STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Okaloosa Regional Juvenile Detention Center

Department of Juvenile Justice

(State-Operated)
4448 Straightline Road
Crestview, Florida 32539

Review Date(s): November 3-6, 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:

Jill Foy, Office of Accountability and Program Support, Lead Reviewer (Standard 1)
Lea Herring, Office of Accountability and Program Support, Regional Monitor (Standard 4)
Patrick McKinstry, Office of Accountability and Program Support, Regional Monitor (Standard 3)
James Ken Phillips, Office of Accountability and Program Support, Regional Monitor (Standard 5)
Fred Vrgora, Circuit 1, Juvenile Probation Officer Supervisor (Standard 2)

Program Name: Okaloosa Regional Juvenile Detention Center
Provider Name: State Operated
Location: Okaloosa County / Circuit 1
Review Date(s): November 3-6, 2020

MQI Program Code: 828
Contract Number: N/A
Number of Beds: 35
Lead Reviewer Code: 168

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

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

Standard 1: Management Accountability
Detention Rating Profile

Indicator Ratings

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

Okaloosa Regional Juvenile Detention Center is a state-owned detention facility, operated by the Department, located in Crestview, Florida. The center serves youth in Okaloosa and Walton counties in Circuit One. The center has a juvenile assessment center (JAC) which provides assessment and screening services for youth. The JAC is operated by G4S services, a contracted provider. Male and female youth who are detained pending adjudication, disposition, or placement in a residential commitment program are housed in the thirty-five-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 Okaloosa County School Board. The center's management team includes the superintendent, one assistant superintendent, one administrative assistant, and seven juvenile justice detention officer (JJDO) supervisors.

Mental health and healthcare services are provided through the contracted provider, Camelot Community Care, Inc. Mental health services are provided by one licensed mental health counselor (LMHC) who serves as the center's designated mental health clinician authority (DMHCA) and one non-licensed mental health staff. Psychiatric services are provided by a licensed psychiatrist. Clinical services provided by the center include mental health and substance abuse evaluations, mental health treatment planning, individual, group and family therapy, mental health crisis intervention services, on-site psychiatric services, and availability for substance abuse services for youth with co-occurring disorders. Medical services are provided by one medical doctor (MD) who serves as the center's designated health authority (DHA), one advanced practice registered nurse (APRN), one full-time registered nurse (RN) who serves as the clinic manager, one full-time licensed practical nurse (LPN), two part-time LPNs, and one medical records clerk. The medical clinic maintains nursing coverage Monday through Friday, from 7:30 a.m. to 7:30 p.m., and on weekends, from 8:00 a.m. to 4:30 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 three living modules which are divided by male and female. There are seventy-two security cameras at the center, of which all were operational. The center was observed to overall be clean and free of graffiti. No major maintenance issues were observed. At the time of the annual compliance review, the center had fourteen vacancies, which included eleven juvenile justice detention officer I (JJDO) and three JJDO II positions.

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.	

The center has a written policy and procedures to ensure all Department employees, contracted providers and grant recipient employees, volunteers, mentors, and interns with access to youth will undergo a criminal background screening prior to hiring or utilizing the services of the volunteer, mentor or intern. Since the last annual compliance review, the center has had fifteen new hires, five of which are contracted staff. Each of the fifteen new staff members had a background screening completed by the Department's Background Screening Unit (BSU) prior to the hire date. None of the fifteen new hires were applicable for an exemption. Ten of the fifteen new hires were applicable for a pre-employment assessment (Ergometric), of which nine achieved a passing score. One staff member did not achieve a passing score but was approved for hire by the Detention Services Assistant Secretary. This staff member also completed additional training provided by the center's field training officer prior to having any contact with the youth. Based on a review of the volunteer list, the center did not have any new volunteers since the previous annual compliance review. The center submitted the Annual Affidavit of Compliance for Level 2 Screening Standards on January 2, 2020 and the Okaloosa County School Board submitted their Annual Affidavit of Compliance for Level 2 Screening Standards on January 9, 2020.

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

The center has a written policy and procedures which require a rescreening completion every five years from the date of hire for all staff. Two staff members were eligible for a five-year rescreening. Both five-year rescreening for the eligible staff members were completed prior to the anniversary date of initial hire. No contract staff or volunteers were eligible for a five-year rescreening.

1.03 Staff Code of Conduct	Satisfactory Compliance

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

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

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

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

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

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

The center has a written policy and procedures to ensure staff communicate and interact with youth in a manner which provides a role model of socially accepted behaviors and staff will be respectful of others and reflect desired behaviors for youth. The center provided three staff records applicable for violations of code of conduct for review. Each of the three records contained a signed and dated code of conduct. Documentation in the three records reviewed reflected one staff received a verbal reprimand, one received a written reprimand, and one received a three-day suspension. The center provided three additional staff records for review which were applicable for commendations. Two of the three records reflected the staff members received Employee of the Months awards and one staff member received the North Region Juvenile Justice Detention Office I (JJDO) of the Year Award.

All three staff members interviewed indicate they have never heard coworkers using profanity, threatening or intimidating behavior towards youth. Two of the three staff members reported working conditions during the previous year to be good and one staff reported them to be fair. All three interviewed youth reported they have never needed to call the Florida Abuse Hotline since they have been at the center. All three youth reported staff are respectful when talking with them and other youth. Two of the three youth reported they have never heard staff using profanity when speaking with youth and one youth reported staff occasionally use profanity when speaking to youth. All three youth stated they feel safe at the center and none have heard staff threatening them or other youth. All three interviewed youth reported they have never had contact with staff members via social media, telephone numbers, or emails. According to the superintendent, corrective actions are provided when staff are in violation of the code of conduct and appropriate responses are based on the severity of the violation.

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

The center has a written policy and procedures to ensure consistency and expediency in reporting all incidents. The center had thirty-three reportable incidents to the Central Communications Center (CCC) in the previous six months. This is an increase of reportable incidents compared to last year's report during the annual compliance review period. Five reportable incidents were reviewed. All five CCC reports reflected they were reported within the required two-hour time frame. Five reviewed reports were documented in the logbook or shift report, as required. There were no internal incidents or grievances which should have been reported to CCC. The superintendent attributes the increase of reportable incidents to the COVID-19 pandemic. The superintendent added all reportable incidents are called into the CCC hotline within two hours of the incident or two hours of gaining knowledge of the incident, all staff and youth are able to contact the Florida Abuse Hotline at any time, and any CCC or abuse reported are documented in the master control logbook.

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 has a written policy and procedures to ensure detention center staff use physical intervention techniques in accordance with Florida Administrative Code. In the previous six months, the center has had thirty-four uses of Protective Active Response (PAR). Five incidents were reviewed. All five incidents were completed by the end of the staff member's workday, included statements from all staff involved, did not require mechanical restraints, did not result in serious injury to youth or staff, and there were no instances in which youth alleged abuse. In each case, the reports were reviewed and processed within seventy hours by all required parties. Post-PAR interviews were conducted within thirty minutes of the incident in all five reports reviewed. None of the reports required a PAR medical review. A review of incidents/grievances did not reflect any additional PAR incidents. The center's PAR rate during the annual compliance review period was 23.55, which is above the statewide Detention PAR rate of 16.56. The center's current PAR rate is higher than the rate reported during the previous annual compliance review. The superintendent credits the increase in rate to the nature of the youth received at the center such as committed youth and stop-hold youth. According to the superintendent, when Level 3 PAR (mechanical restraints) are used, logs to document checks are kept in the superintendent's office. The superintendent added PAR incidents are reviewed in the Facility Management System (FMS) daily by the superintendent or designee and the purpose of the reviews are to monitor the number of incidents and provide feedback for incident reduction. Three staff interviewed reported staff talk with youth prior to using PAR or mechanical restraints.

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

The center has a written policy and procedure to ensure proper training equips staff with the skills necessary to conduct themselves in a manner consistent with the ethical standards established by the Department. Three staff training records were reviewed. Three staff reviewed completed all required essential pre-service training prior to any contact with youth. One of three staff completed the required 120 hours of training and was certified within 180 days of hire. Two of the three staff completed the required 120 hours of training and were certified within 186 and 182 days of hire, respectively. A trainee extension request and approval were included in each of these staff records. All pre-service training was documented in the Department's Learning Management System (SkillPro).

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

The center has a written policy and procedure to ensure proper training equips staff with the skills necessary to conduct themselves in a manner consistent with the ethical standards established by the Department. Three staff records were reviewed for in-service training. Documentation reflected each of the three staff completed over the required twenty-four hours of annual in-service training to include: cardiopulmonary resuscitation (CPR), first aid, automated external defibrillator (AED), Protective Action Response (PAR) update, ethics, active shooter, human trafficking, and suicide prevention. One of the three staff members was applicable for eight hours of supervisory training in which case the staff member completed fifteen hours of supervisory related training. All in-service training was observed to be documented in the Department's Learning Management System (SkillPro) for each of the three staff reviewed. The center has an annual training calendar, which is updated when changes occur. According to the superintendent, management training includes a minimum of eight hours of supervisory training and an annual Equal Employment Opportunity (EEO) training. The superintendent added, staff are required to complete twenty-four hours of in-service training annually to include CPR, first aid, AED, and PAR.

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 a written policy and procedures to ensure each youth has the right to grieve and ensure all youth are treated fairly, respectfully, without discrimination, and their rights are protected. The center had twenty-six grievances filed since the previous annual compliance review. Five grievances were reviewed. Documentation in all five grievances reflected the grievance were reviewed and responded to within the required time frames. The center's grievance procedures require the officers to attempt to resolve any dispute or issue which could lead to a grievance prior to the actual filing of the grievance. Grievance forms were observed available to youth throughout the center. Grievances are entered into the Facility Management System (FMS) on behalf of the youth.

Three interviewed youth could explain the grievance process. One of three youth interviewed rated the grievance process as fair, one rated the process as good, and one youth reported they never filed a grievance. Three interviewed staff were able to explain the center's grievance process. The superintendent was able to explain the center's three phase grievance process and further reported grievances for the previous year are maintained in the assistant superintendent's office.

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.

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

The center has a written policy and procedures in place to ensure the safety and well-being of youth with critical or special alerts and to ensure alerts are reviewed, responded to and appropriately documented. Three youth were reviewed for mental health, medical, and security alerts. All three youth were applicable for alerts. In each case, alerts were entered, reviewed, and updated as required by the appropriate staff member. Logbooks and shift reports were available for review and reflected alert documentation as needed. Alerts are immediately entered into the center's alert system if a youth is admitted with special needs/risks such as suicide, mental health, substance abuse, physical health, or security risk factors. Appropriate staff are notified based on the nature of the youth's alert to include medical, mental health, and food service. The Department's Juvenile Justice Information System (JJIS) alert report is printed out each day and reviewed during shift briefings. Each officer receives a hard copy of the alert report during shift briefing and keeps it on their person for their entire shift. The alert report is reviewed daily by supervisors and administrators. All three staff interviewed reported they receive alert information during shift briefings, and each stated they receive a hardcopy of the alert report each day. Staff added, any additional information from management is received by email, meetings, and briefings. Two staff members reported these means of communication are fair and one reported it was good. According to the superintendent, medical alerts are review by medical staff to ensure alerts are entered and tracked correctly.

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.*	

Three youth records were reviewed for admission requirements. All three records contained an admission wizard which reflected the following: arrest affidavit/custody order and/or trip ticket, Detention Risk Assessment Instrument (DRAI), and Suicide Risk Screening Instrument (SRSI). Additionally, all three admission wizards indicated youth were full body visual searched. All three records contained medical, mental health, and substance abuse screenings. All three youth were offered a meal during the admissions process; however, one youth refused as indicated on the admission wizard. All three admission wizards indicated the youth either made or received a phone during the admission process. An admission was unable to be observed during the annual compliance review.

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.*	

Three youth records were reviewed for orientation requirements. All three youth records contained an orientation checklist, which was signed and dated by both youth and staff. The signature dates corresponded with the date of admission for all three youth. Orientation is provided both verbally and in writing and includes the following: rules and regulations, youth rights, visitation, telephone calls, grievance procedures, access to medical mental health, and substance abuse services, access to the Florida Abuse Hotline and Central Communications

Center (CCC), behavior expectations and consequences, and possible new law violations. The orientation includes all elements as outlined in the center's written policy and procedures. Additionally, orientation includes a Prison Rape Elimination Act (PREA) video which each youth watches. An admission was unable to be observed during the annual compliance review.

Three youth were interviewed regarding the orientation process at the center. Two of three youth interviewed reported upon admission they were informed of the center's rules, schedule, education services, visitation, abuse reporting, and behavior management system (BMS). However, during the interview process, one youth indicated he did not go through the orientation process; however, the youth was aware of the grievance procedure, activity schedule and other detention procedures explained at orientation. A review of this youth's record reflected the youth signed all of the orientation paperwork.

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.

Three youth records were reviewed for classification. Documentation in each record contained the arrest affidavit/custody order and/or trip ticket, Detention Risk Assessment Instrument (DRAI), and Suicide Risk Screening Instrument (SRSI). Consideration of potential safety and security concerns in room assignments include sex, height, weight, age, and level of aggressiveness. Identified special needs include 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, suicide, escape, and security risks. Documentation in all three records reflected special needs of each youth as applicable were identified upon admission. Each record contained a completed VSAB and reflected the officer's signature and date of page three. Room assignments are made based on each youth's classification. In the event there is a change in behavior or status, room

assignments will be changed if deemed necessary. According to the superintendent, youth are assigned to a room based on their classification and youth are reclassified if changes in their behavior or status are observed and documented.

Currently, due to the center's population of ten youth, nine males and one female, all youth have been assigned to a single room. Due to the low population one living module of the detention center is used only to house positive COVID-19 youth. Youth alerts are entered, updated, removed based upon admission and throughout the youth's time in detention as needed. Staff review the VSAB, youth face sheet, admission screening, alerts, Human Trafficking Screening Instrument (HTSI) if applicable to assist in identifying youth who are vulnerable to victimization as well as the youth's type of aggression.

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."*	

Three youth records were reviewed for gang involvement or gang affiliation. All three records reviewed were applicable for suspected gang involvement. All three records reflected a pre-existing alert for suspected gang involvement in which law enforcement was notified and an alert was entered by the youth's assigned juvenile probation officer (JPO). The superintendent reported there is no one person assigned as the gang liaison for the center, but the responsibility is held collectively by all detention staff. The superintendent reported any suspected gang member or activity is shared with the circuit's gang representative.

An example in which detention staff notified the youth's assigned JPO of suspected gang affiliation was observed during the weekly detention review meeting on the first day of the annual compliance review. The superintendent reported they keep in close contact with the circuit gang representative, concerning any gang activity at the center. The circuit gang representative informs the center's staff of any suspected gang member and all updates concerning gang activity in their area.

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.	

Three youth records were reviewed for personal property. All three youth records contained a personal Property Receipt form which reflected both youth and staff signature. Additionally, each record contained a letter of acknowledgement regarding unclaimed property, signed by the youth. All three youth reviewed were applicable for valuable property in which a Valuable Property Receipt form was observed in the record. Youth's valuable property was observed to

be stored in a clear, tamper-proof property bags, in the safe monitored by video surveillance. The bag included the following information: date, youth's name, Department of Juvenile Justice Identification Number (DJJID), and a listing of items in the bag. The drop safe logbook was available for review and contained the all required information. None of the youth refused to sign the Property Receipt form. All three youth's personal property was observed bagged, included a copy of the Property Receipt form, and stored in a secure room. Access to the property room is limited to only supervisory-level staff and higher. An admission was unable to be observed during the annual compliance review. All three youth interviewed reported staff checked their personal property upon admission and had the youth sign a form stating the personal property was correct. According to the superintendent, supervisors or higher ensures a youth's personal property is stored and if the property is of value, both the admitting officer and supervisor conduct safe drops and document in the logbook.

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.	

All youth personal property was observed stored in a green mesh bag which included a copy of the personal Property Receipt form (inventory) and was kept in a secure room. Access to the property room is limited to supervisory-level staff or higher. The drop-safe is under video surveillance and includes a bound safe logbook. All three youth reviewed were applicable for valuable property in which the property was stored in a clear, tamper-proof bag and the storage of the youth's property was appropriately logged in the drop safe logbook. A review of Central Communications Center (CCC) reports for the previous six months reflected no incidences involving youth property. According to the superintendent, youth's personal property is stored in a bag with a property sheet documenting all the youth's property. The superintendent added, property is stored in a secure room in which only supervisors or higher have access.

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 provided three closed youth records to review for release requirements. Documentation in all three records reflected the on-duty supervisor reviewed all paperwork prior

to the youth's release. Prior to release of two of the three closed records reviewed, the youth's identification was verified, identification of the parent/guardian was photocopied, and the youth and the person the youth is being released to was reminded of any future court dates. However, one of the youth reviewed had no photocopy of the parent/guardian picking up the youth. The Release Wizard reflected the youth was released to a family member and the driver's license number was documented on the Release Wizard. Documentation in all three records reflected appropriate parties signed the release forms and the date of admission and release corresponded with the admission and release dates in the Department's Juvenile Justice Information System (JJIS). None of the youth were applicable for endangered person alerts in JJIS. A release was unable to be observed during the annual compliance review. A review of Central Communications Center (CCC) reports for the previous six months reflected no incidents of unauthorized releases.

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 provided three closed youth records to review for release of property. All three files contained a Property Receipt form which was signed by both youth and parent/guardian. The center also provided reviewers with three examples of written notification to the youth's parent/guardian for property held for more than thirty days. Documentation on property receipts further reflected all three youth's property were claimed by the parent/guardian. There have been no instances in the previous six months where youth's property was disposed. A release was not observed during the annual compliance review. According to the superintendent, all property not picked up within thirty days is considered abandoned, in which case it is inventoried, and a money order is sent to the regional office which is then forwarded to headquarters.

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 provided three closed applicable youth records for review of release of medication. Documentation reflected all three youth were released to their parent/guardian. All three records contained an Office of Health Services (OHS) Medication Receipt, Transfer, and Disposition form (053) and OHS Health Discharge Summary - Transfer Note form (012). Documentation further reflected the parent/guardian signature on the OHS form 053 in each record. All three youth reviewed were under the age of eighteen. A copy of the person's identification for each youth released to their parent/guardian was found in their record.

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 detention center conducts detention reviews every Tuesday at 11:00 a.m. A juvenile justice detention officer supervisor (JJDOS) is designated as the detention review specialist. Detention reviews were observed during the annual compliance review in which the following participated: detention review specialist, commitment managers, registered nurse (RN), designated mental health authority (DMHCA), the center's lead teacher, and the assigned juvenile probation officer and juvenile probation officer supervisor. Due to COVID-19 protocol, all members participated by video conferencing. Youth placed on either home or secure detention were reviewed, and updates were given as needed. Detention review documentation was reviewed for the previous six months. Documentation consistently reflected participation by representatives from all parties who have responsibility for the youth. According to an interview with the superintendent, detention reviews are conducted weekly and all required staff participate in 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.	

A copy of the center's activity schedule reflected youth are provided with the opportunity to participate in constructive activities which will benefit the youth and the center. The center's daily activity schedule was observed posted throughout the center and included times the youth are to participate in school activities, conduct personal hygiene/showers, have meals/snacks, attend visitation, recreation activity, and participation in small group discussions or social activities. Due to COVID-19 precautions in place, visitations were suspended by the Department**.** The schedule reflects when educational programming is offered, times of phone calls and letter writing, bedtimes for youth with higher levels in the behavior management system, and when to conduct unit/facility cleaning. All three youth interviewed reported the center has an activity schedule and the schedule is followed daily. Three interviewed staff each reported the center's daily activity schedule is followed.

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

The center has a daily activity schedule for Monday through Friday and a daily activity schedule for weekends (Saturday and Sunday). Observations of adherence to the activity schedule were observed each day of the annual compliance review. A review of center shift reports found no significant changes in the center's activity schedule. A review of the center's logbooks over the previous six months reflected adherence to the daily activity schedule. The classrooms are connected to each dorm and youth attends school in the classroom; however, the teacher is not physical present in class. The teacher instructs students using the video conferencing platform.

All three youth interviewed reported the center has an activity schedule and the schedule is followed daily. Three interviewed staff each reported the center's daily activity schedule is followed.

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

All youth at detention center are given access to education. School begins at 8:00 a.m. and ends at 2:00 p.m. A review of the education schedule and school district calendar revealed the youth are provided education 250 days a year distributed over twelve months, with a minimum of twenty-five hours of instruction a week. Teachers are given six days for training and planning throughout the school year. Youth enrolled in educational programs at the center have an opportunity to earn course credit for completion of the education and training experience. A review of master control logbooks documented there were no missed school days. The center's logbook indicates the student were late to school two days out of the six days reviewed. Lead educator, staff, superintendent and student interviews revealed there is minimal interference of educational instruction. Three interviewed youth stated they attend math, science, history, and social studies at the center.

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

An interview with education staff revealed the center is providing the requirements for Type 1 programming to include life skill groups activities and instructions. The center uses My Career Shines, job applications, and mock interviews. The career education programming includes communication, interpersonal skills and decision-making skills. In addition, the youth take a career interest inventory.

2.15 Trauma-Informed Care	Satisfactory Compliance

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

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

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

The center has incorporated trauma-informed practices into current operations to deliver services and to provide care to youth in custody. The center has two soft rooms one on the girl's mod and one on the boys. These soft rooms are painted using soothing colors. A review of six staff training records reflected all staff had completed Trauma Informed Care training as part of their pre-service and in-service training requirements. According to an interview with the superintendent, soft colors and age-appropriate artwork are placed throughout the center. In addition, the superintendent reported staff are trained in practicing trauma-informed care in Phase One training, in-service training, and implementation of the statewide behavior management system (BMS).

Standard 3: Mental Health and Substance Abuse Services

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

The center has identified a single licensed mental health professional as the designated mental health clinical authority (DMHCA). The DMHCA is a licensed mental health counselor (LMHC) under Chapter 491. The DMHCA is a full-time employee and is on-site forty hours a week. The functions of the DMHCA, include appropriate coordination and implementation of mental health and substance abuse services. The center has a designated a back-up DMHCA; who is licensed under Chapter 491 and license expires on March 31, 2021. The contract between the Department and Camelot Community Care, Inc., was reviewed, which addresses the DMHCA job description and responsibilities. The DMHCA was interviewed and asked to describe their role in the coordination and implementation of mental health and substance abuse services at the center. The DMHCA stated, they coordinated and implement all mental health and substance abuse services at the center.

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

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

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

The service provider, Camelot Community Care, Inc., is licensed under Chapter 397. The service provider's licensure at Okaloosa Regional Juvenile Detention Center expires April 1, 2021. A review of documentation supports the clinical supervisor assures those non-licensed clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience. The one non-licensed mental health clinical staff person holds a master's-level degree from an accredited university in the field of counseling and is a mental health intern. The non-licensed substance abuse clinical staff person is able to provide substance abuse services within the center as an employee of this service provider who is licensed under Chapter 397.

The non-licensed mental health clinical staff person conducted Assessments of Suicide Risk (ASR) and was in receipt of twenty hours training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services.

The training included administration of, at a minimum, five ASRs or Crisis Assessments conducted on-site in the physical presence of a licensed mental health professional and documented on non-licensed mental health clinical staff person's training in ASR form (MHSA 022). The non-licensed mental health clinical staff person's training was completed May 3, 2018. The non-licensed mental health and substance abuse clinical staff has received at a minimum of one hour a week, of on-site face-to-face direct supervision by the licensed clinical supervisor. Supervision notes completed by the clinical supervisor, were observed for the past six months. Each of the clinical supervision notes were documented on the Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log form (MHSA 019). The licensed mental health professional providing direct supervision has reviewed assessments which were conducted by the non-licensed mental health clinical staff within twenty-four hours of the referral. Each of the completed assessments which were conducted by the non-licensed mental health clinical staff, were signed by the licensed mental health professional the next scheduled time he was on-site. The non-licensed mental health and substance abuse clinical staffing is in accordance with the Florida Administrative Code and the current contract between the Department and Camelot Community Care, Inc.

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

A sample size of three youth records were reviewed for mental health and substance abuse admission screening. The screening documents completed by probation staff, were the Suicide Risk Screening Instrument (SRSI) and the Massachusetts Youth Screening Instrument – Version 2 (MAYSI-2). Documentation of review of these instruments were completed by detention staff. The three SRSI reviewed, were completed at the youth's intake. Each of the SRSI and MAYSI-2 reviewed, were completed using the Department's Juvenile Justice Information System (JJIS). The nurse and/or mental health staff completed required sections of the SRSI. There were completed entries observed in each of the three youth records reviewed, which included summary and recommendations in "Screening Results" sections. One of the three youth records reviewed, were applicable and contained a "Yes" response on the SRSI. The applicable youth was placed on suicide precautions and a mental health referral was completed. In the applicable record, results of the SRSI and MAYSI-2 indicated a need for further assessment. A referral was generated for the youth. Notification was made to the superintendent and/or designee as needed. In one out of the three youth records reviewed, a MAYSI-2 assessment indicated elevated suicide risk subscales. The applicable youth was placed on suicide precautions and referred for an Assessment of Suicide Risk (ASR). One of the three youth records reviewed, required a referral for a comprehensive assessment. An interview with the superintendent revealed, the juvenile assessment center (JAC) staff, admitting detention staff, medical, and mental health staff complete screenings. Those screenings used include, SRSI, Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB), and MAYSI-2.

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

A sample size of three youth records were reviewed, where one was applicable for completion of a mental health and substance abuse evaluation. The mental health and substance abuse evaluation was not required to be completed at time of the annual compliance review, as the youth had not been at the detention center long enough. A review of the contract between the Department and Camelot Community Care, Inc., revealed specific guidelines and time frames are required for the completion of a mental health and substance abuse evaluation. The designated mental health clinical authority (DMHCA) explained those practices as required within contract leading up to the completion of a mental health and substance abuse evaluation when necessary. When evaluations are conducted, they are completed within the Department's Office of Health Services (OHS) Electronic Medical Record (EMR) within the Department's Juvenile Justice Information System (JJIS). None of the youth reviewed, required a comprehensive assessment through a community provider.

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

A sample size of three youth records were reviewed for treatment; where one youth was applicable for an initial treatment plan. The initial treatment plan was developed on the Initial Mental Health/Substance Abuse Treatment Plan form (MHSA 015). The reason for referral for treatment was noted, along with the initial Diagnostic Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis and symptoms. The initial treatment included counseling, treatment goals, and psychiatric services. The initial treatment plan contained appropriate signatures from the mental health professional, youth, and mini-treatment team members involved in development of the initial treatment plan.

None of the three-youth reviewed required an individual treatment plan at time of the annual compliance review. The one applicable youth had just received an initial treatment plan, whereas the individual treatment plan was not required at time of the annual compliance review.

A sample of three youth records were reviewed for mental health and substance abuse treatment discharge. The reviewed records contained a Mental Health/Substance Abuse Treatment Discharge Summary form (MHSA 011), which was completed upon the youth's discharge. Each of the Mental Health/Substance Abuse Treatment Discharge Summary forms,

documented and were provided to the juvenile probation officer (JPO), parent/guardian, and the youth.

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

A sample size of three youth records were reviewed for mental health and or substance abuse treatment; where one youth was applicable. The one youth requiring treatment, was assigned to a mini-treatment team. The youth was determined to be in need of mental health treatment, which included either individual, group, and or family counseling. None of the youth reviewed were applicable for inclusion of substance abuse treatment. A proper consent for mental health treatment was found for the one applicable youth receiving mental health treatment. Treatment notes, Counseling/Therapy Progress Notes (MHSA 018) were found for the one youth. A discussion was held with the designated mental health clinician authority (DMHCA), who verified the mental health staff have adequate access to youth in order to provide treatment services.

Group therapy is limited to ten or fewer youth with mental health diagnoses. Video observation of groups was not able to be reviewed at time of the annual compliance review. The detention center's digital video recording (DVR) system was removed prior to video review; the DVR was removed from the center for shredding. An interview with the designated mental health clinician authority (DMHCA) was conducted. The DMHCA stated there were no type of specialized services offered at the center. The DMHCA did state they offer mental health and substance abuse, crisis counseling and services as needed. A sample size of three youth was interviewed and asked how they would rate the mental health and substance abuse services they are receiving. One youth responded good; the remaining two youth responded they were not receiving any mental health and or substance abuse services.

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

A sample size of three youth records were reviewed for psychiatric services; where one youth was applicable for an initial psychiatric interview. The one youth's initial psychiatric interview included a reason for referral, history, mental status examination, Diagnostic Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis and symptoms, and treatment recommendations. This one youth was currently taking or prescribed medications at time of the initial psychiatric interview. The youth had an explanation of the need for psychiatric medication and frequency of monitoring and management of taking medications. None of the three youth were applicable for an in-depth psychiatric evaluation within thirty days of referral and or admission. A consent for psychotropic medication was documented within the one applicable

youth's health record. The Clinical Psychotropic Progress Note (CPPN), page three was completed due to changes to the one youth's psychotropic medication regimen. There was no noted need for tele-medicine or tele-psychiatry required per contract.

The provider, Camelot Community Care, Inc., employs a psychiatrist, who is licensed pursuant to Chapter 459, Florida Statutes; license expires March 31, 2022. The provider does not employ a licensed certified psychiatric advanced practice registered nurse (APRN). The provider's back-up psychiatrist is licensed under Chapter 459, Florida Statutes, and license expires January 31, 2021.

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

The detention center has a written plan detailing suicide prevention procedure, which was reviewed and signed by designated mental health clinician authority (DMHCA) on July 21, 2020 and by the superintendent on July 21, 2020. The written suicide prevention plan included the following necessary components: 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.

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

A sample size of three youth records were reviewed for suicide prevention services. The three reviewed youth were determined to be at risk and placed on precautionary observation during the admission screening. Each of the youth had a Juvenile Justice Information System (JJIS) alert initiated upon identification of suicide precautions. A suicide risk assessment referral was found for each of the youth identified in need. The Assessment of Suicide Risk (ASR) was conducted and completed in real time. Each of the three youth had a suicide precaution observation logs completed during the youth's time on supervision. One youth had one documented time period lapse of two minutes over the required thirty-minute observation time frame. All other time entries documented for each of the precautionary observation logs contained the required thirty-minute intervals. Each of the youth reviewed, had a qualified mental health professional involved is the assessment of suicide precautions. None of the reviewed youth were released prior to receiving an ASR or released while on suicide precautions. The staff person conducting the ASR documented a consultation with the designated mental health clinician authority (DMHCA). For each of the youth reviewed, the superintendent or designee was notified of the youth's suicide risk. The youth had a completed

ASR conducted within twenty-four hours of referral. Each of the youth reviewed, as a result of the ASR were placed on standard supervision. Two of the three reviewed ASRs were conducted by the non-licensed mental health professional. The non-licensed mental health professional completed appropriate twenty hours of ASR training on May 3, 2018. There was evidence in the facility logbook and suicide risk assessments, where administrative or supervisory staff were provided instructions related to the youth's precautionary decisions. A review of JJIS demonstrated alerts were appropriately entered/removed as needed. There were no occasions of youth requiring to be placed into secure observation. The superintendent has an established review process for every serious suicide attempt or serious self-inflicted injury and a mortality review for a completed suicide. The multidisciplinary review included, circumstances surrounding the event, written facility operating procedures relevant to the incident, training received by involved staff, pertinent medical and mental health services involving the victim, possible precipitating factors, and recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and/or operational procedures. The center has two suicide response kit; which both included a knife-for-life, separate set of wire cutters, and pair of needle nose pliers.

A sample size of three youth were interviewed; one of the three youth stated they have been placed on suicide watch while at the center. The remaining two youth stated they had not been placed on suicide watch. The one applicable youth confirmed staff watched him at all times while on suicide precautions. A sample of three staff were interviewed and each were able to identify practices they are responsible for, if a youth expresses suicidal thoughts.

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

A sample size of three youth records were reviewed for suicide precaution observation logs. There was a total of four suicide precaution observation logs reviewed between the three-youth reviewed. Each of the suicide precaution observation logs were maintained for the duration the youth was on suicide precautions. The youth had the appropriate level of supervision and observation of behavior documented in real time. One youth had one documented time period lapse of two minutes over the required thirty-minute observation time frame. All other time entries for each of the four precautionary observation logs reviewed, contained the required thirty-minute intervals. All the suicide precaution observation logs were reviewed and signed by each shift supervisor. All the suicide precaution observation logs were reviewed and signed by the mental health clinical staff. Completed suicide precaution observation logs each documented safe housing requirements. A sample of three staff were interviewed and asked to identify where the suicide response kits were located. Staff were able to identify where a suicide response kit was located within the detention center.

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

A total of six staff training records were reviewed for completion of suicide prevention training; three training records were pre-service and the other three were in-service training records. All the reviewed staff have received a minimum of six hours annual suicide prevention and

implementation of suicide precautions training. Training at the detention center, has included a total of eighteen mock suicide drills; six mock suicide drills for each of the centers three shifts. The mock drills included all staff who encounter youth, which included kitchen and maintenance staff. Documentation of the mock suicide drills demonstrated staff have participated in quarterly drills (with a minimum of one quarterly drill semi-annually). Drills conducted demonstrated, the direct-care staff have participated in at least one mock drill, which included the use of cardiopulmonary resuscitation (CPR) annually. Those staff members not present during a quarterly drill have the opportunity to review each mock drill scenario and procedures during shift briefings.

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

The detention center has a written mental health crisis intervention plan, which details crisis intervention procedures. The written mental health crisis intervention plan was reviewed and signed by designated mental health clinician authority (DMHCA) on July 21, 2020 and by the superintendent on July 21, 2020. The written mental health crisis intervention plan included the following required procedures: notification and alert system, means of referral (including self-referral), communication, supervision, documentation, and a review process.

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

The detention center has a written Emergency Care Plan which included the following necessary components: immediate staff response, notification, communication, and supervision. The written Emergency Care Plan included process for authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment under Chapter 394, Florida Statute (Baker Act), transport for emergency substance abuse assessment and treatment under Chapter 397, Florida Statute (Marchman Act). The written Emergency Care Plan included procedures for documentation, training, and review process. The detention centers written Emergency Care Plan was last reviewed and signed by designated mental health clinician authority (DMHCA) on July 21, 2020 and by the superintendent on July 21, 2020. The location of the written Emergency Care Plan is in the center's medical office, mental health office, administrative office area, and located on the center's network drive; which are 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 detention center has a written mental health crisis intervention plan, which details crisis intervention procedures and practices. The designated mental health clinician authority (DMHCA) advised there has not been any occurrences of youth in need of crisis intervention, during the annual compliance review period.

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 detention center has not had any Baker or Marchman Acts during the annual compliance review period; therefore, the 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.	

Camelot Community Care, Inc. is contractually required to provide comprehensive medical services to the youth in the center. The center has a board-certified physician who has a clear and active license and meets all the requirements to serve as a medical doctor/designated health authority (DHA). The physician's specialty is in family practice. The DHA is responsible for the overall clinical activities, policies, and protocols for the medical services provided. The center utilizes the services of an advanced registered nurse practitioner (ARNP), who holds a clear and active license to practice in the State of Florida. A review of sign-in logs for the six months prior to the annual compliance review, confirmed the DHA was on-site weekly for one hour with the exception of one week. During the DHA's absence, the center utilized coverage provided by another medical doctor by telehealth visits and provided services to youth for the week. The DHA is responsible for making the necessary arrangements for a qualified doctor to cover the center during vacations or extended absences. The APRN provided services on-site and works in collaboration with the DHA, who signed the nurse practitioner protocol/collaborative practice agreement on August 31, 2020. All medical staff licenses were filed in a notebook in the clinic and all licensed medical staff were found to be clear and active. An interview with the DHA confirmed the DHA conducts physicals, meets with youth for initial and follow-up chronic care evaluations, evaluates youth referred from sick call, assists with policy and procedure development, collaborates with APRN, and is available for on-call service for clinic staff.

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

The center utilizes Facility Operating Procedures (FOP) and treatment protocols for all health-related concerns. The FOPs were found to be well organized in a three-ring binder, all FOPs and treatment protocols contained the signatures of the designated health authority (DHA) on August 31, 2020, and the superintendent on July 20, 2020. The FOPs or other protocols related to psychiatric services and psychotropic medication management, were approved by the center's psychiatrist. Documentation confirmed all medical staff received a comprehensive clinical orientation to the Department's healthcare policies and procedures, which was provided by the registered nurse. Documentation confirmed nursing staff completed the annual review of FOPs and signed the cover page.

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

A review of three youth healthcare records confirmed each youth had a signed Authority for Evaluation and Treatment (AET). All three AET were stamped “Copy” and filed in the youth’s Individual Healthcare Record. Two of the three youth had signed AETs prior to entering the center and one record showed the AET was signed by the parent/guardian the next day the youth entered the center. None of the AETs included a refusal to sign and showed consent for medical services prior to emergency care and routine medical/mental health care.

According to the nurse interview, the youth's parent/guardian is contacted and advised to sign or update AET. If parent/guardian cannot be reached, a limited AET is obtained from the major or captain. In addition, weekly emails are sent to the assigned juvenile probation officer (JPO) to advise of youth needing an AET on file.

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

A review of three youth Individual Healthcare Records (IHCR) found all three were applicable for a parent/guardian notification. The three applicable youth records were evaluated and found each youth was placed on over-the-counter (OTC) medications not covered by the Authorization for Evaluation and Treatment (AET). Each instance IHCR contained documentation a parental notice was sent. In addition, the parental notifications were sent to the parent/guardian using the Department approved health services forms for parental notifications. According to the nurse interview, parent(s)/guardian(s) are notified when any medication is started, changed, or discontinued which is not covered in the AET, vaccinations/immunizations not consented for on the AET, changes in youth's medical condition/medication for youth with chronic conditions, and off-site emergency care. Notifications are made by telephone and subsequently in writing, hospitalizations, surgeries/invasive procedures, non-routine dental procedures, and off-site care.

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.	

Three youth Individual Healthcare Records (IHCR) were reviewed for screenings upon admission for healthcare concerns. Each of the five evaluated IHCRs contained a Medical and Mental Health Screening form completed, on the date of admission, by a juvenile justice detention officer (JJDO) and evaluated by a registered nurse (RN), or licensed practical nurse (LPN) within twenty-four hours. Documentation confirmed the designated health authority (DHA) was notified upon entry of all youth. None of the three records reviewed was applicable for a qualitative urine pregnancy screening at the time of admission. According to the nurse interview,

the DHA is notified within twenty-four hours by the RN or LPN once a youth is identified as having a chronic condition.

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

Three Individual Healthcare Records (IHCR) were evaluated for completion of youth orientation. In all three IHCR reviewed, revealed documentation of each youth received orientation to health care services. Youth orientation to healthcare services addressed all of the required topics, including access to medical care, sick call, what constitutes an emergency, medication process, the right to refuse care, and what to do in the case of a sexual assault or attempted sexual assault, the role of healthcare staff at the center.

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

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

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

Three youth Individual Healthcare Records (IHCR) were reviewed for Health-Related History (HRH). Each record had a completed/updated HRH form within seven days of admission to the center by a licensed nurse. All three were new HRH forms and were completed on the Department's form. Two of the three records revealed the designated health authority (DHA) or designee evaluated the HRH forms. One record was of a youth who transferred into the center from another center. The DHA did not sign the original HRH and the nurse completed a new HRH during the youth's admission. The HRH was updated during the annual compliance review to include the DHA's signature. An HRH form was complete prior to completing the Comprehensive Physical Assessment (CPA) in all three records reviewed, and the one HRH was updated later to include the DHA's signature.

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 three youth Individual Healthcare Records (IHCR) revealed a Comprehensive Physical Assessment (CPA) were completed for each youth. Each CPA was evaluated and initialed by the physician. Each CPA was completed within seven days of admission by a medical doctor or the advance practice registered nurse (APRN). Two of the three CPAs reviewed were new, the one CPA was completed from the transferred center, with all documenting a valid CPA on record. All three youth records, the youth "voiced no concerns", and each youth refused the Tanner stage exam. The doctor documented "no complaints" on the CPA and all three records documented the refusal for the exam on an additional Refusal of Treatment form. A review of the Department's Problem List indicated it was updated for each youth, as required.

A review of three youth IHCRs reflected each youth had a minimum of one verified Tuberculosis Skin Test (TST) documented in each youth's IHCR. Each of IHCRs documented Tier One TB screenings were completed within seventy-two hours of admission. There were no further evaluations or treatments needed. The information was documented on each youth's Infectious and Communicable Disease (ICD) form and on the CPA. In the interview with the nurse, she reported purified protein derivatives (PPD) are administered on intake if youth has an Authorization for Evaluation and Treatment (AET) signed or the PPD is completed as soon as the AET is completed. The PPD can be read in forty-eight to seventy-two hours after being administered to the youth.

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.	

Three Individual Healthcare Records (IHCR) reviewed with each youth reporting having been sexually active. The center screens each youth for STIs and attempted to make accommodations for all youth interested in submitting to STI test and human immunodeficiency virus (HIV). All three youth submitted to the STI evaluation and all three had the results in their IHCR and were documented on the Infectious and Communicable Disease (ICD) form. The youth's test results were noted on the Department's ICD form filed in the youth's IHCR, if applicable. All three youth records were reviewed, one record contained documentation the youth refused human immunodeficiency virus (HIV) testing and treatment. Two records documented consent to HIV testing and pre/post testing was received by the Oasis Center which includes a certified HIV counselor conducting the testing. The results of the two youth were filled in a confidential manner and documentation supported the results were evaluated by a practitioner. All three youth interviewed reported 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.	

All youth in the center can make sick call requests and have their complaints treated appropriately through the sick call process. Sick calls are conducted twice daily, as needed, by a licensed medical staff. Medical staff reserve time Monday through Friday from 10:00 a. m. and 5:00 p.m. On Saturday and Sunday at 10:00 a.m. to 3:00 p.m. is scheduled to address sick calls. Three youth records were reviewed with one applicable for sick call submissions. Two additional applicable records were reviewed. Documentation confirmed each youth was seen by medical staff within twenty-four hours of submitting the request. None of the evaluated youth presented a sick call with a similar complaint three or more time within a two-week period. There were no youth complaints of any severe pain with which medical staff was unfamiliar with. The center documented the sick calls in three ring binders. According to the nurse, there were no instances of restricted housing to review. Three youth were interviewed concerning sick calls, one reported being seen within twenty-four hours and the doctor conducts sick calls. Two youth reported they had never submitted a sick call. The three youth were asked to rate the medical care at the center. Two youth said it was good and one youth stated it was very good. Three staff were interviewed and all report the nurse reviews and conducts sick calls. In addition, one staff indicates the supervisor as someone who reviews sick calls.

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

The center has an established policy and procedures for the provision of episodic care, first aid, and emergency care. An evaluation of three youth Individual Healthcare Records (IHCR) revealed none were applicable; therefore, three additional applicable youth records were reviewed. An evaluation of three applicable youth IHCRs found each contained appropriate documentation of the episodic care events. Each youth was seen by medical staff. The center maintained an Episodic Care Log to document the provision of episodic care and first aid treatment. An evaluation episodic care documentation found to conform to professional standards. An evaluation of the logs indicated episodic care was administered by the nursing staff.

According to the nurse, the center has a total of thirteen first aid kits. First aid kits were reviewed and inspected to confirm all approved items were contained, as required. All content was up-to-date, and each first aid kits was resealed with a tamper tag. The program has two automated external defibrillators (AED), with one tested and it was functional during the annual compliance review. The batteries were installed on August 20, 2018 and will expire August 20, 2022. The AED pads expire March 28, 2021. Documentation confirmed the nursing staff review inventory and restock all first aid kits monthly and document the review on a log located on each first aid kit. All three staff interviewed reported they could call 9-1-1, when necessary.

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

The center has a written policy and procedures to provide timely referrals and coordination of medical services for youth requiring off-site care. An evaluation of five youth Individual Healthcare Records (IHCR) revealed none were applicable; therefore, three additional applicable youth records were evaluated. The evaluated documents confirmed the center provided timely referrals and coordination of off-site healthcare medical services. Information was documented on the Episodic Care Log. The IHCRs contained a Summary of Off-site Care form and discharge instruction documents, when applicable. Documentation evaluated confirmed the designated health authority (DHA) was notified of the event and the youth followed-up with the DHA in all three instances. In all three instances follow-up appointments were required; however, the youth were released from the center prior to their scheduled appointment.

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

An evaluation of three youth Individual Healthcare Records (IHCR) found all three youth were identified with a chronic medical condition and/or taking prescribed medications. The center maintained a chronic conditions roster to document the youth identified with medical conditions each youth is also classified using a numerical medical grade. Each IHCR contained documentation the youth were receiving treatment for a physical health condition and periodic evaluations a were scheduled on the nursing staff calendar. None of the evaluations exceeded a three-month interval. Each evaluation was documented in the youth's IHCR. When applicable, the treatment orders reviewed were clearly distinguishable for clinical staff. There were no lapses in treatment and the Problem Lists were updated in all instances. According to the designated health authority (DHA), all periodic evaluations are conducted every thirty days. Interview with the nurse confirmed the DHA is notified immediately after the chronic condition is verified.

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.	

A review of three youth Individual Healthcare Records (IHCR) found three youth were prescribed medication prior to their admission to the center. In each of the three IHCRs, the medication was verified, and the youth was continued on medications. All medication has a current, valid order and the IHCR documented the prescription and practitioner's orders. The center used the standard Department Medication Administration Record (MAR) to document consumption and refusal of medications. The MAR documented all of the required information including medication start and stop dates, and staff and youth initials of medication received.

The medical staff document weekly side effects monitoring on the MARs. Youth and staff initial the MAR acknowledging medications was provided. There were no lapses or errors in medication administration except for when a youth refuses medication. A Refusal for Treatment form is filled out in every incident of medication refusal. The center has trained non-healthcare staff to assist in the delivery of medications, only when licensed staff are not on-site.

One youth was applicable for psychotropic medication upon admission, both IHCR document the psychiatrist was notified upon admission. The youth received their psychiatric interview within fourteen days of admission and was continued on medication. A medication pass was observed during the annual compliance review, the registered nurse (RN) verified the Six Rights of Medication Administration (Right youth, right medication, right dose, right route, right time, and right documentation). After the RN gave the youth the medication, the RN verified the youth consumed or applied the medication by checking the youth's mouth and provided the youth a small sum of water. Three youth were interviewed with one stating the nurse provides their medication and the two other youth interviewed reported they have inhalers if needed, but have not used them. Of the three staff interviewed, one reported they could give medication to the youth.

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

The center maintains a written policy and procedures ensuring medical equipment classified as medications/sharps are secured and inventoried by using a routine perpetual inventory. The medical staff ensure all medication and sharps are stored and locked in a designated area inaccessible to youth. Observation of the medications confirmed, medications are stored in a locked medication cart, cabinets, and in the locked refrigerator all of which are situated in the medical clinic which is locked and inaccessible to youth. All medications are stored separately. All controlled medications were stored in the medication cart behind two locks. A shift-to-shift inventory count of all controlled substances was documented on the youth's individualized Controlled Medication Inventory Record. There was documentation of shift-to-shift counts being conducted.

A review of the center's inventory was conducted. Documentation showed the center inventoried all medications and medical equipment such as sharps by using a routine perpetual inventory descending count as each sharp is utilized and disposed, when applicable. A random inventory of three different sharps, three prescribed medications, and three over-the-counter (OTC) medications revealed each count was accurate and documented by licensed nursing staff correctly. An evaluation of the past six months of medications revealed all counts and inventories matched medications on-site. The number of pills, tablets, or dosages remaining after each administered dosage was documented on the youth's Individualized Controlled Medication Inventory Record. According to the nurse, if there is a discrepancy with the counts, they will recount the content and notify the Central Communications Center, if necessary. The center utilizes an RX Destroyer container to chemically destroy all unused or expired medication.

According to the nurse interview, unused medications are sent back to Diamond pharmacy for a credit. If it is a controlled medication it is kept in a double lock box until the consulting pharmacy comes to the center and it is destroyed with RX destroyer, then recorded on the destruction log.

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

An evaluation of the center's Infection Control Plan was conducted and confirmed the plan included all of the required elements. Three youth Individual Healthcare Records (IHCR) were reviewed and confirmed each youth received infection control training within seven days of admission. Training included guidelines for hand-washing techniques, universal/precautions, prevention/transmission of communicable diseases, prevention of blood borne pathogens, and guidelines for infection control. A copy of the Health Education Record form was maintained in each evaluated IHCR. All trainings and education were provided in accordance with the Centers for Disease Control and Prevention (CDC) guidelines. A review of three staff training records confirmed each staff received pre-service and in-service infection control training.

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

The center has a written policy and procedure which ensure access to prenatal care for all pregnant youth and health education is provided to both youth and staff. An evaluation of the staff's training roster verified the center's registered nurse provided training/education to staff involved in the supervision or treatment of pregnant youth. The training/education addressed the monitoring, observation and care of pregnant youth. The center was unable to provide any youth to review as an example of prenatal care.

Standard 5: Safety and Security

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

During the annual compliance review, youth were observed being supervised and accounted for at all times by staff. Interaction between youth and the center's staff was observed positive. Logbooks reviewed showed youth movement and counts being conducted consistently. The master control operator documents any youth movement from one location within the center to another. During daily observations, the center was adhering to the weekday activity schedule. Youth were seen supervised during dayroom activities, mealtimes, and educational classes. All three staff interviewed agreed the center has enough staff to provide for the safety and security of the youth and other staff members.

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

The center's behavior management system (BMS) was indicated within the written Facility Operating Procedures. Postings of the BMS were seen in youth living areas and hallways. The center's BMS has been approved by the detention regional director. The system includes rewards for positive behavior and consequences for inappropriate behaviors. Daily activities were observed which determined the proper implementation of the BMS. The youth daily points earned are captured on point cards. Samples of these completed point cards were observed in three selected youth case management records to show consistency with this practice. Points

earned allow youth to move up a level system, thus earning additional privileges as they increase their level. Incentives earned may include things such as special meals, token store items, extra phone call minutes, and later bedtimes. An incentive calendar was posted in living areas featuring rewards for each week.

The center's superintendent was interviewed concerning the BMS and stated it is a standardized system, and the goal is not to be punitive towards youth, but to provide guidance and positive tools for managing behavior. The superintendent was able to summarize the center's BMS. Three interviewed staff were able to summarize the system and defined it as a level and point system. None of the interviewed staff indicated items can be taken from a youth due to a behavior with the exception of their points or level. All three staff reported they felt the BMS was effective and noted staff speak with youth to discuss any consequence being imposed. According to all three interviewed staff, youth also are given opportunities to explain their behavior. Three youth were interviewed concerning the BMS. Two rated the BMS as good and one youth rated it poor. All three were able to list various rewards given at the center. Two youth stated staff were consistent with implementation of the BMS. One youth stated they were not. All three denied youth were allowed to punish other youth in the center.

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

The center's behavior management system (BMS) was identified within the written Facility Operating Procedures. The center's BMS was seen posted in youth living areas. The system includes rewards for positive behavior and consequences for inappropriate behaviors. Three interviewed staff were also able to summarize the system and defined it as a level and point system. None of the interviewed staff indicated items can be taken from a youth due to a behavior with the exception of their points or level. All three staff reported they felt the BMS was effective and noted staff speak with youth to discuss any consequence being imposed. According to all three interviewed staff, youth also are given opportunities to explain their behavior.

Three youth were interviewed concerning the BMS. Two rated the BMS as good and one youth rated it poor. All three were able to list various rewards given at the center. Two youth stated staff were consistent with implementation of the BMS. One youth stated they were not. All three denied youth were allowed to punish other youth in the center. The three interviewed youth were asked if they have been sent to their room for punishment. Two replied no and one stated yes, also stating the door was locked. Two of the three youth stated when they received

consequences, the consequences were fair. One youth replied they have never received any consequences. Youth only reported their level or points were taken from them as a result of a consequence.

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

The center's maintenance mechanic reports having a total of seventy-two cameras, with all reported to be operating accordingly. Video storage is maintained for thirty-days. During the annual compliance review, the center's digital video recording system was receiving an upgrade according to the center's administration. A sample of six ten-minute video checks were observed during the annual compliance review. The center operates on three shifts. The sample size included observations of checks being completed on both second and third shifts, in all youth living units, and on weekends and weekdays. Ten-minute checks were seen being completed by five different staff members.

The center utilizes the electric wand system in which staff touch the wand to the door when conducting the checks. The electronic wand system then captures the time and date as to when the check was conducted. Corresponding wand logs were observed with the sample of video checks completed to show the practice was being completed consistently. Video observations made found in each of the six samples the staff were seen stopping and checking the youth within their rooms. One of the five staff observed was not seen pausing briefly at the youth door on some rooms. This was documented and the staff name given to the center administration for further training. None of the checks observed were conducted outside the ten-minute required time frame, with the exception of one check which was done at the eleven-minute mark. Three interviewed staff all reported checks are to be completed every ten-minutes. The center's superintendent was interviewed and stated youth are checked every ten minutes when in their rooms. Checks are documented on Visual Observation Reports (VOR) or using the electronic wand system.

5.05 Census, Counts, and Tracking	Satisfactory Compliance

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

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

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

A review of master control and mod logbooks for the scope of the annual compliance review found evidence counts were being conducted at least three times each shift. Formal counts are held at the beginning, middle, and end of the shifts. The master control operator was observed performing counts and documenting youth movement during the annual compliance review. The number of youth are accounted for and documented in the logbook prior to movement from one location of the center to another. Emergency drills were observed documented within the logbooks. The master control operator was interviewed and explained the count process. Three interviewed staff all were able to summarize the count process. Staff indicated if a count is not cleared, a re-count will be completed. The staff indicated emergency counts may be completed if a youth is believed to be missing, when visibility is hindered, after a major disturbance, or medical emergencies.

5.06 Logbook Maintenance	Satisfactory Compliance

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

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

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

The center maintains a master control logbook and logbooks for each youth living area. A review of all logbooks provided for the scope of the annual compliance review was completed. Logbooks are bound with numbered pages. No pages were observed missing or falling apart. The date is documented at the top of each page. Entries observed include the time of the event

with the name of the staff and youth involved, as well as a brief description of the event and the initials of the staff making the entry. Entries impacting the security of the center are highlighted in yellow. Errors found in the logs were struck through with a single line and dated and initialed by the person correcting the error. The master control logbook includes documentation of Protective Action Response incidents, population counts, youth on special supervision, admissions and releases, youth movement, presence of law enforcement, emergency situations, emergency drills, and youth confinement placements.

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

The center maintains a master control logbook as well as logbooks for each youth living area. A review of master control and mod logbooks for the scope of the annual compliance review was completed. Evidence was found showing the superintendent or designee reviewed logbooks on at least a weekly basis and provided any recommendations as needed. The supervisor reviews mod logbooks and the log within the master control to indicate responsibility for the shift. Documentation found the superintendent or designee tour youth living areas and sign the log for the assigned area. The superintendent was interviewed and stated the juvenile justice detention officer reviewed the mod and master control log daily, and the superintendent and assistant superintendent reviews the master control log weekly.

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 which outlines the key control process. The procedures include the processes for addressing missing or lost keys, as well as the reporting

and replacement of damaged keys. A review of the Central Communications Center reports for the scope of the annual compliance review, as well as an interview with the center's superintendent, found no documentation or incident involving a missing or lost facility key.

All keys were observed secured and inaccessible to youth. Facility keys were maintained secure in the master control room. Keys were kept behind a locked box. The superintendent maintains a master key inventory for all facility keys. A sampling of seven sets of keys were observed to compare with the inventory log. All keys were accounted for and matched the number of assigned keys on the key ring affixed to the set of keys. Staff are not authorized to keep personal keys on them in the secure areas. Personal keys are kept in an assigned staff locker. Youth do not have access to keys. Informal interviews with youth and staff confirm this. Keys are maintained on a tamper-resistant ring with a color-coded ring hub identifying the area the keys are assigned to. Emergency keys are kept in the superintendent office and are noted on the master inventory form. The key inventory includes the ring number, number of keys on the ring, capability of the key, and to who the keys are issued.

Observations of electronic shift report information were made to show the date and time of key issuance, name of staff receiving keys, and time keys returned. The center maintains this information in the master control log, and key inventory logbook, and a Beginning of Shift Key form. All three staff training records reviewed had evidence each staff received training on the center's key control policy. The master control operator was interviewed and was able to summarize the key control process, as well as the process of storing youth personal items. The items are kept in a secure safe which is only able to open using a two-key system. Only supervisors have access to the personal storage safe. Six random staff were asked to present their assigned facility keys. Each had the correctly assigned key ring with the correct number of keys affixed to the ring. The superintendent was interviewed and stated the facility does issue permanent keys to designated staff. Three interviewed staff were all able to identify examples of restricted keys at the facility. All staff were able to summarize the key control process. Each stated in the event keys were missing, master control is notified, and a facility search of the building and youth would be done.

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 maintenance mechanic was interviewed and stated the center has a total of six vehicles used to transport youth. A review of all vehicles found each to be secured when not in use. Each of the vehicles had the appropriate number of seatbelts. The vehicles were clean and contained an approved fire extinguisher. A vehicle log is kept by the maintenance mechanic which indicates each vehicle had completed weekly visual checks to include a check of the water coolant, lights, oil, emergency equipment, brakes, horn, interior/exterior, and cleanliness. In addition, weekly checks were completed for each vehicle to show an inspection of tires, batteries, windshield wipers, windows, mirrors, and overall damage. Inspection forms are documented on the mandatory inspection form and copies maintained by the maintenance mechanic. Each vehicle had evidence of an updated annual inspection completed by a certified mechanic. Prior to a youth transport, staff are required to obtain the vehicle keys from master

control and take with them a vehicle bag which consists of an approved first aid kit, a seat belt cutter, flashlight, and window punch. The bags are kept in master control. Vehicle logs were reviewed and contained documentation of acknowledgement the vehicle was used, the destination, number of youth and staff names, and time the transport began and ended.

A transport was observed during the annual compliance review. Staff were observed searching youth prior to transporting to court. There were four youth and two staff for the transport. Staff ensured each youth, including themselves, were fastened in with a seatbelt prior to leaving the facility. Documentation of completed Vehicle Inspection forms were obtained to show the staff completed the vehicle inspection as required. Staff are given a cell phone to take with them on the transport. Transportation logs were completed documenting the names of youth and staff along with the time of return. Informal interviews were completed with youth and staff to confirm both wear seatbelts when being transported.

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

The center has a written policy and procedures which addresses tool inventory and management. Inspections of the maintenance tool rooms, kitchen tool and knife storage, and mop and broom closets found each area to be secured and inaccessible to youth. Maintenance tools were marked with an identification code engraved in each tool which identified them as Department of Juvenile Justice (DJJ) and Okaloosa Regional Juvenile Detention Center property. Maintenance tool inventory sheets were reviewed to show the maintenance mechanic conducts monthly inventory of all tools. The superintendent reviews and signs the inventory forms as required. A sampling of ten percent of all maintenance tools stored was completed to ensure the tools were in place as designated. All tools were accounted for. The maintenance mechanic did not have a sign-in/out inventory log for the tools taken out of the area. The maintenance mechanic had sign in-out logs for tools leaving and returning to the maintenance office and was instructed to begin the process. An inspection of the kitchen area found all kitchen tools and knives were securely stored behind two locked doors. The food service director was interviewed and stated the knives are inventoried each monthly, and a perpetual inventory of all kitchen knives is completed daily.

Samples of the inventory forms were observed for the scope of the annual compliance review to determine consistency with the practice. The maintenance mechanic and food service director were interviewed and stated in the event a tool is missing, this gets reported immediately to management, and a complete search is done for the item. All staff are to participate in the search. In the event a tool is damaged, the maintenance mechanic reported they are notified by staff and the superintendent is notified. The maintenance mechanic and food service director reported not having any issue with missing tools or knives. The center currently reports having no vocational work projects where youth utilize any tools other than brooms or mops. The superintendent was interviewed and stated youth may only use cleaning items such as mops, brooms, and buckets under direct supervision.

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

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

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

The center's Continuity of Operations Plan (COOP) addresses their Safety Plan. All flammable, toxic, caustic, and poisonous items were observed stored in areas inaccessible to youth. Chemicals and cleaning agents were kept in separate locations, one which included the kitchen closet. Observations of these areas were made, and the items present were compared with the inventory and observed for a corresponding Safety Data Sheet (SDS) to be present with the stored item. Ten percent of items observed in each area were sampled for review of these requirements. Each item was listed on the chemical inventory form and included an SDS in the area, with the exception of two bottles of disinfectant cleaners found secured in the male youth mod storage closet. These items did not have a corresponding SDS. The center revised the SDS during the annual compliance review to include the SDS for these items. The center maintains three large binders in the staff conference room area in administration. These binders contain SDS for all items within the facility. All staff have access to these binders.

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

The center has a written policy and procedures concerning access and authorization for flammable, toxic, and poisonous items. The policy indicates only authorized personnel are permitted to have access to these items.

Observations during the annual compliance review found all chemicals were secured and inaccessible to youth. No youth were observed handling any chemicals. Three interviewed youth all reported they do not directly handle chemicals. They indicated staff sprays the item and they wipe it off when cleaning. All three interviewed staff stated youth are not permitted to clean with substances which may be flammable, toxic, or poisonous.

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

The center has a written policy and procedures outlining the disposal of flammable, toxic, caustic, and poisonous items. A review of Central Communications Center (CCC) information and interview with administration revealed the center has not had any instances of chemical spills, nor have they disposed of any flammable or toxic items within the last six months. The maintenance mechanic was interviewed and stated the center does not use any grease for cooking. The maintenance mechanic reported in the event a chemical is to be disposed of, it is done so accordance with the Safety Data Sheets (SDS) requirements to ensure it was not toxic to the environment. An interview with medical staff was conducted. Nursing staff present reported they have a contractual agreement with Steri-Cycle who comes to the facility to pick up and dispose of any biohazardous waste. The waste is kept in containers and the company comes to dispose of it as they are called by the center's medical staff. The medical department maintains a disposal log which showed documentation and consistency with this practice.

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

A review of the Facility Management System (FMS) found documentation of confinement reports for under twenty-four hours. Observations made during the annual compliance review did not find any obstructions on room windows. There are no cameras in the rooms. A sample of five confinement reports were reviewed for completion requirements. According to interviews

with center administration and the written policy and procedures, all youth are provided educational materials as applicable when in confinement. All five confinement reports reviewed had documentation the supervisor approved each placement. No youth are placed in confinement with other youth per administration and policy. Three of the five confinements reviewed had noted the room was searched prior to youth placement. Two were checked indicating it was not searched. The supervisor conducted an initial confinement review no later than two hours in all incidents reviewed. In each report, the review contained the reason for confinement and the full report completed done before the shift's end. Documentation for all but one found the supervisor conducted additional reviews every three hours and documented this in FMS. The one remaining incident was not applicable for the three-hour supervisor review. Supervisors continuously counsel the youth to consider removal from confinement. The superintendent or designee conducted confinement reviews within twenty-four hours for all incidents reviewed. Visual Observation Reports were kept in closed records for the confinement incidents selected for review. All but one was located for review. In the four reviewed, each was completed as required, indicating staff conducted visual checks of the youth every five minutes the first hour and every ten minutes after. The superintendent was interviewed and stated confinements are reviewed daily by the superintendent or designee. In addition, the superintendent states the regional detention management conducts monthly reviews of confinement usage.

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

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

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

The center has a Continuity of Operations Plan (COOP) which includes disaster preparedness planning. Annexes were attached to the plan. A review of drill documentation revealed the center conducted two disaster drills for the scope of the annual compliance review. The disaster drills were related to severe weather preparedness. The superintendent had a checklist of items included for the drill which indicated responsible parties in preparation for the inclement weather. The superintendent was interviewed and stated the COOP is set in place for environmental emergencies. The COOP-related drills are conducted twice annually. Fire drills

are completed monthly, and escape drills are completed quarterly. All three interviewed staff reported they have participated in the following drill types: weather, fire, escape, and medical or suicide drill.

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's escape prevention plan is incorporated within the Continuity of Operations Plan (COOP). The center has a written policy and procedures which addresses escape prevention planning as well as drills required. The center is required to conduct escape drills on a quarterly basis. A review of drill documentation found the center conducted quarterly escape drills as required. The drills were completed quarterly and on each shift. Logbook documentation reviewed found the center documents drills in the log as required. An interview with three staff revealed all participated in escape drills within the scope of this annual compliance review.

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

The center's fire prevention plan is incorporated within the Continuity of Operations Plan and Facility Operating Procedures. The center's fire procedures were approved by a local fire marshal. The maintenance mechanic completed a monthly fire safety and emergency light inspection. Documentation of this practice was observed to show consistency. The center had an annual fire inspection completed. During the annual compliance review, B & C Fire Safety were on-site to complete the annual sprinkler inspection and test the fire alarm system. Random sampling of seven fire extinguishers were observed and found all were inspected annually as required. The center conducts fire drills at a rate of monthly and on each of the three shifts. Drill documentation was found in a large drill binder. Drills were found completed as required, as well as documented within the master control log. Three interviewed staff all report they have participated in fire drills during the last six months. Three youth were interviewed. Two stated they have not been instructed as what to do in the event of a fire. One stated he has received the instruction.