation the supervisor approved the placements. No youth are placed in confinement with other youth according to administration. Eleven of the fourteen confinements reviewed had noted the room was searched prior to youth placement. Three were checked indicating it was not searched.

Observations made during the annual compliance review week did not find any obstructions on room windows. There are no cameras in the rooms. The supervisor conducted an initial confinement review no later than two hours in all fourteen incidents reviewed. Each report contained the reason for confinement and the full report was completed before the shift's end. Documentation for all fourteen reports found the supervisor conducted additional reviews every three hours and was documented in the FMS. Supervisors continuously counsel the youth to consider removal from confinement. The superintendent or designee conducted confinement reviews within twenty-four hours for all but one of the fourteen incidents reviewed. The one incident indicated the superintendent or designee reviewed the confinement one day late. The superintendent was interviewed and stated confinements are reviewed daily by the superintendent or designee. They are reviewed to determine if they were appropriate for the infraction. In addition, the superintendent stated the regional detention management reviews the use of confinement, lockdown, and restraints monthly.

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

The center has a written policy and procedures outlining requirements for confinements over twenty-four hours. There were no confinements which were applicable to being over twenty-four hours. The superintendent was interviewed and stated confinements are reviewed daily by the superintendent or designee. They are reviewed to determine if they were appropriate for the infraction. In addition, the superintendent stated the regional detention management reviews the use of confinement, lockdown, and restraints monthly.

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

The center has a Continuity of Operations Plan (COOP) which includes disaster preparedness planning. Annexes were attached to the plan. A review of drill documentation revealed the center conducted two disaster drills for the scope of the annual compliance review. The drill documentation outlined the drill scenario, participants, and critique or corrective action needed. Both drills involved a scenario for severe weather-related incidents. Five interviewed staff reported they participate in various drills at the center to include incidents related to weather, flooding, fire, bomb threats, and major disturbances. The superintendent was interviewed and stated the COOP is set in place for environmental emergencies. COOP drills are conducted twice annually. Fire drills are conducted monthly and escape drills are conducted quarterly.

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

The center's escape prevention plan is incorporated within their Continuity of Operations Plan (COOP). The center also has a written policy and procedures which addresses escape prevention planning as well as drills required. The center is required to conduct escape drills on a quarterly basis. A review of drill documentation found the center conducted quarterly escape drills at the beginning quarter and ending quarter. There were two quarters unaccounted for escape drills. A review of the logbook documentation found the center documents drills in the log as required. An interview with five staff revealed each reported participation in escape drills within the scope of this annual compliance review.

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

The center's fire prevention plan is incorporated within their Continuity of Operations Plan (COOP) and facility operating procedures. The center's fire procedures were approved by a local fire marshal who had documentation of an inspection completed at the center on January 24, 2020. The inspector noted the center did not have any violations. Samples of fire extinguishers were observed to confirm they have been inspected annually, as required. The center is required to conduct fire drills monthly and on each shift. The center operates on three shifts. A review of fire drill documentation for the past six months found all drills were completed as required with the exception of one drill on the second shift in the month of July. The center's logbook did not note all fire drills as required. Evidence of five fire drills were found documented within the logs. All drills were captured on the Departmental form which indicated the date and shift of the drill, the scenario, and a list of drill participants. Five interviewed staff reported fire drills occur monthly. Three of five interviewed youth reported they have been instructed on what to do in the event of a fire. Two of three reported they have not.