STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Marion Regional Juvenile Detention Center

Department of Juvenile Justice
(State-Operated)
3040 NW 10th Street
Ocala, Florida 34476

Review Date(s): November 17-20, 2020

Promoting Continuous Improvement and Accountability
in Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

LeAnn Gruentzel, Office of Accountability and Program Support, Lead Reviewer (Standard 1)
Jeff Campbell, Office of Education, Education Specialist (Standard 2)
Renette Crosby, Office of Accountability and Program Support (Standard 4)
Tara Gilligan, Office of Accountability and Program Support, Regional Monitor (Standard 4)
Delmonica Harris, Duval Regional Juvenile Detention Center, Assistant Superintendent (Standard 5)
Kristine Harshaw, Office of Accountability and Program Support, Regional Monitor (Standard 3)
Jennifer Schad, Office of Accountability and Program Support, Regional Monitor (Standard 2)

Program Name: Marion Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: Marion County / Circuit 5
Review Date(s): November 17-20, 2020

MQI Program Code: 094
Contract Number: N/A
Number of Beds: 60
Lead Reviewer Code: 192

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

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

Standard 1: Management Accountability
Detention Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Detention Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Detention Rating Profile

Indicator Ratings

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

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Program Overview

Marion Regional Juvenile Detention Center is a state-owned detention facility, operated by the Department, located in Ocala, Florida. The center serves youth in Citrus, Hernando, Lake, Marion, and Sumter Counties in Circuit 5. Male and female youth who are detained pending adjudication, disposition, or placement in a residential commitment program are housed in the sixty-bed center. Youth are provided services which include youth orientation, behavior management, safety and emergency procedures, transportation, mental health, and healthcare services. The center's educational services are provided by the Marion County School Board. The center's management team includes the superintendent, two assistant superintendents, one administrative assistant, eight juvenile justice detention officer supervisors (JJDOS), and forty-seven juvenile justice detention officers (JJDO).

Mental health and healthcare services are provided through the contracted provider, Camelot Community Care, Inc. Mental health services are provided by a licensed mental health counselor (LMHC) who acts as the designated mental health clinician authority (DMHCA) and one unlicensed mental health counselor. A psychiatrist is on-site weekly. Clinical services provided by the center include mental health and substance abuse evaluations, mental health treatment planning, individual, group, and family therapy, mental health crisis intervention services, on-site psychiatric services, and availability for substance abuse services for youth with co-occurring disorders. Medical services are provided by contracted provider Camelot Community Care, Inc. The following positions are provided: a medical doctor who serves as the center's designated health authority (DHA), an advanced practice registered nurse (APRN), a registered nurse (RN) who serves as the clinical manager, two full-time licensed practical nurses (LPN). The medical clinic maintains nursing coverage seven days a week, from 7:00 a.m. to 5:00 p.m., and on weekends, from 7:00 a.m. to 3:00 p.m.

Food services are provided by Department staff and include menus, meal planning, meal schedules, special diets, nutritional analysis, daily allowance, food preparation, health certifications, food product standards, sanitation, and cleaning. Staff are responsible for the custody and control of youth in their care, providing youth supervision twenty-four hours a day, seven days a week. The center has four living modules which are divided by male and female. There are eighty-nine security cameras at the center, of which eighty-four were operational at the time of the annual compliance review. The center was clean and free of any noticeable graffiti, odors, or pests. At the time of the annual compliance review, the center had eleven juvenile justice detention officer vacancies.

Standard 1: Management Accountability

1.01 Initial Background Screening (Critical)	Satisfactory Compliance
Background screening is conducted for all Department employees and volunteers and all contracted provider and grant recipient employees, volunteers, mentors, and interns with access to youth and confidential youth records. A contracted provider may provide training and orientation to a potential employee before the screening process is completed. However, these individuals may not have contact with youth or confidential youth records until the screening is completed, the determination is "Eligible," a copy of the criminal history report has been reviewed, and the employee demonstrates he or she exhibits no behaviors warranting the denial of employment. An Annual Affidavit of Compliance with Level 2 Screening Standards is completed annually.	

An initial background screening was required for fourteen new employees and eight new contracted employees. All initial background screenings were completed prior to staff hire dates. None of the individuals hired required an exemption prior to working with youth. Since the last annual compliance review, there were thirteen remaining new direct care staff hired and each had a completed pre-employment assessment tool with passing scores. The Annual Affidavit of Compliance with Level Two Screening Standards was completed and sent to the Background Screening Unit on January 2, 2020, meeting the annual requirement. An Affidavit of Compliance with Level Two Screening Standards for School Board Personnel was signed on January 10, 2020.

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

Nine staff and two volunteers were eligible for a five-year rescreening. The five-year rescreenings were completed on, or prior, to the anniversary date of the initial staff hire or start dates and each was completed no more than twelve months prior to the anniversary date.

1.03 Staff Code of Conduct	Satisfactory Compliance

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

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

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

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

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

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

Seven staff records were reviewed regarding staff code of conduct. Each contained a signed code of conduct. None of the records contained commendations for staff. The superintendent stated the employee code of conduct provides communication and interactions between staff and the public or youth, are professional and respectful in nature, provides directions for behaviors not acceptable, and lists all standards of conducts for employees. If there are allegations of threats, abuse, or profanity they are investigated and if founded, the employee can face disciplinary action up to and including dismissal. If it is believed an employee abused a youth the Florida Abuse Hotline is notified.

Seven staff were interviewed regarding the Central Communications Center (CCC) process. All seven stated to notify supervision; however, none stated to notify superintendent. All stated youth and staff are allowed to make the call to CCC, and two stated supervisors can make the call. Of the seven staff interviewed, one reported they never heard a staff use profanity to a youth, one reported once, and five reported occasionally. None of the staff interviewed indicated hearing a staff member using threats, intimidation, or humiliation when interacting with youth. Three of the interviewed staff indicated working conditions for the past year have been fair, two reported good, and two stated very good.

Seven youth were interviewed regarding being stopped from reporting abuse. One stated they have been stopped from reporting abuse, four stated they were not stopped, and two stated they have not needed to report abuse. The one youth who reported not being allowed to report abuse was released from the center the day of the interview; therefore, there was no follow-up with this youth. This youth was given the opportunity to file a grievance; however, the youth did not choose to proceed in filing a grievance. Six youth stated staff are respectful when speaking to them, one stated they were not. Four youth indicated they have never heard staff use profanity, one indicated often, and two indicated occasionally. Five youth have never heard staff threatened them or other youth, two stated occasionally. Six youth stated they feel safe at the center, one stated they do not. All seven youth stated they have not exchanged emails, telephone numbers, or social media contact information with staff.

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

There were fifty-eight incidents reported to the Central Communications Center (CCC) in the past six months, of which six were reviewed. Each incident was reported within two hours and five of the six were documented in the logbook. No other additional incidents or grievances should have been reported to CCC. There were ninety incidents report to the CCC in the last year, forty of which were COVID-19 related, which explains the increased number reported since the last annual compliance review. The superintendent stated youth have the right to contact the Florida Abuse Hotline at any time. If staff observe abuse, as mandatory reporters, they are obliged to report any instances of abuse. The CCC is contacted within two hours by the supervisor or administration when incidents meet reporting guidelines.

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

The center had seventy Protective Action Response (PAR) incidents in the past six months, of which seven were reviewed. For each of the PAR reports reviewed, the report was completed by the end of the staff member's workday and included statements from all staff involved. None of the incidents involved the use of mechanical restraints, nor did the PAR result in serious injury to youth or staff. None of the youth alleged abuse. All six reports were reviewed and processed within seventy-two hours and were reviewed by a supervisor or PAR instructor to determine if the use of force was consistent with policy. The superintendent or designee reviewed the report, after all other reviews, and made comments, if necessary, within seventy-two hours, normally within twenty-four hours. The post-PAR interview, including to determine if the youth had any physical complaints or visible injuries, was within thirty minutes after the incident. None appeared to be in distress to require a PAR medical review. Video reviews and written statements are reviewed as incidents occur to ensure PAR was used in accordance with the PAR policy. Each of the seven staff interviewed reported they attempt to talk to the youth prior to using physical restraints or mechanical restraints.

Seven staff were interviewed regarding PAR procedures. All seven stated they try to talk to the youth prior to using physical restraints or mechanical restraints. The superintendent stated physical restraints or mechanical restraints are tracked through the facility management system module and would be required appropriate reviews within the system. Superintendent explained PAR incidents are reviewed on video and reports are reviewed in the Department's Juvenile Justice Information System (JJIS) to ensure documentation supports the actions occurred, and PAR was reasonable and necessary. The regional office provided oversight through monthly reports. The center's PAR rate during the annual compliance review period was 11.14, which is above the statewide Detention PAR rate of 16.56.

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

Five staff training records were reviewed for pre-service training requirements. All five staff were certified within 180 days of hire and received all required essential skills training prior to being in the presence of youth. All five staff were Protective Action Response (PAR) certified, with passing scores in the performance tests and written exams within ninety days of hire. The Department's Learning Management System (SkillPro) documented Phase One and Phase Two Academy Training.

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

Seven training records were reviewed for in-service training requirements, including two supervisors. Each staff completed between forty and eighty-five hours of training, exceeding the annual twenty-four hour requirement. All staff had current Protective Action Response (PAR) certification updates, cardiopulmonary resuscitation (CPR), first aid and automated external defibrillators (AED) certifications. Documentation for all seven staff included suicide prevention, professionalism and ethics, and active shooter training. All three supervisors exceeded the annual eight hour requirement receiving eighteen and twenty-four hours of training in management, leadership, personal accountability, employee relations, communication skills, fiscal matters, and Epinephrine Auto Injector training. The center has an annual in-service training calendar which is updated as changes occur. All in-service training was documented in the Department's Learning Management System (SkillPro). The superintendent stated he received the following management training: Certified Public Management (CPM), real colors, annual Equal Employment Opportunity (EEO), workman's compensation (WC), and Family Medical Leave Act (FMLA) retraining. The superintendent stated staff complete eight hours of annual management training which was accomplished through real color training and supervisory training provided by general counsel.

1.08 Grievances	Satisfactory Compliance

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

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

The center has policy and procedures regarding each youth's right to grieve and to be treated fairly, respectfully, without discrimination, and their rights are protected. The process includes an informal phase, a formal phase, and an appeal phase. Grievance forms were available in the living areas for the youth. During the past year, no grievances were filed for review. Superintendent interview results explained the phases of the grievance process and any grievances would be kept in the quality integrity binder and entered into the Facility Management System (FMS) system on behalf of the youth. All seven interviewed staff were able to explain the grievance process. Each of the seven interviewed youth indicated they had never filed a grievance. Six of the seven youth interviewed knew if they wanted to file a grievance, they would complete the form, and submit it to a supervisor. One youth stated he was not sure if he ever had a grievance. Five youth stated they have never filed a grievance, one stated the grievance process was fair, and one stated it was very good.

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

Superintendents shall ensure critical and special alerts are reviewed and responded to appropriately.

Upon completion of the Admission Wizard, the officer shall ensure all critical and special alerts are listed in JJIS.

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

If the electronic system is inoperable, for any reason, the juvenile justice detention officer supervisor (JJDOS) shall ensure the last hard copy of the alerts shall have a written notification or update of the recent admissions or changes to existing alerts on the alert sheet and distribute to all staff within the center immediately.

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

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

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

Seven youth management, mental health, healthcare records, and the Department's Juvenile Justice Information System (JJIS) were reviewed for alerts. Four of the seven reviewed were medically graded two through five and had a corresponding alert in JJIS created by nursing staff. Three youth had a medical grade of one therefore did not have any alerts. Four youth had a medical or mental health alert initiated or updated by a mental health or medical professional. One youth had a security alert initiated by mental health professional. Youth alerts were entered into JJIS, as required, for all four youth. The center verifies and documents all youth alerts in JJIS daily, which includes supervisors and administrators, which is made available to all staff.

The superintendent stated the medical alert process is alerts are entered upon admission and updated by the nurse once reviewed and verified. Superintendent stated staff receive copy of alerts at the beginning of their shift and updated verbally with new youth alerts when admitted. Seven staff were interviewed regarding being informed of youth alerts. Seven of the staff interviewed stated, in general, they are informed of youth alerts through shift debriefings and alert forms. Three of the seven stated they are informed through the logbook or alert board. One of the seven stated they are informed through JJIS. Seven staff stated they are informed of alerts from management through shift briefings and meetings. Six of the seven stated there are informed through emails. Three of the seven stated they are informed through alerts. Two of the seven stated they are informed through the logbook. A review of shift briefings confirmed alerts were reviewed and provided to staff. Three of the seven believed the effectiveness of this process for communicating information was very good, three stated it was good, and one stated it was fair.

Standard 2: Assessment and Performance Plan

2.01 Admission	Satisfactory Compliance

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

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

The center has written policy and procedures for the admission of youth. Seven youth management records were reviewed. Six records contained an Admission Wizard which indicated the arrest affidavit and Detention Risk Assessment Instrument (DRAI) were reviewed. One youth was transferred into the center from another center and did not require a review of the arrest affidavit or DRAI. All seven records had documentation the Suicide Risk Screening Instrument (SRSI) was reviewed upon admission. Documentation on the Admission Wizard in all seven records indicated the youth were searched, allowed to make a telephone call, offered a snack or meal, and screened for medical, mental health, and substance abuse needs. An admission was observed during the annual compliance review. The youth watched the video on Prison Rape Elimination Act (PREA), the video on COVID-19 precautions, and received a meal.

2.02 Orientation	Satisfactory Compliance

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

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

The center has written policy and procedures for orientation of youth admitted to the center. The orientation procedure at the center advises each youth verbally and provides a brochure to each youth. Seven youth management records were reviewed, and each record contained a signed acknowledgement of orientation during the admission process. The information shared with the youth provides the rules and regulations of the center, youth rights, visitation, telephone calls, grievance procedures, access to medical, mental health, and substance abuse services, access

to the Florida Abuse Hotline, behavior expectations and related consequences, and possible new law violations for destruction of property. An admission was observed during the annual compliance review where the youth received the orientation verbally, signed for the orientation, and was provided a youth handbook. Seven youth were interviewed, and each stated they were provided orientation about the center when they were admitted.

2.03 Classification	Satisfactory Compliance

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

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

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

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

The center has a policy and procedures for the classification of youth admitted into the center. The procedure ensures all youth admitted to the center are classified by the admitting officer to provide the highest level of safety and security. Seven youth management records were reviewed and indicated each youth was appropriately classified upon admission. The classification process included reviewing the youth's history and status as documented during the admission process. Consideration of potential safety and security concerns for room assignment include height, weight, age and level of aggressiveness, as well as a review of any special needs such as mental illness, intellectual disabilities, physical disabilities, history of violent behavior, gang affiliation, criminal behavior, history of sexual offenses, Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB), medical issues, suicide risk, escape risk, and other security concerns. Documentation in each record confirmed youth were assigned to a room based on their classification. Due to COVID-19 related health concerns, each youth in the center is in a single room regardless of classification. A review of each youth record confirmed each youth had the required alerts entered into the Department's Juvenile Justice Information System (JJIS) as determined during the classification process. Each youth had a VSAB form completed as part of the classification procedures. An interview with the superintendent confirmed the classification procedures used to determine the youth's room assignment and level of supervision.

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

The center has a policy and procedures for the classification which includes gang members. A review of seven youth management records confirmed all youth are screened for gang affiliation. One of the seven youth records reviewed was a documented gang member. Two closed records were requested and reviewed. Each youth had an alert in the Department's Juvenile Justice Information System (JJIS) as a documented gang member. On the Admission Wizard, the question for gang member was answered yes and for one youth, it was answered no. The center does not have a designated juvenile justice detention officer supervisor assigned as the center's gang representative. The center notifies the youth's assigned juvenile probation officer (JPO) and the probation circuit reform specialist. During weekly detention reviews, any youth with a gang alert are discussed with probation staff. Any youth involved in any suspected gang activity while in the center, has a suspected gang affiliation alert is entered. The center then notifies the assigned JPO regarding the gang activity.

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

The center has a policy and procedures for the admission of youth's personal property. Seven youth management records were reviewed, and each had a personal property form signed by the youth and the juvenile justice detention officer (JJDO). Personal property is inventoried upon their admission and stored in an individual property bag, in a secure room. All seven youth had a Property Receipt form placed in the record. Four of the seven records reviewed contained documentation of valuable property. All valuable items are inventoried and placed in a clear and tamper-resistant sealed bag, signed by the youth and the JJDO. The sealed bag is locked in a locked file cabinet located in a secure room. The youth's valuable items are documented in the property logbook. Three of the four youth had a valuable Property Receipt form in the youth record. One youth record incorrectly had the form signed indicating the youth did not have any valuable personal property and the form indicating the youth did have valuable property. An admission was observed during the annual compliance review. Seven youth were interviewed, and each stated staff checked their personal property and had the youth sign a form for the correct property upon admission. An interview with the superintendent confirmed the procedures for personal property and valuable personal property.

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

The center has a policy and procedures for the storage of youth's personal property. The center safeguards each youth's personal property until it can be returned to the youth and/or parent/guardian. The storage and security of valuable and personal property was observed. All valuable items are inventoried and placed in a clear and tamper-resistant sealed bag, signed by the youth and the juvenile justice detention officer (JJDO). The drop safe is under video surveillance with limited access. Items in the drop safe are moved daily to a locked file cabinet located in a secure room with no youth access, also under video surveillance. The youth's valuable items are documented in the property logbook. A review of the Central Communications Center (CCC) incidents for the past six months did not include any incidents involving youth property. An admission was observed during the annual compliance review. An interview with the superintendent confirmed valuable property is dropped in a safe, under video surveillance with only access by supervisors and administrators.

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

The center has a policy and procedures to ensure all releases from detention occur promptly and accurately. Three closed youth management records were reviewed. A juvenile justice detention officer supervisor reviewed all paperwork related to the release prior to youth's release including paperwork provided from the court. The youth identification and identification of parent/guardian was verified prior to release. A copy of the parent/guardian's identification was placed in the record. None of the youth had any future court dates. The date of admission and the date of termination documented in the youth record correlated with the Department's Juvenile Justice Information System (JJIS). All required parties signed all applicable release forms. A review of Central Communications Center (CCC) reports for the past six months did not include any unauthorized releases. During the annual compliance review, one release was observed with no exceptions. The youth signed for her clothing and personal property which was still in the clear sealed bag.

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

The center has a policy and procedures for release of youth's personal property. Seven youth management records were reviewed. Each contained a signed acknowledgment of the process for unclaimed property by each youth. Three closed youth management records were reviewed. Each closed record had documentation of the youth and parent/guardian signing the receipt of property upon release. If the items of the youth's personal property remain unclaimed for more than thirty days, the superintendent or designee shall arrange for their disposition. If the property is currency, it is sent to the Department headquarters as a money order. For other valuable property, is donated to the local sheriff's office for repurposing or auction where the funds go to a non-profit. An interview with the superintendent confirmed the process for unclaimed property. During the annual compliance review, one release was observed with no exceptions. The youth signed for her clothing and personal property which was still in the clear sealed bag.

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

The center has a policy and procedures for the release of youth with medication and aftercare instructions. Three closed youth management records were reviewed. The documentation in all three records reflected the person to whom the youth was being released to was given the youth's medications, as indicated by the parent/guardian's signature. Each record included the Department's Health Discharge Summary Transfer Note form (HS012) and Medication Receipt, Transfer, and Disposition form (HS053.) Form HS053 included a nurse signature and a witness signature. During the annual compliance review, a release with medication was not available to be observed.

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

The center has a policy and procedures for the review of youth in secure detention. Detention reviews occur weekly, on a set schedule. The weekly detention reviews were observed for youth in secure detention during the annual compliance review. A review of weekly detention review paperwork included notes on what was discussed. Weekly documentation included those in attendance. Detention staff attend in-person and probation staff attend by telephone. Reviewed documentation included the alert list, residential waiting list, and detention census list. An interview the superintendent confirmed the process for weekly detention reviews.

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

The center has a policy and procedures for the daily activity schedule. The center utilizes a weekday and a weekend schedule. Postings of the daily activity schedule were observed in the living units. The daily schedule includes time for wake-up, personal hygiene, meals, visitation, education, recreation, indoor activities, bedtime, and groups. A review of logbooks confirmed the center follows the daily activity schedule. Seven youth were interviewed, and each stated the center has a daily schedule.

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

The center has a policy and procedures for the daily activity schedule. A review of logbooks, observations, and interviews reviewed determined the center adheres to the daily schedule. If the schedule has to be altered, a supervisor authorizes any changes required. Reasons for altering the schedule include inclement weather, staffing emergencies, and COVID-19 related health concerns. Seven youth and seven staff were interviewed, and each stated the daily schedule is followed.

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

The center has a policy and procedures to provide for educational access. The center provides education services through the Marion County School Board. The center integrates education into the daily schedule to ensure the youth are receiving the required minimum instruction time distributed over a twelve-month period. The district and daily school calendars were reviewed and incorporated the required 250 days of instruction with eight days used for teacher planning this school year as a result of the change of the start of the school year as a result of COVID-19. This schedule provided four forty-five minute class periods for four periods in the a.m., and three classes in the p.m. for forty-two minutes and one thirty-eight minute class. Fulfilling the weekly requirement of twenty-five hours of instructional time and receive credit for course completions as appropriate. An interview with the lead educator verified the youth are attending school according to the daily schedule. In a review of the logbook, and confirmation with the lead educator, due to the COVID-19 pandemic, students were communicating with teachers through a virtual platform with live instruction. The lead educator would come into the facility every day to set the rooms up and turned and signed on the computers for the youth to work. The center has resumed face-to-face instruction in all classrooms.

Seven youth were interviewed, and each confirmed youth attend school Monday through Friday. The youth reported they are taking core education classes (Math, Science, History, English). They also reported their education needs are being met either well or very well.

During the interview with the superintendent, it was reported there is minimal interference of educational instruction. The center has asked for juvenile probation officers and counselors to visit or call after 3:00 p.m. Mental health tries to see youth in the a.m. prior to school or during lunch breaks. The superintendent reported the only main disruptions may come from medical due to the limited hours and time restraints on clinical staff to provide services.

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 has a policy and procedures to provide for career education. An interview with the lead teacher revealed the center offers Type 1 career education development which includes career learning strategies such as: interviewing skills and techniques, career interest, inventories, budgeting, résumé writing, as well as completing employment applications. The center provides character education including lessons in citizenship, integrity, and good moral character traits. It should be noted it is district policy all youth grades six and up have a My Career Shines account.

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 a policy and procedures in place regarding trauma-informed care. An interview with the superintendent revealed the center's practice of implementing trauma-informed care includes faith-based activities and celebrations such as holiday parties. The center continues to make improvements to incorporate trauma-informed practices. The center has a soft room and rooms painted with soothing murals. Seven in-service training records were reviewed. Each staff had documentation of annual training on trauma-informed care.

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 a licensed mental health professional serving as the designated mental health clinician authority (DMHCA), whose license is clear and active with an expiration date of March 31, 2021. The DHMCA is on-site for forty hours a week, Monday through Friday. The DMHCA is a licensed mental health counselor (LMHC) under Chapter 491. The backup DMHCA is licensed under Chapter 491, with a license expiring in March 31, 2021.

The interview with the DMHCA confirms their responsibility to provide daily oversight of the department to ensure services are being provided. Provided services include Assessments of Suicide Risk (ASR), development of treatment plans, individual sessions, group sessions, discharge summaries, psychosocial evaluations, and crisis evaluations. The DMHCA attends detention reviews weekly, chairs weekly mini-treatment team meetings, and communicates with detention administration about any mental health needs of youth in facility.

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

The center's clinical staff includes a psychiatrist and licensed mental health professional. The psychiatrist has a clear and active license specializing in child and adolescent psychiatry, with an expiration date of March 31, 2021. Based on the contract, the psychiatrist is to be on-site two hours each week.

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

The center employs one non-licensed mental health professional who is an employee of a service provider licensed under Chapter 397. 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 non-licensed mental health clinical staff person has a master's-level degree in mental health counseling. Documentation reflected the non-licensed staff has received twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. This training included administration of five Assessments of Suicide Risk (ASR) or Crisis

Assessments conducted on-site in the presence of the licensed mental health professional. The non-licensed staff received one hour a week of on-site face-to-face supervision by the designated mental health clinical authority, as documented on Licensed Mental Health Direct Supervision Log.

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.	

The center has a policy and procedures regarding mental health and substance abuse admission screening. Seven youth records were reviewed, and all seven records had completed admission screenings. Each youth had a Suicide Risk Screening Instrument (SRSI) and Massachusetts Youth Screening Instrument – 2 (MAYSI-2) completed at intake by a juvenile probation officer. Documentation reflected a review of these instruments were completed by detention staff. These documents were completed in the Department's Juvenile Justice Information System (JJIS). All seven reviewed records indicated youth were placed on precautionary observation due to screening instruments identifying risks for suicide. Documentation demonstrated the referral process was initiated and a mental health professional was notified in all seven records and completed an Assessment of Suicide Risk (ASR). All screenings were completed by trained staff. In all seven records, the results of the SRSI and/or the MAYSI-2 indicated a need for further assessment. In each of the records, a mental health referral was made for the youth and the superintendent or designee was notified of the youth's status. Five of the seven youth had an elevated suicide risk sub-scales based on the MAYSI-2 and were placed on suicide precautions. The results of six youth's MAYSI-2 indicated a need for a Comprehensive Assessment and this was reported to mental health clinical staff by detention staff.

3.05 Mental Health and Substance Abuse Evaluation [Detention Staff/Contract Provider]	Satisfactory Compliance
The probation and JAC intake/detention screening process ensures youth identified through preliminary screening 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.	

Seven records were reviewed for completions of mental health and substance abuse evaluations. One youth received a comprehensive assessment through a community provider, which was completed within thirty days. The remaining six youth were scheduled for an evaluation within two weeks. Two of the evaluations were completed within thirty days and contained all the required elements including the signature of the licensed mental health professional. The remaining four evaluations will be completed within thirty days of the referral date.

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.*	

Five of the seven youth records were applicable for requiring a treatment plan. The initial treatment plan was in place within seven days of the initiation of treatment and developed on the Department's Initial Mental Health/Substance Abuse Treatment Plan form (MHSA 015) in three records. The treatment plan contains the reason for the referral for treatment, the initial Diagnostic and Statistical Manual of Mental Disorders – Forth Edition (DSM-IV) diagnosis and symptoms, counseling, initial treatment goals, psychiatric services including psychotropic medication and frequency of monitoring, and the signatures of the mental health professional, youth and mini-treatment team members in three records. In the remaining two records, each of the youth refused services, as such, initial treatment plans were not created.

Two of the seven youth records were applicable for individual treatment plans. Both plans were developed for youth receiving mental health and/or substance abuse treatment services in the center by the thirty-first day of the youth's admission. A licensed mental health professional signed both plans within ten days of completion. Both treatment plans included a DSM-IV diagnosis, symptoms are treatment focused, treatment goals which include mental health or substance abuse services. Strengths, abilities, preferences and needs, psychiatric services including psychotropic medication and frequency of monitoring, pharmacological interventions, and progress notes validate youth are receiving treatment services as stipulated on the treatment plan. The two applicable plans were signed by both the youth and mental health professional. One plan was signed by the treatment team members, and the other was emailed to the treatment team members. Each of the parent(s)/guardian(s) were called regarding the treatment plans, but due to the COVID-19 pandemic, parent(s)/guardian(s) were not allowed to be on-site for signatures. None of the youth were applicable for individual treatment plan reviews. Each of the youth were applicable for psychiatric treatment services. Each of the youth's treatment plans included treatment and services provided by a licensed psychiatrist. None of the youth were an alleged victim of a Prison Rape Elimination Act (PREA) event.

Three closed records were reviewed. All three youth records showed a Mental Health/Substance Abuse Treatment Discharge Summary form (MHSA 011) completed upon the youth's transition/discharge. A copy of each summary was provided to the youth and family by mail.

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.*	

Seven youth records were reviewed. Five of the seven records required treatment. Two of the youth refused treatment services. The remaining three youth were assigned to a mini-treatment team, consisting at a minimum of mental health clinical staff, one staff from a different service area, youth and youth's parent/guardian. All three youth were receiving individual or family counseling sessions provided according to frequency required by the plan. Group counseling is being provided individually due to COVID-19 pandemic health and safety precautions. Service frequency reflects diagnoses and treatment needs in all three plans. Three of three youth had a proper consent for treatment obtained for mental health. Two youth were applicable for substance abuse services, and each had a Youth Consent for Substance Abuse Treatment form (MHSA 012) and a Youth Consent for Release of Substance Abuse Treatment Records form (MHSA 013). In all three records, treatment notes were documented in the Department's Counseling/Therapy Progress Notes form (MHSA 018) or notes containing all required elements. Mental health staff have adequate access to youth to provide treatment services in all three records.

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.	

Three of the seven reviewed youth records were applicable for entering the center on psychotropic medication. The initial psychiatric interview for each youth included the following information: reason for the referral, history (medical, mental health, and substance abuse history), mental status examination, Diagnostic and Statistical Manual of Mental Disorders – Fourth Edition – Text Revision (DSM-IV-TR) or Diagnostic and Statistical Manual of Mental Disorders – Fifth Edition (DSM-5), treatment recommendations, prescribed medications, explanation of the need for psychotropic medication, and frequency of medication monitoring/management. For each youth, an in-depth psychiatric evaluation was conducted within thirty days of admission. The in-depth psychiatric evaluation included all of the following elements: the stated reasons and factors leading to the referral, social history, history of psychiatric illness, mental status examination, diagnostic formulation, treatment recommendations and interventions, prescribed medication, explanation of the need for psychotropic medication, and the signature of the practitioner conducting the evaluation.

The Clinical Psychotropic Progress Note (CPPN), page three, was completed when a new psychotropic medication was prescribed or there were any changes to the existing prescription. The psychiatric evaluation included the following when a new psychotropic medication was prescribed/dispensed/administered by the psychiatrist: identifying data, diagnosis, target

symptoms of each medication, evaluation and description of effect of prescribed medication of target symptoms, side effects, youth's adherence to the medication regimen, height, weight, and blood pressure, whether there was telephone contact with the youth's parent/guardian to discuss the medication, the signature of the psychiatrist and date of his signature. Each youth had a completed Authority for Evaluation and Treatment (AET). The contract was reviewed for the tele-medicine/tele-psychiatry inclusion. None of the seven youth were applicable for tele-psychiatry. There is not a specified back-up psychiatrist. If needed, the provider will choose from available psychiatrists, licensed under Chapter 490, to provide coverage.

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

The center has a written plan detailing suicide prevention procedures, which is reviewed and signed by the designated mental health clinician authority (DMHCA) and superintendent annually. The plan includes identification and assessment of youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and a review process as referenced in Department's Rule 63N-1(2)(e)3(I).

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).*	

All seven youth records reviewed were identified as being at risk for suicide during the admission screening process. Each youth was placed on precautionary observation as a result. An alert was automatically generated in the Department's Juvenile Justice Information System (JJIS) as a result of the Suicide Risk Screening Instrument (SRSI) assessment. The Assessment of Suicide Risk (ASR) was completed for each youth using the Department's form. Each ASR form documented assessment of the youth in real time. Each youth began on constant supervision as a result of the SRSI and after the completion of the ASR, were placed on standard supervision. Suicide Precaution Observation Logs were completed in their entirety, including documenting safe housing areas and required signatures. A qualified mental health professional was involved in all seven records. None of the youth were released prior to receiving an ASR. In all seven records, staff documented a consultation with the designated mental health clinician authority (DMHCA) or licensed mental health professional on the mental/health substance abuse referral summary.

In all seven records, the superintendent or designee was notified immediately of suicide risk and a referral was made to a mental health professional. All seven youth were placed on authorized

precautionary observation. An ASR was completed within twenty-four hours in all seven records. A follow-up ASR was completed prior to the removal of all seven youth from precautionary observation, and included all elements required by the Mental Health/Substance Abuse Manual. A conference was held by the superintendent and licensed mental health professional to reduce the level of supervision and discontinuation of close supervision is documented in accordance with the center's suicide prevention plan in all seven records reviewed.

In all seven records, an ASR was completed by a licensed mental health professional or clinical staff under the supervision of a licensed mental health professional. In two youth records, the ASR was administered by non-licensed staff, both of whom had documentation of twenty-four hours of ASR training. There was evidence in center's logbooks and the suicide risk assessment administrative or supervisory staff provided instructions related to the suicide risk assessment findings/suicide precaution decisions in all seven records. Alerts were appropriately entered and removed following the youth being removed from precautionary observation in all seven records. Logbooks were reviewed to determine if beginning and ending times are documented for youth placed on precautions. Six of seven youth had all the beginning and end times documented. The remaining youth had a begin time but did not have an end time for precautionary observation found in the logbooks. No youth were applicable for secure observation.

The superintendent has an established review process for every serious suicide attempt or serious self-inflicted injury (requiring hospitalization or medical attention) and a mortality review for a completed suicide. The multidisciplinary review includes the circumstances surrounding the event, facility procedures relevant to the incident, all relevant training received by involved staff, pertinent medical and mental health services involving the victim, possible precipitating factors, as well as recommendation for changes in policy, training, physical plant, medical or mental health services, and/or operational procedures. The center has a suicide response kit including a knife-for-life, wire cutters, and needle nose pliers.

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.	

Each of the seven youth records reviewed has Suicide Precaution Observation Logs maintained for the duration the youth were on suicide precautions. The appropriate level of supervision and observations of the youth's behavior are documented in real time and did not exceed thirty-minute intervals in all seven records. When warning signs were observed, notification of the program director or designee and mental health clinical staff was documented on the Suicide Precaution Observation Log in all seven records. Suicide Precaution Observation Logs were reviewed and signed by each shift supervisor and mental health clinical staff in all seven records reviewed. Five of the youth who were on suicide precautions were interviewed and all five youth reported staff were with them at all times while they were on precautionary observation. A review of the seven completed Suicide Prevention Observation Logs confirmed supervision, supervisory reviews, response warning signs, and safe housing requirements were met.

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

Seven in-service training records were reviewed. All seven completed training in the Department's Learning Management System (SkillPro), and six of the seven completed an instructor-led training which totaled over six hours. One of the six staff had one and half hours of the four hour required instructor-led training. Training for staff included mock suicide drills which were held no less than quarterly on each shift, for all staff who come in contact with youth. A review of the mock suicide drills confirmed the drills are typically completed monthly on each shift, but no less than quarterly. Each of the reviewed staff participated in quarterly drills with a minimum of one quarterly drill semi-annually. Staff members who are not present during a drill are given the opportunity to review each drill scenario and procedures.

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 included in the combined emergency services plan. The plan includes the notification and alert system, means of referral, including self-referral, communication, supervision, documentation and review.

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 an Emergency Care Plan which includes immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment under Chapter 394, Florida Statutes (Baker Acts), transport for emergency substance abuse assessment and treatment under Chapter 397, Florida Statutes (Marchman Acts), documentation, training, and review. The plan was signed by the superintendent and designated mental health clinician authority on July 17, 2020. The plan is located in the superintendent office, medical clinic, mental health office, and the briefing room. The 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 has a policy and procedures to address Crisis Assessments which includes all required elements. The center has not completed any Crisis Assessments since the last annual compliance review.

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

The center did not utilize a Baker Act or Marchman Act procedure during this review period; therefore, this indicator rates as non-applicable.

Standard 4: Health Services

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

The Department contracts with Camelot Community Care, Inc., to provide medical, mental health, substance abuse, and psychiatric services for youth in the Department's twenty-one regional juvenile detention centers. Camelot Community Care, Inc., subcontracts with a medical doctor (MD) to serve as the designated health authority (DHA) at the center. The MD has a clear and active license to practice in the State of Florida, which expires March 31, 2022. The DHA is available twenty-four hours a day, seven days a week by telephone to address any medical concerns at the center. Sign-in logs for the past six months were reviewed and confirmed the DHA was on-site for at least one hour each week. Another MD has been identified to provide services if the DHA is on vacation or otherwise unavailable. Camelot Community Care, Inc., employs an advanced practice registered nurse (APRN). The APRN holds a clear and active license to practice in Florida, which expires on July 31, 2022. The APRN provides services on-site ten hours a week. The APRN works in collaboration with the DHA and there is a signed Collaborative Practice Protocol between the APRN and DHA. The DHA and APRN perform Comprehensive Physical Assessments or focused evaluations on each youth, evaluate youth with chronic conditions, conduct sick call and episodic care when on-site, and make referrals for testing and/or off-site care. A check of all licensed medical staff confirmed all had current State of Florida medical licenses, verified by the Department of Health.

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

The center has Facility Operating Procedures (FOP) and treatment protocols for all healthcare-related services provided at the center. All healthcare FOPs and treatment protocols were reviewed and signed the designated health authority and the superintendent in August 2020. The psychiatrist reviewed and signed the FOPs related to psychiatric services in November 2020. All nursing staff signed a cover page acknowledging all healthcare FOPs and treatment protocols. The center has three newly hired nurses since the last annual compliance review. Training documentation demonstrated the newly hired nurses received a comprehensive clinical orientation to the Department's healthcare policies and procedures, which was provided by a registered nurse.

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.	

Seven youth Individual Healthcare Records (IHCR) were reviewed for this indicator, with six reviewed for the completion of an Authority for Evaluation and Treatment (AET) and one reviewed for the completion of the Limited Consent for Evaluation and Treatment and court order for youth in the custody of the Department of Children and Families (DCF). The six

records for youth requiring an AET contained an AET signed by the parent/guardian. A Limited Consent for Evaluation and Treatment and court order authorizing medical treatment were present for the one DCF youth. The AETs and Limited Consents for Evaluation and Treatment were obtained prior to medical services being provided at the center. The nurse completing the interview was familiar with procedures for the completion of an AET.

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

Seven youth Individual Healthcare Records (IHCR) were reviewed for this indicator, which included six youth requiring parental notifications and one youth in the custody of the Department of Children and Families (DCF) requiring court ordered consent for psychotropic medication. The six youth requiring parental notifications included six notifications for over-the-counter medications not covered by the Authority for Evaluation and Treatment (AET), one notification for off-site care, and three notifications for psychotropic medications. Verbal notifications to the parent/guardian were documented in each case. A witness was documented for each notification for psychotropic medication. Written notifications were completed in each case. For psychotropic medications, the notifications included page three of the Clinical Psychotropic Progress Note (CPPN). For the youth in the custody of DCF, a court order authorizing prescribed psychotropic medications and DCF form 5339 were in place prior to the youth receiving the medication. The nurse interviewed was knowledgeable of the parental notification and consent requirements.

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.	

A review of seven youth Individual Healthcare Records (IHCR) found each youth received a medical and mental health admission screening upon admission. Each screening was completed on the day of admission. Each youth was screened by a juvenile justice detention officer (JJDO) or JJDO supervisor and there was documentation of each screening being reviewed by a licensed nurse within twenty-four hours. Two of the seven IHCR for female youth were reviewed. Each female youth consented to and received a qualitative urine pregnancy test. There were no instances of youth with a change in physical custody requiring a healthcare admission rescreening. The superintendent interview revealed medical and mental health admission screenings are completed by the admitting JJDO and reviewed by nursing staff within twenty-four hours. The nurse completing the interview was knowledgeable of the process for initial screenings and re-screenings for youth with a change in custody.

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.	

Seven youth Individual Healthcare Records (IHCR) were reviewed. Each record documented nursing staff provided a general orientation to healthcare services within twenty-four hours of admission to the center. The healthcare topics reviewed during orientation included access to medical services, sick call, what constitutes an emergency and who to notify, medication

process and side effects monitoring, the right to refuse care and how it is documented, what to do in the case of a sexual assault or attempted sexual assault, and the non-disciplinary role of the healthcare providers.

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.	

A review of seven youth Individual Healthcare Records (IHCR) found four were applicable for notification to the designated health authority (DHA). The DHA was notified when youth were confirmed as possessing a medical concern or chronic condition. The psychiatrist was notified when youth had prescriptions for psychotropic medication. The notifications were documented in each youth's IHCR. The nurse reported the DHA is immediately notified when youth are admitted with serious or chronic conditions.

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.	

Seven youth Individual Healthcare Records (IHCR) were reviewed. Each record had a Health-Related History (HRH) form completed within seven days of admission. Six of the HRH forms were new, and one was updated. All seven HRH forms were completed by a licensed nurse and reviewed by the designated health authority (DHA) or the advanced practice registered nurse (APRN). Each of the HRH forms were completed before the Comprehensive Physical Assessment (CPA). In addition, HRH forms were updated as new medical information became available, such as the youth being placed on medication. The nurse interview indicated medical staff completed the HRH within twenty-four hours of admission if a signed Authority for Evaluation and Treatment is in place.

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.	

A review of seven youth Individual Healthcare Records (IHCR) found each contained a current Comprehensive Physical Assessment (CPA). Six of the records had a current CPA at the time of the youth's admission. In these six records, the designated health authority (DHA) or advance practice registered nurse (APRN) documented a review of the CPA and completed a focused evaluation within seven days of admission. One record documented a new CPA was completed within seven days of admission. If a youth refused any part of the exam, the clinician documented "Youth Refused" and the youth signed a Refusal of Care form. The Department's Problem List was updated for each youth. Six youth had at least one verified Tuberculin Skin Test (TST) documented in the IHCR on the CPA and Infectious and Communicable Diseases form and the Tier 1 Tuberculosis screening was completed within seventy-two hours for each youth. One youth refused to be tested; none of the youth tested had a positive TST or symptoms of Tuberculosis requiring them to be transported to the nearest hospital for further evaluation. The nurse interviewed was able to explain the process for completion of CPAs and TSTs.

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.	

Seven youth Individual Healthcare Records (IHCR) were reviewed. Each youth was screened and evaluated for sexually transmitted infections (STI) and each screening was reviewed by the advanced practice registered nurse (APRN). Each youth was offered human immunodeficiency virus (HIV) testing, and five youth chose to be tested. The ARNP ordered STI testing for five youth, but two youth refused the testing. Results of the STI testing for the three youth were documented on the Infectious and Communicable Disease (ICD) form. STI testing was completed and the results were documented on the ICD form and lab section for all three youth. Each of the three youth were offered and consented to HIV testing. The Department of Health conducts HIV testing at the center. Pre-test and post-test counseling were documented on the Health Education Record for each youth and test results were documented in a confidential manner. The nurse completing the interview described the screening and testing processes for STIs and HIV. Seven youth were interviewed, and all stated they could ask for an HIV test.

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

The center has a policy and procedures in place for the completion of sick calls. Three instances of sick call care were reviewed. All Sick Call Request forms and narrative progress notes conformed to the professional standards, to include all elements of the subjective, objective, assessment, and plan (SOAP) format. Each sick call was conducted within twenty-four hours of the Sick Call Request being completed by the youth. Three sick calls were conducted by a licensed practical nurse (LPN) and was reviewed by a registered nurse within twenty-four hours. Sick calls were found to be documented on the youth's Sick Call Index and the center's Sick Call log. None of the youth presented a similar sick call complaint three or more times within a two-week period. There were no youth complaints regarding any severe pain with which medical staff were unfamiliar. Sick calls are conducted in the medical clinic by licensed medical staff at the center. When there is not a licensed nurse on-site, the center has procedures in place for the shift supervisors to review Sick Call Requests no longer than four hours after a request is submitted. Sick call is scheduled seven days a week from 9:00 a.m. to 10:00 a.m. and 2:00 p.m. to 3:00 p.m. and can be done as needed throughout the day. There were no opportunities to observe sick call during the annual compliance review.

The nurse completing the interview reported sick call is provided daily by nursing staff. The nurse explained any sick calls conducted by licensed practical nurses (LPN) must done under the direction of a registered nurse (RN) or higher level medical professional. The nurse further explained youth presenting with a similar complaint three or more times in a two-week period require a referral to the designated health authority (DHA) or advanced practice registered nurse (APRN). Seven direct-care staff were interviewed, and all stated nursing staff provide sick call care, with two stating the supervisors provide for sick call when there is no nurse on-site. Of the seven youth interviewed, two youth said they are seen immediately, three state being seen within one day, and two reported they had never submitted a sick call request. Six youth

reported a nurse conducts sick call, two of them stated staff conduct sick call, and one stated he has not had a sick call.

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

The center has a policy and procedures for first aid care, episodic care, and emergency care. A review of seven youth Individual Healthcare Records (IHCR) found none of the youth received episodic/first aid care from a non-healthcare staff. Medical staff reported there have not been any instances of non-healthcare staff providing episodic care. One instance of episodic care provided by medical staff was reviewed. The episodic care was documented in the subjective, objective, assessment, and plan (SOAP) format. All instances of episodic care were documented in the Episodic Care Log.

First aid kits were located in sub-control, master control, the conference room, intake, the staff break room, the kitchen, and in each vehicle. The designated health authority (DHA) approved the contents of each first aid kit, and a list of approved items signed by the DHA was in each observed first aid kit. First aid kits in the building were checked monthly by nursing staff, which was documented on a log attached to each first aid kit. The first aid kits in the building had all required contents.

The center has two automated external defibrillators (AED), with one located inside of the sub-control nine and the other in the conference room. Each of the AEDs were tested during the annual compliance review and showed ready for use. Documentation showed the AEDs were checked monthly by medical staff. The AED pads expire on September 28, 2021. The AED batteries expire on August 20, 2022.

A review of the center's medical drills confirmed the center conducts emergency medical drills monthly on each shift. The emergency drills included a CPR/AED demonstration at least once each quarter. All direct care staff had participated in emergency drills. All of the licensed healthcare staff have a current CPR/AED certification. A review of seven pre-service and seven in-service training records found all had current CPR/AED First Aid certification. The center has a list of emergency telephone numbers and cellular telephone numbers posted in master control, which is accessible to all staff.

The nurse interviewed knew the location of all first aid kits and AEDs. The nurse explained the requirements for conducting medical emergency drills and documentation requirements for episodic care. All seven direct-care staff said they are able to call 9-1-1 if they feel necessary.

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

The center has a policy and procedures in place for off-site care. The center has two instances of off-site care in the last six months. Each instance of off-site care was reviewed, finding a Summary of Off-Site form was completed and filed in each IHCR, along with discharge instruction documents. The designated health authority (DHA) and advanced practice registered nurse (APRN) reviewed the discharge instructions. No youth required emergency care or a follow-up appointment for further off-site care. The nurse completing the interview stated orders

from the off-site care providers were obtained and reviewed by the advanced practice registered nurse (APRN) and designated health authority (DHA). Any follow-up care would be tracked and scheduled by nursing staff.

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

The center has a written policy and procedures for the delivery of treatment to youth identified as having a chronic medical condition. A review of seven youth Individual Healthcare Records (IHCR) found five youth were identified with a chronic medical condition and/or taking prescribed medications. Each youth was classified with a medical grade two through five. Each applicable record documented an initial assessment of the youth was conducted by the designated health authority (DHA) and the youth's chronic condition was monitored. The Department's Problem List was updated in each of the IHCRs to identify the youth's chronic condition, as required. None of the three youth required a reevaluation, as none of the youth were in the center for ninety days. There were no youth with a condition requiring periodic evaluations who had been in the center for over ninety days. The nurse completing the interview knew the requirement for periodic evaluations for youth with chronic conditions, stating the frequency of the evaluations would be based on the youth's condition and, in no case, would the time between evaluations exceed 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.	

The center has a written policy and procedures to ensure medication is received, verified, and administered in a safe and effective manner. Seven Individual Healthcare Records (IHCR) for youth taking medication were reviewed. Five youth were admitted with their medication. Nursing staff verified this youth's medication upon his arrival at the center. Chronological notes indicated nursing staff followed-up with parents/guardians regarding the medication, and the parent/guardian subsequently delivered the medication to the center. Nursing staff verified the medication upon receipt in each case. The designated health authority (DHA) and/or psychiatrist was notified in each case and ordered the medication be continued as prescribed.

The center uses the standard Department's Medication Administration Record (MAR) to document administration of medications. Each MAR included the youth's name, DJJID, date of birth, youth allergies, medical alerts, medication precautions, and a picture of the youth. All seven MARs had the correct medical grade listed. There were no laps or errors in medication administration. The medical staff documented weekly side effect monitoring on the MARs. There was one refusal documented. The center's practice is to clearly document refusals on the MAR and Refusal forms, which was completed. The center had not had any youth who required parenteral medication during the annual compliance review period.

Three of the seven youth reviewed were taking psychotropic mediation. The psychiatrist was notified when youth were identified as being prescribed psychotropic medication. The initial diagnostic psychiatric interview was conducted with fourteen days of admission for the three youth. None of the youth required a thirty-day monitoring for psychotropic medication, as none

of the youth had been in the center for thirty days after the initial psychiatric interview. Center policy and procedures required psychotropic medication monitoring every thirty days.

A medication pass completed by a nurse was observed during the annual compliance review. The nurse followed the Six Rights of Medication Administration (right youth, right medication, right dose, right route, right time, and right documentation). After the nurse gave a youth his medication, the nurse verified the youth consumed the medication by checking his mouth. The center has trained non-healthcare staff to assist in the delivery of medications when licensed staff are not on-site.

The nurse interviewed was able to explain all aspects of medication management, to include receipt and verification, storage, administration, and disposal of medication. Seven youth were interviewed. Three youth reported nursing staff gives them medication and the remaining youth said they do not take 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 has a written policy and procedures ensuring medications and sharps are secured and inventoried. Medications and sharps were found stored and locked in designated areas inaccessible to youth. Medications storage areas include a locked medication cart, locked cabinets, and a locked refrigerator in the medical clinic. Active medications are stored in the medication cart; sharps and stock medication are stored in cabinets. All controlled medications are stored in a lockbox within the locked medication cart. The center had one youth on controlled medication at the time of the annual compliance review. A shift-to-shift inventory count of the controlled medication was documented on the youth's individualized Controlled Medication Inventory Record.

The center has a policy and procedures for sharps and medication inventories, which includes procedures to identify and report discrepancies in sharps and medication inventories. Three sharps inventories were randomly selected to review for accuracy. All three of the inventories had accurate physical counts. Three over-the-counter (OTC) medications inventories were randomly selected to review for accuracy. Inventories were documented weekly for all OTC medication, and perpetual inventories were accurate.

The center has a policy and procedures in place for the disposal of medication. The contracted pharmacy consultant is responsible for the disposal of medication. Documentation showed the pharmacy consultant, witnessed by the medical staff, properly disposed of expired or discontinued medication.

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

The center has a written policy and procedures and an Exposure Control Plan addressing infection control, which includes staff training and education for youth on infection control. The Exposure Control Plan is written in accordance with Occupational Safety and Health Administration (OSHA) Standards. The Exposure Control Plan was signed by the designated health authority and superintendent. The Central Communications Center (CCC) has been notified whenever a youth or staff was tested for COVID-19. The local health department was notified of youth placed in quarantine at the center.

A review of seven youth Individual Healthcare Records (IHCR) found each youth received infection control training within seven days of admission. Training included guidelines for hand-washing techniques, universal/precautions, prevention/transmission of communicable diseases, prevention of blood borne pathogens, and guidelines for infection control. A copy of the Health Education Record form was maintained in each reviewed IHCR. A review of fourteen staff training records confirmed all staff received infection control training. All training and education were provided in accordance with the Centers for Disease Control and Prevention guidelines. The nurse completing the interview was aware of the location of the Exposure Control Plan and knew requirements for infection control training for youth and staff.

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

The center has a written policy and procedures in place for prenatal care for pregnant youth. The policy and procedures address health education for youth and training for staff on healthcare issues for female youth. A review of ten training records found all staff received training on prenatal healthcare. A review of medical alerts for the center found no pregnant youth have been admitted to the center during the annual compliance review period. The nurse interviewed fully explained the center's procedures and practices for pregnant youth, including testing for youth who may be pregnant, dietary and other provisions of care for pregnant youth, off-site services available, and training for staff on girls' healthcare.

Standard 5: Safety and Security

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

The center has a written policy and procedures addressing the active supervision of youth. Staff was observed supervising youth during open module, school, dining hall, and recreation time. Youth were properly supervised by staff with the correct staff and youth ratio. There are currently three working modules. Observation included movement to and from school classroom and to and from the dining hall area. There are logbooks within the module areas. One logbook is maintained in the master control area which documents movements, incidents, admission/releases, medication pass, meals served, shower times as well as staff arrival and departure times from the center. When the count is not reconciled, all movement is stopped, youth are secured and visually counted by staff. This status remains until the count is reconciled with an explanation as to what led to the error. Six interviewed staff stated there was enough staff to provide for the safety and security of youth and staff, with ratio being met on the day of the interview. One staff stated there is not enough staff.

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 provides a system of rewards, privileges, and consequences to encourage youth to fulfill the center's expectations. A level system is used with youth for their behavior management system (BMS). The center supports positive behavior and confronts negative behavior. Youth earn points through leadership merits (clean room, bed made up, room organized and neat,

completing schoolwork and behaving while in school). Youth can drop levels or remain in frozen status (not earning points) for failing to follow the center rules. Youth receive orientation regarding the BMS during their admission process, understanding the different levels and how to move between the different levels. Token store is given weekly, alternating between extra telephone calls, ice cream social, game night and later bedtime. Six staff received training regarding the BMS system.

The superintendent explained the center utilizes a level system for BMS. Youth come in on level two and on level three youth obtain additional privileges such as access to game room, special snacks, and additional events over the weekend. It takes three days to gain a level and three days after being demoted. Youth are provided with a monthly calendar outlining incentives.

Seven youth were interviewed regarding the BMS. Each of the youth stated the BMS was good, one stated it was very good, and one stated it was fair. All seven youth were able to explain the BMS has three different levels with the different rewards. Six youth stated the staff are consistent with the BMS, one stated the staff show favoritism.

All seven staff interviewed explained the BMS and rewards accurately. Six staff stated things can be taken away from youth as a consequence (levels, points, canteen, books, and games) and one stated they cannot, though they indicated their level can be taken away. Six staff stated the BMS is effective, and one stated it is not effective. Six staff stated staff discuss consequences being imposed towards youth, and one staff stated they do not speak with youth. All seven staff stated youth are given an opportunity to explain their behavior and speak with youth about alternative acceptable behaviors. Three staff stated supervisors provide BMS feedback daily during debriefings and four staff stated supervisors will discuss how to be consistence when applying BMS and policy and procedures. One staff stated the supervisor will speak with youth and may even re-train staff. Three staff stated feedback is given by supervisors weekly, two stated it is given monthly, two stated it is given quarterly, three stated it is given yearly, and five stated it is given as needed.

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 restricts certain types of penalties on youth who demonstrate negative behaviors. Group punishment is not used as a part of the center's behavior management plan. Policy prohibits group punishment, unauthorized use of punishment, and corporal punishment. Five interviewed youth stated youth are not allowed to punish youth. Room restriction is used for major infractions. Reviewed incident reports for

infractions, date and times were noted, who recommended/approved the restriction, counseling of the youth while on restriction and approved removal of the youth.

All seven interviewed youth stated they are not ever allowed to punish other youth. Three interviewed youth stated they have been sent to their rooms for punishment and four stated they have not been sent to their rooms for punishment. Four youth interviewed stated they received fair consequences and three youth stated they never received consequences. All seven youth stated only points and levels were taken away for consequences. All seven interviewed staff stated only levels and six stated points can be taken away as consequences. Five youth stated for consequences their room was shut and locked, two were non-applicable. Two youth stated handcuffs or leg irons are not used on out of control youth and five youth stated they never witnessed this. None of the seven staff stated they have even seen a co-worker take meals, snacks, clothing, education, or medical care from youth because they were acting out. None of the seven staff have ever observed any staff encouraging youth to beat up 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 has a written policy and procedures to ensure ten-minute checks are conducted when youth are in their rooms. Staff conduct ten-minute checks by visually looking into the rooms when a youth is secured behind their room doors. All staff complete their visual observations of the youth using the Silver Guard Wand System. Ten-minute checks are conducted manually by staff. The center has eighty-nine cameras, of which eighty-four are operational. Video recording are stored for thirty days. Closed circuit television was reviewed over various days and time frames to ensure the accuracy of what staff are notating on their logs. All appeared to be in order and no issues noted.

The superintendent explained staff utilize the electronic wand and do rounds approximately ten minutes apart. Staff observe each youth while they are sleeping to ensure they are safe and secure. Supervisors download wand-data to the computer. Six interviewed staff stated room checks are every ten minutes when youth are in their room for sleeping (non-suicidal), and one staff stated it was under ten minutes.

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).

The center has a written policy and procedures in place to track all youth placed in the center. Review of the master control logbook noted head counts at the start and end of the shift, youth movement and any adjustments to the census due to an admission or release from the center. A white board is maintained in master control area with the center count, counts of the male and females' modules and the breakdown of the individual groups. Daily population census is distributed during briefing for each area and master control. The shift supervisor maintains a copy of the population census. Emergency counts are conducted when the count cannot be reconciled, after an incident, and after a drill is completed.

Seven interviewed staff stated youth counts are at the beginning of the shift and at the end of the shift. Six staff stated youth counts are before and after school and each meal. All seven staff stated emergency youth counts are conducted when a youth is believed to be missing, when visibility is hindered, and 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 has a written policy and procedures regarding logbook maintenance. The center maintains bound, with numbered pages, logbooks in the master control, and in each module area. Entries are legible, noted with the dates, real, non-military times, and shifts. Entries

contain movements for school and mealtimes, medication pass start and end times, incidents, departure and return of youth to the center, staff entering and exiting the center as well as scheduled census counts (including counts at the start and end of each shift). Entries impacting safety and security were highlighted.

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 has a written policy and procedures in place addressing logbook reviews. The center administration review logbooks on a weekly basis and provide recommendations as to the completeness and accuracy of the information recorded. Supervisors are required to review logbooks in all living spaces to include master control daily during the tour of their assigned shift. Each staff is required to review the logbook entries for the past two shifts upon reporting for duty. The superintendent confirms supervisors are expected to review logbooks daily and administration is expected to review them weekly. Once logbooks have been used in their entirety, they are given to the assistant detention superintendent to store for record retention. A new log is opened and provided to staff. Administration reviews the logbooks to verify all confinements are reported and ensure the center activity schedule is being followed.

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

The center has a written policy and procedures regarding key control. The center staff keys are maintained in the master control area, which is restricted to education, medical, and mental health. Staff are provided keys from the shift supervisor during daily briefing. A chit is provided to visitors for their personal keys and an entry is written on the key control log. This log contains the staff name, time of arrival/departure, what chit was assigned, their work area and the

agency they work for. Each of the key control boxes are secured and monitored by the master control staff. Center keys are reconciled at the start and end of every shift by the master control staff. Assistant detention superintendent or the on-call administrator and the shift supervisor is immediately contacted when there is a key missing or lost. All youth movement is stopped and youth are secured. A thorough search of the center is conducted until the key count is properly reconciled. Youth do not have access to the center keys.

The superintendent stated permanent keys are issued to staff, which are assigned by administration and documentation of signed issuance form is maintained by assistant detention superintendent in the key binder. Seven staff were interviewed regarding which center keys are restricted. Six stated youth property keys are restricted, five staff stated medical records, mental health records, and case management records are restricted, three stated the kitchen is restricted, once stated none of the above, and one stated just the dinner area not the back area of the kitchen. Seven staff stated personal keys are securely stored, visitors personal keys are given to master control with chit/token given, there is a daily tracking of keys (key log), keys are assigned, youth do not have access to keys, youth and facility are searched for missing keys, and damaged keys are replaced. Six staff stated there is an inventory of keys and staff is to notify master control of missing keys. One staff stated staff keys are given to master control upon entry into center.

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 has a policy and procedures for vehicles and maintenance. The center has six vehicles in use for transportation of youth. Vehicles logs were maintained with invoices for services/repairs on both vehicles. Logs for daily inspection were documented and completed by maintenance staff. Vehicles had all required equipment inside and required number of seatbelts needed for the youth. A transport was unable to be observed for there are limited transports due to COVID-19 pandemic. All seven youth interviewed state they feel staff drive safely when being transported. All youth stated they have never seen anyone place contraband into a transport vehicle.

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 for tool inventory and management. Observation of the tool inventory with the assistant facility administrator and maintenance staff confirmed tools are inventoried by maintenance staff upon their arrival for duty. Tools are kept in the maintenance shop, which is restricted. A log is maintained for all tool items, which is reviewed daily and monthly. Youth do not have access to any tools while at the center.

The superintendent stated only maintenance has access to tools and youth are only allowed to use mops and brooms under direct staff supervision. Five interviewed staff stated supervisor/management are to be informed of damaged or missing tools, six started to inform maintenance, and one stated the search for the tools.

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.	

The center has a written policy and procedures for youth access and use of tools and cleaning items. Youth do not have access to any tools while at the detention center. Youth can use items for cleaning, such as mops, brooms and dustpans, under the direct supervision of staff. All seven interviewed youth stated they are only allowed to use mops and brooms. Seven staff interviewed stated the youth are only allowed to use 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 has a written policy and procedures which addresses the inventory of all flammable, toxic, caustic, and poisonous items. The center maintains an inventory of all chemicals. Safety Data Sheets (SDS) are properly maintained at the center by maintenance staff. All materials were stored and secured in an area with limited access to staff (shift supervisors are responsible for distributing the supplies needed to their staff and collect them at the end of the shift).

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 which addresses access to all flammable, toxic, caustic, and poisonous items. Only authorized personnel are permitted access to flammable, toxic, caustic and poisonous items. Youth do not have access nor are they permitted to use these items. Six youth interviewed stated they are do not clean with any cleaning agent and one

youth stated sometimes. Seven staff interviewed stated youth are not allowed to clean with toxic, flammable, or poisonous substances.

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 addressing the disposal of flammable, toxic, caustic, and poisonous items. According to the center's administrators and maintenance staff, liquid waste resulting from work details are disposed of in the plumbing area of each module unit with a drain. Liquid waste resulting from work details shall be disposed of in sinks located in the mop storage areas. Kitchen liquid waste shall be disposed of in the kitchen drain. Kitchen grease shall be placed in a separate container for disposal. Any hazardous materials shall be disposed of according to the manufacturers' Safety Data Sheets (SDS). According to the maintenance personnel, the grease trap area is pumped quarterly. Trade Mark recycling company disposes of all flammable, toxic, caustic, and poisonous items, as needed.

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.	

The center has a written policy and procedures regarding the use of confinement under twenty-four hours. Five confinement examples were reviewed for under twenty-four-hour review. Two examples were for medical isolation. Confinements were approved by the shift supervisor or center administration. Only one youth per room assignment. Rooms were searched for contraband and documentation in the Facility Management System (FMS). Cameras were free of any obstruction. Youth were supervised properly by staff for the first hour (five-minute intervals) followed by ten-minute intervals. Supervisors conducted the initial review and additional reviews of the youth while on behavioral confinement. Reports were completed by staff in a timely manner. One report had a staff complete their report entry the following day. The superintendent or designee reviewed confinement reports within twenty-four hours.

The superintendent explained confinements are documented in FMS. Confinements are approved by superintendent beyond eight hours and regional administrators over twenty-four hours. Seven staff interviewed stated the room is searched and ten-minute checks are conducted and documented when youth are placed in confinement. Six staff stated they are to complete a confinement report. Two staff specified for the first hour, they are to complete checks every five minutes, then complete checks every ten minutes thereafter. Four staff stated youth are provided educational material in confinement and three stated youth are not.

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 regarding the use of confinement over twenty-four hours. There were no confinements during the annual compliance review period over twenty-four hours. This was verified within the Facility Management System (FMS). The superintendent explained the region reviews confinements monthly and sends a monthly report to the director.

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) to ensure the center is prepared to manage emergency and disasters. COOP plan is located in the superintendent's office area. Review of the policy reveals the center has a primary and alternate location in the event during they must evacuate youth and staff, which includes medical. COOP drills were completed within the required time frame. Superintendent stated the Department's Facility Operating Procedure 5.10 is the center's escape plan which describes signs of escape and what to do in an escape attempt. Escape drills are completed and documented annually. The center maintained a Continuity of Operations Plan manual has contingencies for multiple scenarios. Six interviewed staff stated they participated in weather and major disturbance drills within the last six months. Four interviewed staff stated they participated in bomb threat and flooding drills within the last six months. Three interviewed staff stated they participated in hostage situations and chemical spill drills within the last six months. Two interviewed staff stated they participated in a terrorism drill within the last six months.

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

The center has a policy and procedures addressing escape drills. Escape drills were completed on a quarterly basis by all three shifts. Staff are trained annually for escape prevention. Examples of completed drills were reviewed for proper completion as they are entered in SharePoint for documentation purposes. Seven staff interviewed stated they participated in escape drills within the last six months.

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 has a policy and procedures addressing fire drills. Fire drills were completed monthly by all three shifts. Documentation was turned in and reviewed by administration. Examples of completed drills were reviewed for proper completion as they are entered in SharePoint for documentation purposes. Six interviewed youth stated they have been instructed what to do in case of a fire and one youth stated he has not. Seven interviewed staff stated they participated in fire drills once a month.