STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

St. Lucie Regional Juvenile Detention Center

Department of Juvenile Justice

(State-Operated)
1301 Bell Avenue
Fort Pierce, Florida 34982

Review Date(s): July 30 - August 2, 2019

Promoting Continuous Improvement and Accountability
in Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Shakela Minns, Office of Program Accountability, Lead Reviewer (Standard 1)
Teves Bush, Office of Program Accountability, Regional Monitor (Standard 4)
Pamela Cummings, DJJ Probation, Circuit 19, Juvenile Probation Officer Supervisor (Standard 2)
Gary Mogan, Office of Program Accountability, Regional Monitor (Interviews)
Mamine Saintil, Palm Beach Regional Juvenile Detention Center, Superintendent (Standard 5)
Maryann Sanders, Office of Program Accountability, Deputy Regional Supervisor (Standard 3)
Yvrose Sylvain, Office of Program Accountability, Regional Monitor (Standard 3)

Program Name: St. Lucie Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: St. Lucie County / Circuit 19
Review Date(s): July 30 - August 2, 2019

MQI Program Code: 225
Contract Number: NA
Number of Beds: 50
Lead Reviewer Code: 159

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.01 * Initial Background Screening	3.01 Designated Mental Health Clinician Authority (DMHCA)
1.07 In-Service Training	
3.15 Crisis Assessments *	

Standard 1: Management Accountability
Detention Rating Profile

Indicator Ratings

Standard 1 - Management Accountability		
1.01	Initial Background Screening*	Limited
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	Limited
1.08	Entering Alerts(JJIS) and Sharing of Alert Information *	Satisfactory

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

Standard 2: Youth Management
Detention Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Detention Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Detention Rating Profile

Indicator Ratings

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

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Program Overview

St. Lucie Regional Juvenile Detention Center is a state-owned detention facility, operated by the Department, located in Fort Pierce, Florida. The center serves youth in St. Lucie, Martin, Indian River, and Okeechobee Counties in Circuit 19. The St. Lucie Juvenile Assessment Center (JAC) is connected to the center. Male and female youth who are detained pending adjudication, disposition, or placement in a residential commitment program are housed in the fifty-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 St. Lucie County School District. The center's management team includes the superintendent, one assistant superintendent, one administrative assistant, eight juvenile justice detention officer (JJDO) supervisors, and forty-three JJDOs. The center maintains a contract with Maxim Healthcare Services, Inc. to provide mental health and substance abuse services. Maxim Healthcare Services, Inc. subcontracts with Camelot Community Care, Inc., to provide comprehensive mental health, substance abuse services, and psychiatric services. Mental health services are provided by one licensed designated mental health clinician authority (DMHCA), and one non-licensed staff. Clinical services provided in the center include mental health and substance abuse evaluations, mental health treatment planning, individual, group, and family therapy, mental health crisis intervention services, on-site psychiatric services, and availability for substance abuse services for youth with co-occurring disorders. Medical services are provided by one designated health authority (DHA), one advanced practice registered nurse (APRN), one registered nurse (RN), one full-time licensed practical nurses (LPN), three part-time LPNs, and one medical clerk. The medical clinic maintains nursing coverage seven days a week. The RN is scheduled from 7:30 a.m. to 4:00 p.m. and the LPN is scheduled 11:45 a.m. to 8:15 p.m., Monday through Friday, and on weekends, 8:30 a.m. to 5:30 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 fifty-seven security cameras at the center and all were operational at the time of the annual compliance review. The center was observed to be clean and free from insect infestation. Common areas, living modules, bathrooms, classrooms, kitchen, and dining areas were observed to be clean, organized, and well maintained. A tour of the center was conducted by the annual compliance review team and observations found there was no graffiti. Common areas were observed to be hygienic, organized, and well preserved. At the time of the annual compliance review, the center had ten vacancies, which included six JJDO I, three JJDO II, and one JJDO supervisor.

Standard 1: Management Accountability

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

The center maintains a written policy and procedures addressing the completion of a background screening prior to hiring an employee or utilizing the services of a volunteer, mentor, or intern. Twelve staff, eight contracted staff, and four volunteers were eligible for an initial background screening during the annual compliance review period. A review of all applicable staff and contracted staff personnel records confirmed background screenings were completed, by the Department's Background Screening Unit (BSU)/Clearinghouse, prior to each individual's date of hire and/or contact with youth or access to confidential information. Four volunteer records were reviewed. Reviewed documentation found one of the four volunteer's background screening was not completed by the Department's BSU/Clearinghouse, prior to the staff's date of hire and/or contact with youth or access to confidential information. The volunteer's initial background screening was determined with an overall rating as closed/ineligible and the additional requested information was not received by the Department's Background Screening Unit (BSU) by November 8, 2018, as required. The Department's annual compliance review team brought this to the attention of the superintendent and the assistant superintendent and the incident was called into the Department's Central Communications Center (CCC). The administrative assistant notified the volunteer immediately and completed the required documentation to send to the Department's BSU. The administrative assistant informed the volunteer he/she would not be able to volunteer until an approval was received from the Department's BSU. None of the newly hired staff required an exemption. Each newly hired staff's Florida Department of Law Enforcement (FDLE), criminal history, Staff Verification System (SVS) module, and CCC Person Involvement Report was reviewed. Twelve staff were applicable for the pre-employment assessment tool administered to direct care staff. Ten staff records documented a passing score. Two records documented a failed score and had supporting documentation indicating the Department provided consent for the center to hire the staff. The Annual Affidavit of Compliance with Level Two Screening Standards was completed and submitted to the Department's BSU on January 15, 2019, meeting the annual requirement. The Annual Affidavit of Compliance with Level Two Screening Standards for school board teachers was completed and submitted to the Department's BSU on January 14, 2019, meeting the annual requirement.

1.02 Five-Year Rescreening	Satisfactory Compliance

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

The center maintains a written policy and procedures requiring the completion of a five-year background rescreening for all applicable staff. A rescreening is completed on all Department staff, contractors, and volunteers every five years based upon their original date of hire. Rescreening documentation must be submitted to the Department's Background Screening Unit (BSU)/Clearinghouse at least ten days prior to the staff's five-year anniversary date. A review of the staff roster found six staff, two contracted staff, and one volunteer applicable for having a five-year rescreening completed. Reviewed documentation confirmed five out of six staff's five-year rescreenings were completed and submitted to the BSU/Clearing house at least ten days prior to the anniversary hire date. One staff's five-year rescreening was submitted two business days prior to the staff's five-year anniversary. All applicable volunteers and contracted staff's five-year rescreening was completed and submitted to the BSU/Clearing house at least ten days prior to the anniversary hire date.

1.03 Staff Code of Conduct	Satisfactory Compliance

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

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

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

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

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

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

The center maintains a written policy and procedures regarding staff code of conduct. Staff are required to adhere to the code of conduct which prohibits any type of abuse, profanity, threats, harassment, intimidation, horseplay, or personal relationships with youth. Five staff personnel records were reviewed, and each contained the signed acknowledgement, receipt, and review of the Department's Code of Conduct. An additional three personnel records were reviewed for disciplinary action to meet the minimum sample size. Documentation found two staff received a written reprimand and one staff received a demotion for violations of the Department's Code of

Conduct. An additional three personnel records were reviewed for commendations to meet the minimum sample size. Documentation confirmed one staff received a Training Coordinator of the Year award, one staff received the Employee of the Month, and one staff received the Food Service Director of the Year award. A review of the internal incidents, Department Central Communications Center reports, and Protective Action Response reports determined there were no incidents which should have been documented as a violation of a code of conduct but were not. An interview was conducted with the center's superintendent and confirmed the center adheres to a strict code of conduct inclusive of youth confidentiality, prohibiting staff horseplay, verbal or physical abuse, and any personal relationships between staff and youth. Five staff were interviewed regarding the working conditions of the center. Four out of five staff reported the working conditions at the center in the past year have been good. One staff reported the working conditions to have been very good. One out of five staff reported they have never observed a co-worker use profanity when speaking to a youth. Three of the five staff reported they have witness a co-worker use profanity once when speaking to a youth. One staff reported hearing a co-worker use profanity often. Each staff reported never hearing a co-worker threaten, humiliating, or imitating a youth.

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 maintains a written policy and procedures to ensure when a reportable incident occurs. The center notifies the Department's Central Communications Center (CCC) within two hours of becoming aware of an incident. The center had a total of thirty-seven reportable incidents during the past six months. The center had thirty-five incidents reported to the CCC during the last annual compliance review, demonstrating a minor increase in reported incidents. Five incident reports were reviewed. Documentation validated each incident was reported to the CCC within the mandatory two-hour time frame and in accordance with the CCC reporting procedures. The center maintains a master control logbook for documenting reports to the CCC. A review of the logbook validated all reports were documented. A review of internal incidents and the three grievances filed for the past year determined there were no incidents which should have been reported to the CCC but were not. The superintendent reported all reportable incidents must be called into the Department's Central Communication Center (CCC) within two hours of the incident or two hours after gaining knowledge of the incident. Both detention and contracted providers are mandatory reporters and must report all form of abuse or harassment. All youth placed in secure detention have a right to report any form of abuse or harassment. All youth have access to telephones.

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

The center has a policy and procedures pertaining to the use of Protective Action Response (PAR). A review of five pre-service and five in-service staff training records found each staff

received PAR training approved by the Department's Office of Staff Development and Training. The center had a total of forty-two PAR incidents from January 1, 2019 through July 31, 2019. A review of five PAR incidents reports found each report was completed by the end of the shift, inclusive of statements from all staff involved. Two out of five contained a post-PAR interviews with the youth conducted within thirty minutes after the incident. Three post-PAR interviews were conducted between ten to fifteen minutes after the thirty minutes had passed. None of the youth involved in the reports sustained injuries which required medical attention, or a call to the Florida Abuse Hotline. None of the reviewed reports required a Mechanical Restraint Supervision Log be completed. Each reviewed PAR report contained a review of the PAR incident report by the superintendent or designee within seventy-two hours of the incident. None of the reviewed reports required a report to the Department's Central Communications Center (CCC), and there was no documentation to support any involved youth made a report to the Florida Abuse Hotline. An interview was conducted with the center's superintendent and confirmed PAR reports are entered in the Facility Management System (FMS). All PAR reports are reviewed by juvenile justice detention officer supervisors, the PAR instructor, and an administrator. The center's PAR rate during the annual compliance review period was 2.79, which is below the statewide Detention PAR rate of 11.75.

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 maintains a written policy and procedures regarding pre-service training. Pre-service training is divided into two phases. Phase one consists of instructor-led and web-based courses. Phase two consists of 120 hours of academy instructor-led training. A review of five staff training records for pre-service training indicated three staff completed all required trainings within 180-days of hire. Two staff were still within 180 days of completing training. Each record included Protective Action Response (PAR) training, cardiopulmonary resuscitation (CPR), first aid, mental health services, substance abuse services, suicide recognition and intervention, emergency safety and security, Prison Rape Elimination Act (PREA), human trafficking, and detention operations. All training was conducted by qualified trainers and documented in the Department's Learning Management System (SkillPro).

1.07 In-Service Training	**Limited 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 maintains a written policy and procedures which requires staff to complete twenty-four hours of in-service training each calendar year after completion of pre-service certification training. The policy requires supervisors to complete eight hours of supervisory training annually. A review of five in-service training records found four out of five staff were missing required Department trainings. All staff are required to complete Protective Action Response (PAR) update, cardiopulmonary resuscitation (CPR), first aid, suicide prevention, and professionalism and ethics. One staff was missing training in professionalism and ethics and

two staff were missing active shooter training. Three of the five staff records reviewed were for supervisory staff. Each of the three staff completed the required eight hours of supervisory training. All trainings were delivered by qualified trainers and documented in the Department's Learning System (SkillPro). An interview with the center's superintendent confirmed staff are required to attend suicide prevention, PAR, CPR, and first aid training annually. The center maintains an annual training calendar which is updated to reflect any changes. The calendar was last approved by the Department's Office of Staff and Development and Training on January 14, 2019.

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

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

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

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

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

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

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

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

The center maintains a written policy and procedures regarding entering alerts in the Department's Juvenile Justice Information System (JJIS) and the use of an internal alert system. Alerts were appropriately entered and downgraded or discontinued in JJIS by the appropriate staff member on the date each was identified and no longer applicable. Medical and mental health staff track and manages the youth alerts daily. An interview with the center's superintendent was conducted and confirmed medical alerts are entered at the time of admission and updated when necessary. A review of supporting documentation in comparison with staff interviews confirmed internal alerts were discussed during each shift briefing and printed daily by each shift supervisor. Alert copies are provided to each staff during shift briefings. Observations of a shift briefing validated the youth, applicable alerts, and youth in confinement were discussed. Alerts were also documented in the master control and module logbooks. Five staff were interviewed and two additional informal interviews with staff found staff are made aware of alerts through alert forms and shift debriefings. Two staff reported they are made aware by reviewing the logbook. Four staff reported they are made aware by the alert forms, one staff reported by reviewing JJIS, and another staff reported the alert board. Each

staff reported management informs all staff about issues regarding the center by utilizing the logbook, staff briefings, and meetings.

Standard 2: Assessment and Performance Plan

2.01 Admission	Satisfactory Compliance

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

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

The center maintains a written policy and procedures to ensure the proper screening, evaluation, and documentation is provided for each youth admitted into the center. The St. Lucie Juvenile Assessment Center (JAC) and the center are co-located in the same building. Five youth case management records were reviewed. Each reviewed record included an arrest affidavit. All five records contained a Detention Risk Assessment Instrument (DRAI) and Suicide Risk Screening Instrument (SRSI). All five records included documentation to confirm the youth were frisked and searched by a juvenile justice detention officer (JJDO) the same gender as the youth. All youth received medical, mental health, and substance abuse screenings upon admission. Four records reflected the youth were offered telephone calls and the appropriate documentation was entered on the Department's Secure Detention Admission Wizard. One record reflected the youth did not make a telephone call. There was no documentation to reflect whether the youth refused the call or not. All five records documented a meal was provided to each youth upon intake. The center did not have any new admissions to observe during the annual compliance review week. However, the admission process was discussed with an admission JJDO. The JJDO was knowledgeable and was able to explain the entire admission process in accordance to the center's policy.

2.02 Orientation	Satisfactory Compliance

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

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

The center maintains a written policy and procedures to advise youth of center rules and regulations, expectations for behavior and related consequences for failing to meet those expectations, and youth rights within twenty-four hours of a youth being admitted into the center. A review of five youth case management records found each contained an orientation acknowledgment form signed by the youth, confirming orientation took place within twenty-four hours of the youth’s admission into the center. Each reviewed record revealed all youth were advised both verbally and in writing of the orientation process. Each youth signed the orientation packet acknowledging they received the packet. Each packet included information regarding rules and regulations, youth rights, visitation policies, telephone call policies, grievance procedures, access to medical treatment, mental health and substance abuse services, access to the Florida Abuse Hotline, the Department's Central Communications Center (CCC), and behavior related consequences. The packet identified behavior related consequences such as level drops, privilege restriction, room confinement, new law violations, and assault/battery. During an informal interview, the assistant superintendent indicated all youth watch a Prison Rape Elimination Act (PREA) video upon admission, prior to receiving a tour of the center. Five youth were interviewed, and all youth reported receiving information about the center’s rules and regulations, daily schedule, education services, visitation, abuse reporting, and behavior management system (BMS) when admitted.

2.03 Classification	Satisfactory Compliance

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

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

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

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

The center has a written policy and procedures regarding classification and orientation to ensure each youth is protected from harm, violence, and/or victimization. The policy takes into consideration the youth's gender, age, weight, level of aggression, special medical or mental health needs, criminal behavior, history of violent behavior, gang affiliation, history of sexual offenses, and security and escape risk. Five youth records were reviewed, and all included the required classification elements. All youth were assessed using the Vulnerability to Victimization Sexually Aggressive Behavior (VSAB) form, Secure Detention Admission Wizard, juvenile offense history, active alerts, and the Suicide Risk Screening Instrument (SRSI). Each reviewed youth record documented appropriate classification alerts were entered into the Department's Juvenile Justice Information System (JJIS). The center also has a screening process for youth newly admitted into the center to determine if the youth is a gang member or gang affiliated. The center's practice is to enter all suspected gang affiliation alerts into the Department's Juvenile Justice Information System (JJIS) if there is a youth suspected to have gang affiliation. A review of five case management records found one was applicable for suspected gang affiliation. Two additional records were requested and reviewed. Each of the three applicable reviewed records showed an alert was entered into JJIS. An informal interview was conducted with the center's superintendent. The superintendent reported documented gang members are verified by law enforcement and an alert is entered into JJIS. All staff are briefed on all alerts and pertinent information during daily shift briefings and provided an updated list of active alerts for the youth currently in center.

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

The center has a screening process for youth newly admitted into the center to determine if the youth is a gang member or gang affiliated. The center's gang representative is responsible for notifying the circuit's juvenile probation officer (JPO) representative, St. Lucie County Sheriff's Office, and superintendent regarding any indication of gang activity by e-mail. The center's assistant superintendent and one shift supervisor serve as the gang representatives who reviews identified youth for suspected gang involvement. The identified staff also collaborates with the Circuit 19 gang liaison. Gang alerts are discussed weekly at the center's detention review meetings with the JPO supervisors, detention staff, school board representatives, and social service agencies. The circuit gang liaison was not available for an interview during the annual compliance review week. The circuit gang liaison also attends meetings with St. Lucie County Restoring the Village Youth Initiative. Restoring the Village Youth Initiative serves as the circuit's gang prevention initiative. Community outreach staff working with the families also attend meetings to discuss gang-related issues. The center's practice is to enter all suspected gang affiliation alerts into the Department's Juvenile Justice Information System (JJIS) if there is a youth suspected to have gang affiliation. All staff are made aware of the alerts during daily shift briefings. A review of five case management records found one was applicable for suspected gang affiliation. Two additional records were requested and reviewed. Each reviewed record contained an e-mail to a liaison from the St. Lucie County Sheriff's Office and the assigned JPO.

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

The center maintains a written policy and procedures to ensure a youth's personal property is maintained securely and returned to them in a timely manner upon their release. The youth's property is itemized and documented on the personal property receipt form in the Department's Juvenile Justice Information System (JJIS) module. Each of the five reviewed records contained a property receipt. Each receipt documented the youth and staff names and signatures, letter of acknowledgement of unclaimed property form, and a property receipt for the youth's personal property. The center places personal property such as clothing and foot wear in a brown bag in a secured locker. One of the five reviewed records documented valuable property. All valuable property is placed in a clear tamper-proof bag, logged into the logbook with date, time, name of the youth, Department identification number (DJJID), name of the juvenile justice detention officer (JJDO) securing the property, and the officer's initials. The center's practice is to place the clear bag into a drop safe, which is under video surveillance twenty-four hours a day. None of the youth refused to sign the property receipt forms. An admission process was not observed

during the annual compliance review week due to the center not having any new admissions. Reviewed documentation showed all five records only had clothing logged and one required valuable property storage. The assistant superintendent demonstrated the process of handling youth's valuable and personal property during the annual compliance review week. The center also documents all safe entries in a logbook. The safe logbook was reviewed, and entries were present for each youth with valuable property. Each of the five interviewed youth reported staff checked their personal property upon admission, and youth signed a form stating their personal property was correct. An informal interview was conducted with the superintendent regarding the admission process and the disposal of unclaimed items. The superintendent reported all personal items are placed in a tamper-proof property bag, which is signed by the staff and youth to ensure all items are present before the initial drop located in master control. A picture of the bag is placed in the youth's active record. The superintendent further stated the center has a process in place to ensure all youth items are returned. Letters are sent out to inform the youth and parents/guardians they have thirty days to claim the property or it will be disposed of. Five youth were interviewed regarding the admission process, and each reported staff checked their personal property upon admission, and youth signed a form stating their personal property was inventoried.

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

The center maintains a written policy and procedures to ensure a youth's personal property is maintained securely and returned to them in a timely manner upon their release. The center safeguards each youth's personal property until it can be returned to the youth and/or parent/guardian. Observations of the center's storage area during the annual compliance review week found non-valuable property, such as clothing and shoes placed in a brown bag and stapled shut and secured in a locked room under video surveillance. Each youth's personal property had a signed receipt form. Observations showed valuable property is placed in clear tamper-proof plastic bags, signed by youth and staff, dated, and logged by the master-control operator. The valuable property is then dropped in the initial drop safe located inside master control under video surveillance. A copy of the property receipt is placed in the youth's record. The center administrators then remove the property, placing it in a storage safe located in the file/property room, in a secured locker. The items remain there until the youth is released or property is released to parent/guardian. A review of the Department's Central Communications Center (CCC) reports for the past six months did not show any reported incidents regarding youth property. An interview with the superintendent validated the center's property storage practice.

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 maintains a written policy and procedures to ensure all releases from the center occur promptly and accurately. Five records were reviewed, and none were applicable for release procedures; therefore, three closed records were reviewed. All three records documented the on-duty supervisor reviewed all release paperwork prior to the youth's release. All three youth were released to a parents/guardian. A copy of the parent/guardian's driver's license and/or identification card was placed in the record, and the youth and parent/guardian were notified in writing of youth's next court date. The parent/guardian signed the property receipt report acknowledging receipt of the youth's property. The date of admission and the date of termination were documented in the youth's record and the Department's Juvenile Justice Information System (JJIS). An observation of a youth's release process was conducted during the annual compliance review week. Detention staff and the supervisor identified the correct youth, and detention and court orders were reviewed by the supervisor. The reason for release was the expiration of detention time, which was verified by the court order. The supervisor called the nurse to verify if the youth was being released with or without any medication. The parent/guardian driver's license and/or identification card was copied and placed inside the youth's record and all parties signed the required release forms. The parent/guardian and youth were given notice of the youth's court date in writing. The personal and valuable property were released to the youth's parent/guardian and the youth was released back to their parent/guardian in their original clothing. The Department's Release Wizard was completed, and the release information was updated in JJIS. The Department's Central Communications Center (CCC) reports were reviewed for the past six months and there were no negligent releases at the center since the last annual compliance review.

2.08 Release of Youth Personal Property	Satisfactory Compliance

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

The center maintains a written policy and procedures to ensure a youth's personal property is maintained securely and returned to them in a timely manner upon their release. The policy outlines each youth and their parent/guardian are required to sign the property receipt,

acknowledging receipt of youth's personal property. Five youth records were reviewed, and none were applicable for release of valuable property; therefore, an additional three closed records were reviewed. All three closed records showed the youth and parent/guardian signed the property receipt acknowledging receipt of each youth's personal property. An interview with the superintendent was conducted. The superintendent advised the center ensures the youth's property is returned safely with verification and the youth and parent/guardian signs a receipt form. All unclaimed property is disposed of after thirty days. The center donates all unclaimed property to Safe Space. This practice is explained to each youth through the signed property letter of acknowledgement and is given to each youth upon admission. Examples of property disposal forms, logs, and receipts were observed in the safe during the annual compliance review of disposing unclaimed property to Safe Space. An observation of a release process was observed during the annual compliance review which confirmed the center's practice.

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 maintains a written policy and procedures regarding release of youth taking prescription medications. Five records were reviewed, and none were applicable for release of prescription medications. Three closed youth case management records were requested and reviewed. All three reviewed records showed each youth was released to a parent/guardian with a copy of their driver's license and/or identification card. Each record contained a receipt of medication, signed by the parent/guardian or receiving Department staff, the type of medication, strength, dosage, quantity, and any pending medical appointments. An observation of a release during the annual compliance review confirmed the staff telephone the medical staff during the release to determine if a youth was prescribed medication.

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

The center maintains a written policy and procedures ensuring detention reviews are conducted weekly for youth securely detained to ensure proper management of youth and the sharing of information. During the annual compliance review, an observation of a detention review meeting was conducted. All parties were present from all required departments. Staff in attendance included mental health staff, medical staff, education staff, commitment manager, juvenile probation officer supervisor (JPOS), chief juvenile probation officer (CPO), and the superintendent. The center has designated one juvenile justice detention officer II (JJDO II) in the absence of the superintendent to conduct weekly detention review meetings. The JJDO II is responsible for maintaining all notes pertaining to detention review. The center reviews all securely detained youth, alerts, and circuit waiting lists. Waiting lists include all youth currently in adult jail. A review is also conducted of any medical and mental health updates during weekly detention review meetings. Reviewed documentation for the past six months of detention review meetings confirmed the center's practice. An interview with the center's superintendent reported the meeting is chaired by the center's detention review specialist. An interview with the superintendent also confirmed the weekly detention review takes place for secure detention youth at the center in the lobby's conference room.

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

The center maintains a written policy and procedures to address the daily activity schedule. Youth are provided the opportunity to participate in constructive activities benefiting the youth and the center. The center's superintendent develops a daily activity schedule, which is posted in each living area and outlines the days and times for each youth activity. Wake up time starts at 6:30 a.m. every day and bedtime begins at 8:00 p.m., depending on the youth's level. Observations during the annual compliance review week revealed schedules are posted throughout the center and in each living module. Posted schedules include recreation, education, visitation, hygiene, times for meals, gender-specific programming conducted through art classes offered through a local church group, life skills, and restorative justice programming. Visitation times are scheduled twice a week at the center. The center also hosts talent shows on some holidays such as St. Patrick's Day, Christmas, and other selected holidays for youth who display good behavior. A review of the center's logbook and observations confirmed the center adheres to the daily activity schedule with minimal interference. Five staff members were interviewed regarding the daily activity schedule, and each stated the daily schedule is followed. Four out of five staff confirmed the center provides restorative justice activities. Four out of five staff confirmed the center offers gender-specific programming as part of the daily schedule. Five youth were interviewed regarding the daily activity schedule, and each reported there is a daily activity schedule in the center. Each youth reported the staff follow the daily schedule daily.

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 maintains a written policy and procedures which outlines adherence to a daily schedule. The daily activity schedule, logbooks, and movements were reviewed during the week of the annual compliance review. Reviewed documentation indicated the center was adhering to the posted activity schedule. Reviewed sign-in sheets from groups led by mental health staff, volunteers, and staff showed the groups were held and logbooks clearly indicated when and where groups were held. Changes to the schedule require approval from administration. Any cancellation of visitation must be approved by the superintendent. Five youth were interviewed regarding the daily activity schedule and each reported there is a daily activity schedule in the center. Each youth reported the schedule is followed daily. Five staff were interviewed, and all reported the daily schedule is followed.

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

The center maintains a written policy and procedures ensuring educational access to youth in the center. The center offers an education component operating on a year-round basis. The center ensures daily education for qualified youth through St. Lucie County School District. An interview with the lead educator, in comparison with the center logbooks, confirmed the center's educational program is scheduled on-site Monday through Friday. The center provides 250 days of classroom interaction and twenty-five hours of instruction weekly. Ten days are used as teacher training planning days of instruction for the year. Youth enrolled in the educational program can earn course credit for completion of the education and training experience. A review of the program's daily schedule, school instructional schedule, youth and staff interviews, and logbook confirmed minimal interference of instructional programming. There were no on-site observations during the annual compliance review week to suggest the educational experience was unduly interrupted or suspended for any length of time. The education department is equipped with a computer lab with twelve computers used for entry testing and state testing. The teachers utilize scholastic magazine, course specific and real world current events, magazines, and a hip-hop based Language Arts program as supplemental teaching aids. The education department also offers an in-house library system, allowing youth to check in and check out reading materials. An interview with the center's superintendent during the annual compliance review indicated the detention staff work closely with the education department to ensure youth participate in educational and career-related programs. Five staff were interviewed regarding educational interference, and each staff reported there is minimal interference during educational instruction time. Five youth were interviewed regarding educational classes, and each reported the center offers educational classes. Each youth reported attending school Monday through Friday while in the center. All five youth were able to identify the educational classes they were in 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.	

The center has a career education competency development program provided by St. Lucie County School District for all youth in secure detention. The center offers Type One career education. Career education programming is based on the age, assessed educational abilities, the goals of the youth and the typical length of stay to which each youth is assigned. Additional career instruction includes communication and decision-making skills. The center utilizes ARISE and Career Choices for their career education curriculum.

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

The center maintains a written policy and procedures to provide a uniform behavior management system (BMS) offering a predictable set of rewards, privileges, and consequences for behavior. The center provides a system of rewards, privileges, and consequences to encourage youth to fulfill the center's expectations. The system includes rewards for positive behavior and consequences for inappropriate behavior. The behavioral norms and expectations for youth are posted in all living areas and clearly specify appropriate and inappropriate behaviors. Youth are informed of the BMS upon admission through an orientation. The BMS consists of three levels. Each youth enters as a level two, when admitted, and then their level moves up or down, depending on their behavior while in the center. Youth on level three have the privilege of participating in weekly incentives such as pizza parties and ice cream socials. The youth are also rewarded weekly by school officials for their good behavior and educational improvements. Inappropriate behavior is documented in the logbook and an incident report is completed for any youth receiving a reduction in their level. Youth levels are updated nightly on C-shift. Youth are able to view their status and are able to ask questions, if needed. Each living module has a board used for tracking all youth levels. The center uses a point sheet to document youth positive and negative behaviors. Point sheets are reviewed by administration staff weekly. Five youth were interviewed regarding the BMS. Four youth stated the BMS is good. One youth stated the BMS is fair. Four youth reported the consequences they received in the center were fair. One youth never receiving a consequence since admission into the center. Five staff were interviewed regarding their perceived effectiveness of the BMS. Each staff reported they feel the BMS is effective. All staff reported staff speak with youth to discuss the consequences being imposed. All staff reported youth are given an opportunity to explain their behavior. Each staff reported staff speak with youth about alternative acceptable behaviors. Five staff reported points can be taken away as a consequence. Each staff stated the loss of a level can be taken away as a consequence. Three staff members stated the juvenile justice detention officer supervisor (JJDOS) provides feedback to the staff regarding their implementation of the BMS as needed. One staff reported feedback is provided monthly and another staff reported quarterly.

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

The center has a written policy and procedures in place to address the unauthorized use of punishment in the behavior management system (BMS) which restricts certain types of penalties for youth who demonstrate negative behaviors. All allegations of corporal punishment on any youth by detention center staff shall be reported to the Florida Abuse Hotline and the Department's Central Communications Center (CCC). An interview with the superintendent confirmed the center utilizes a three-level reward system to encourage positive behavior. Five staff were interviewed. All staff indicated meals, snacks, sleep, or school cannot be taken away as a consequence for inappropriate behavior. Each interviewed staff reported they have never seen another co-worker deny meals, snacks, sleep, or school from a youth as a consequence for inappropriate behavior. Each interviewed staff denied ever seeing another staff member encourage another youth to beat up another youth. Five youth were interviewed regarding consequences in the center. Each youth reported levels are dropped. Four youth stated points are taken away. One youth stated meals. When the youth was asked to elaborate he refused. Four youth reported they are not allowed to punish other youth. One youth stated youth are allowed to punish other youth. When the youth was asked to elaborate he refused. Four youth stated they have been sent to their room for punishment. One youth stated never being sent to their room. Three out of the four youth who reported being sent to their room stated their door was shut and locked. One out of four youth reported their door was shut. A review of the last six months of incident reports was completed and there were no observed incidents indicating unauthorized use of punishment.

2.17 Grievances	Satisfactory Compliance

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

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

The center maintains a written policy and procedures to ensure each youth has the right to file a grievance and ensure all youth are treated fairly, respectfully, without discrimination, and their rights are protected. The grievance process is posted in each living unit and explained to each youth during the admission and orientation process. An interview with the superintendent was conducted. The superintendent explained the grievance process in detail. The first step in the grievance process is the informal phase which is completed by juvenile justice detention officer (JJDO) whereby the youth and staff attempt to resolve the youth's complaint. If the staff is unable to resolve the issue, the written grievance will be submitted to the JJDO supervisor , beginning the formal grievance process. Next, the appeal phase requires a response from the superintendent or designee. The grievance forms are located on each living area and accessible to all youth at the center. Grievance forms are kept electronically in the Facility Management System (FMS) for at least one year. The center had a total of three grievances since the last annual compliance review. All grievances were reviewed and handled in accordance with the Department's policy. The superintendent further explained, all youth have the right to file a grievance if they feel their rights have been violated. Five staff were interviewed and were able to explain the grievance process. Five youth were interviewed regarding the grievance process. Three youth stated they have never submitted a grievance. Two youth rated the process as good.

2.18 Trauma-Informed Care	Satisfactory Compliance

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

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

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

The center maintains a written policy and procedures which addresses trauma-informed care. Five staff training records confirmed the center is incorporating trauma-informed practices into current operations to deliver services and to provide care to youth in custody, acknowledging

the role which violence and victimization play in the lives of most youth entering the center. A tour of the center during the annual compliance review week confirmed the center has a soft room and numerous areas throughout the center painted in soft, soothing colors. The soft room is utilized to help de-escalate and calm the youth down. The center continues to improve the appearance of the facility making it more youth friendly by adding several murals to the walls, along with inspirational messages. Five reviewed youth records showed each youth admitted to the center received a trauma risk assessment upon intake. An interview with the center's superintendent indicated all staff are required to complete the trauma-informed care training. All youth are treated as if they have experienced trauma.

Standard 3: Mental Health and Substance Abuse Services

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

The center has a single licensed mental health professional who serves as the interim designated mental health clinician authority (DMHCA). The DMHCA is responsible for the coordination and implementation of mental health and substance abuse services. The DMHCA is a licensed clinical social worker (LCSW). Documentation showed the DMHCA has a clear and active license in the State of Florida with an expiration date of March 31, 2021. During an informal interview, the DMHCA reported being subcontracted through Maxim Healthcare Services and employed by Camelot Community Care. The DMHCA also reported being responsible for coordination and administrative oversight of mental health and substance abuse services. According to the center's contract, the DMHCA is required to be on-site forty hours a week and on-site Saturday and Sunday, as needed. A review of supporting documentation reflected the DMHCA was not on-site forty hours a week for the past six months; for the months of May, June, and July 2019. In May 2019, documentation showed the DMHCA was on-site from twenty-three to twenty-four hours a week. In June 2019, documentation showed the DMHCA was on-site from twenty to twenty-four hours a week. In July 2019, documentation showed the DMHCA was on-site from five to twenty-seven hours a week. The center had a new licensed mental health counselor (LMHC) as of July 29, 2019 who will serve as the center's DMHCA. During the week of the annual compliance review, the center provided a schedule which showed the center's interim DMHCA is scheduled to be on-site Monday and Thursday and the new DMHC was not included on the schedule. The schedule reflected the center would utilize a DMHCA from the Palm Beach Regional Juvenile Detention Center to provide coverage on Tuesday. The center was unable to provide supporting documentation to reflect the DMHCA will be on-site for forty hours a week as contractually required.

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

The center maintains a written policy and procedures regarding the licensed mental health clinical staff, which was approved by the superintendent and newly appointed designated mental health clinician authority (DMHCA) on July 29, 2019. The center's contract with Maxim Healthcare Services, Inc. to deliver mental health services for the youth, and a psychiatrist for approximately three hours each week. The DMHCA is employed by Camelot Community Care, Incorporated, and the psychiatrist is subcontracted with Heartwork of Orlando, Incorporated. The center's DMHCA is a licensed clinical social worker (LCSW). The license of the LCSW is active and clear in the State of Florida; issued on January 23, 2014 and expiring March 31, 2021. The psychiatrist's license is active and clear in the State of Florida with an expiration date of January 31, 2020.

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

The center has two bachelor's-level non-licensed mental health and substance abuse therapists. The non-licensed therapists are supervised by the designated mental health clinician authority (DMHCA). Reviewed documentation confirmed each non-licensed therapist received at least one hour weekly face-to-face supervision for the past six months. An interview with the DMHCA found each therapist receives face-to-face clinical supervision weekly in a group and/or individual setting. One of the center's non-licensed therapists resigned from the center on July 21, 2019. Reviewed documentation found one non-licensed therapist was on-site forty hours a week, and one was on-site, at least twenty hours a week. A review of the clinical supervision forms supported the supervision was documented on the required Department's Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Log. Documentation also showed three weeks of clinical supervision was constantly documented on the same form with the same signature and color ink. This was brought to the attention of the superintendent and interim DMHCA during the annual compliance review. Reviewed training documentation found the non-clinical staff who conducts the Assessment of Suicide Risk (ASR) received twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. Each non-licensed therapist is qualified to perform services, based on their education, training, and experience. All treatment services at the center are provided by the DMHCA or the non-licensed bachelor's-level mental health therapists working under the direct supervision of the DMHCA. Although the center utilizes a DMHCA from the Palm Beach Regional Juvenile Detention Center to provide coverage once or twice a week, there was not a site-specific Chapter 397 license in place at the center for a period of approximately one year. Due to there not being a Chapter 397 license in place, only a licensed mental health professional may provide substance abuse services at the center. Reviewed documentation supported all substance abuse services and/or treatment was provided by the licensed DMHCA.

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

The center maintains a written policy and procedures regarding the provision of mental health and substance abuse admission screenings. Five mental health records were reviewed. The detention center staff and mental health staff completed the appropriate section of the Suicide Risk Screening Instrument (SRSI), upon each youth's admission to the center. While the youth are screened for detention at the Juvenile Assessment Center (JAC), the Massachusetts Youth Screening Inventory-Second Version (MAYSI-2) is administered by trained juvenile probation officers. A review of five youth mental health and substance abuse youth records found the

detention staff reviewed the MAYSI-2 for each youth admitted into the center. All five youth records documented the detention staff title completing the appropriate section of the SRSI. Each youth's SRSI and MAYSI-2 were completed in the Department's Juvenile Justice Information System (JJIS). Based on the MAYSI-2 and SRSI results, if it is determined the youth is a possible suicide risk, the youth is placed on precautionary observation (PO) until assessed by a mental health staff. Four out of the five reviewed youth records documented the youth were placed on PO at admission, based on the screening results. The remaining youth record was not applicable. Documentation showed each youth was maintained on PO until the completion of the Assessment of Suicide Risk (ASR). The center's superintendent and assistant superintendent are notified immediately by e-mail of any youth who are a potential suicide risk. Each of the four applicable records contained a referral and documented the mental health staff was notified by the center staff completing the screening.

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

The center maintains a written policy and procedures to address the provision of mental health and substance abuse assessment/evaluations. Five youth mental health records were reviewed, of which two were applicable. One additional record was reviewed for a total sample of three. A review of the three applicable records showed the center completed a new comprehensive mental health and substance abuse evaluation in two of the three youth records within thirty-days of each youth admission. Documentation showed the third youth received a comprehensive mental health assessment prior to admission into the center; therefore, an updated evaluation was completed within thirty-days. Each reviewed comprehensive mental health and substance abuse evaluation contained all required elements, as outlined in Florida Administrative Code 63N-1. Each reviewed assessment was completed by the community provider.

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

The center maintains a written policy and procedures to ensure youth identified in need of mental health and/or substance abuse treatment receives treatment planning and services. Five youth mental health records were reviewed and two were applicable for receiving mental health and substance abuse treatment upon admission to the center. One additional record was reviewed for a total sample of three. The center's mini-treatment team consists of members including the youth, the assistant superintendent, education staff, medical staff, and the mental health staff. Upon completion of each youth's initial mental health and substance abuse

treatment plan, youth requiring treatment are assigned to a mini-treatment team, which is led by the center's mental health staff. The three applicable reviewed records documented each youth was assessed for mental health and substance abuse services. Reviewed records supported each youth had an Authority for Evaluation and Treatment (AET) and proper consent forms for substance abuse treatment and information release. A review of the treatment notes showed all were documented on the Department's Counseling/Therapy Progress Notes form and maintained within the youth's electronic medical record. A review of the center's group therapy sign-in sheets for the past six months showed groups were held at least bi-weekly and when there were not enough participants, individual sessions were provided. Sign-in sheets reflected the center was holding both mental health and substance abuse groups. Sign-in sheets supported all groups were limited to ten or fewer youth with mental health diagnoses for mental health treatment groups and fifteen or fewer youth with substance abuse diagnoses for substance abuse treatment groups. According to Department Rule 63N-1.0083, substance abuse treatment shall be provided by a licensed clinician or by a substance abuse clinical staff who is an employee in a center licensed under Chapter 397, F. S., or an employee of a service provider licensed under Chapter 397, F. S. A review of sign-in sheets for substance abuse groups found only the licensed designated mental health clinician authority (DMHCA) was facilitating substance abuse groups and treatment. At the time of the annual compliance review, the center was not conducting mental health and substance abuse groups due to several of the youth refusing services and not having enough participants. However, reviewed documentation confirmed the center was still providing individual sessions. Observations of the mini-treatment team was conducted during the week of the annual compliance review by the non-licensed mental health staff. An e-mail is sent within twenty-four hours of the mini-treatment team, to each member with the name of the youth scheduled for mini-treatment team, prior to the meeting. Each member of the team provided an update about the youth from their department, addressing youth behavior, medical alert changes, medication update, education, and recommendations for treatment prior to the youth joining the meeting. In addition, the attendance form included the signatures of all those in attendance, including the youth. A review of all applicable youth treatment plans found individual therapy was identified for each youth. Five interviewed youth evaluated the mental health and substance abuse services received in the center. Two youth rated the services as very good, one youth rated it as good, and two youth reported not receiving services at the center. An interview with the DMHCA confirmed psychiatric medication management, screenings, crisis interventions, assessments of suicide risk, group therapy, family therapy, individual therapy, and supportive counseling is provided at the center for any youth identified with mental health and/or substance abuse needs. The DMHCA reported youth admitted on medication and youth who are at the center for more than thirty days receive mental health treatment. It was also reported once a youth is receiving treatment, the DMHCA tracks services to ensure services are provided as prescribed. The center hold's mental health mini treatment teams on Thursday of each week.

3.07 Treatment and Discharge Planning [Contract Provider]	Satisfactory Compliance

The superintendent and DMHCA or mental health and substance abuse clinical staff are responsible for ensuring the development and review of an initial and/or individualized mental health/substance abuse treatment plan for each youth receiving mental health and/or substance abuse treatment in the center.

All youth who receive mental health and/or substance abuse treatment while at the center shall have a discharge summary completed documenting the focus and course of the youth's treatment and recommendations for mental health and/or substance abuse services upon youth's release from the center.

The center maintains a written policy and procedures ensuring mental health and substance abuse treatment planning focuses on providing mental health treatment and/or substance abuse treatment which will reduce or alleviate the youth's symptoms of mental disorder or substance abuse impairment and enable the youth to function adequately. Five youth mental health records were reviewed, and two were applicable for receiving an initial treatment plan. One additional record was reviewed for a total sample of three. Reviewed documentation supported each youth received an initial mental health and substance abuse treatment plan within seven days of admission. Each youth's mental health and substance abuse record documented the initial treatment plan was developed and included all required elements. All three youth were applicable for psychiatric services, including medication and frequency of monitoring by the psychiatrist.

All three youth had completed individualized mental health and substance abuse treatment plans developed within thirty-one days of the youth's admission and included all information obtained during the assessment process, input from the youth, and input from the parent/guardian. The individualized treatment plans documented a diagnostic summary, including the Diagnostic and Statistical Manual, Fifth Edition (DSM-V) diagnosis and the youth's treatment recommendations. Each completed plan was signed by all mini-treatment team members, including the non-licensed therapist and the licensed clinical social worker, within ten days of completion. One individualized treatment plan required the incorporation of psychiatric services and psychotropic medication monitoring. Two plans were not due during the week of the annual compliance review. A review of the youth's individualized treatment plan documented the review plan was conducted every thirty days, as required.

Three closed records were reviewed to verify the center's mental health and substance abuse discharge process. Reviewed documentation reflected the center completed each applicable youth's mental health and substance abuse discharge summary on the Department's Mental Health/Substance Abuse Treatment Discharge Summary form. Each discharge summary was signed by the youth, clinical staff, licensed mental health clinician, and treatment team members. Each reviewed record documented the mental health and substance abuse discharge summary was discussed with the youth, parents/guardians, and the and juvenile probation officer (JPO). Documentation also reflected the final discharge summary was sent with the youth to their commitment program. None of the youth discharge records revealed the youth was at risk of suicide when being discharged from the center. The center conducts mini-treatment team meetings weekly for applicable youth receiving services. Observations of three mini-treatment team showed each youth was provided the opportunity to contact their parent/guardian to participate by telephone. One youth's parent/guardian participated. Two parents were unable to be reached. The treatment team included the designated mental health clinician authority (DMHCA), non-licensed therapist, teacher, nursing staff, and the assistant detention center superintendent. The DMHCA welcomed the youth and explained the purpose and process of the mini-treatment team meeting. The therapist requested for each youth to state the goals they are currently working towards. The teacher discussed the youth's current grades. Each member of the team provided an update of the youth's progress towards their goals and addressed youth behavior.

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

The center maintains an independent contractor agreement with a licensed psychiatrist to oversee the psychiatric services and supervise the treatment of youth who are prescribed psychotropic medications. The psychiatrist is scheduled to be on-site every week for three hours. A review of five youth mental health and substance abuse records found four applicable youth were referred to the psychiatrist for an initial psychiatric evaluation, within fourteen days of the youth's admission to the center. All four youth were admitted with prescribed psychotropic medications. All four youth records had a current Authority for Evaluation and Treatment (AET) consent for continuation of the psychotropic medication. The AET provides the parent/guardian's authorization to continue administration of only those psychotropic medications for which the youth has a bona fide prescription at the time of the youth's entry into the physical custody of the Department, as long as there were no changes in the psychotropic medication dosage or route of administration. The psychiatrist continued all four applicable youth on their psychotropic medications. The center uses the Clinical Psychotropic Progress Note (CPPN) to document the initial psychiatric evaluation and each reviewed record contained an initial psychiatric evaluation. The initial psychiatric evaluations contained the reason for referral, medical and mental health history, mental status examination, treatment recommendations, and prescribed medications for each youth. The psychiatrist signed and dated each youth's initial psychiatric evaluation. Documentation supported the psychiatrist provided psychiatric services to all four-applicable youth at least once a week. The psychiatrist meets with the non-licensed mental health clinician once a week to discuss each youth receiving psychiatric services.

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

The center maintains a written policy and procedures ensuring a suicide prevention plan is in place to safely screen, refer, assess, monitor, and protect youth with elevated risk of suicide in the least restrictive means possible. The center maintains a suicide prevention plan and suicide prevention services. The plan was approved and signed by the designated mental health clinician authority (DMHCA) and the superintendent on July 29, 2019. The plan details all required suicide prevention procedures, included identification of youth at-risk of suicide, description of the referral process, communication, immediate staff response, notification requirements, levels of supervision, suicide precautions, staff training requirements, documentation, and review processes, as required by Rule 63N-1, Florida Administrative Code.

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

The center maintains a written policy and procedures ensuring a suicide prevention plan is in place to safely screen, refer, assess, monitor, and protect youth with elevated risks of suicide in the least restrictive means possible. Five mental health records were reviewed, and four youth were applicable for the completion of an Assessment of Suicide Risk (ASR). All four applicable youth ASRs were completed within twenty-four hours. All youth alerts were entered into the Department's Juvenile Justice Information System (JJIS) and were removed from JJIS appropriately. Each youth's ASR was completed by a bachelor's-level non-licensed therapist and was reviewed by a licensed clinical social worker (LCSW). Reviewed training records for both non-licensed mental health therapists supported each received the required suicide prevention training in order to complete the ASR. Both non-licensed therapists completed twenty hours of training and supervised experience including five ASRs. A review of each applicable ASRs documented consultation with the designated mental health clinician authority (DMHCA) and superintendent or designee's immediate notification of suicide risk. A review of the center's logbooks clearly documented the beginning and ending times the youth were placed on precautionary observation (PO). There was documentation to support administrative and/or supervisory staff provided instructions related to the suicide risk assessment findings and suicide precaution decisions during the shift briefings. The center documents the exact time the youth is placed on PO. Three of the four applicable youth were stepped down to standard supervision from the initial ASR screening. One youth was placed in secure observation due to the youth having suicidal thoughts and aggressive behaviors. The youth was placed in the confinement room and the health status checklist was completed. The center's mental health staff completed a Follow-Up ASR during the youth's stay in secure observation and suicide precaution observation logs were completed as required. The youth's ASR documented the juvenile probation officer (JPO) and the parent/guardian were notified. The Follow-Up ASR transitioned the youth to close supervision and subsequently was stepped down to standard supervision. Five youth were interviewed, and one youth reported having been placed on suicide watch while at the center and the youth stated staff supervised him all the time. Five staff were interviewed, and all reported when a youth expresses suicidal thoughts staff are responsible to notify mental health staff, search youth and room, document supervision, and constant sight and sound of the youth.

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.	

The center maintains a written policy and procedures regarding suicide precautionary observation (PO) logs. Five youth mental health records were reviewed, and four were applicable for suicide prevention services. Three youth were placed on PO due to an elevated risk in suicide upon admission to the center and one youth was placed on PO upon staff observation. Documentation showed all four-applicable youth remained on precautionary observation until an Assessment of Suicide Risk (ASR) was completed. The review of the suicide precaution observation logs found the staff were documenting the youth's behavior at thirty-minute intervals or less. A review of the four youth records who were placed on precautionary observation found the center utilizes the Department's Suicide Precautions – Observation Log. All four youth PO logs included the signature of the mental health clinical staff and the center supervisors. All four youth's suicide PO logs documented safe housing areas. Documentation of the PO logs showed none of the four youth displayed warning signs while they were placed on suicide precaution. Three interviewed youth reported they were never left alone for any time period and the staff maintained visual contact of all youth on elevated supervision levels.

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.	

The center's suicide prevention plan outlines all staff are required to complete at least six hours of suicide prevention training a year. A review of five staff training records for in-service training found four staff completed six hours of annual suicide prevention and implementation of suicide precautions training. The fifth staff did not complete the two hours suicide prevention training in the Department's Learning Management System (SkillPro). A review of the center's mock suicide drills confirmed the center is conducting drills monthly on each shift. A sample size of fifty-percent of all staff validated staff participated in at least one quarterly drill semi-annually. Documentation also showed staff with direct contact on a day-to-day basis with youth participated in at least one mock drill which included the use of cardiopulmonary resuscitation (CPR) annually. A review of the center logbooks for the past six months showed drills scenario and procedures are reviewed during shift briefings for staff members who are not present during a quarterly drill. Five staff were interviewed, and each reported the knife-for-life, wire cutters, and needle pliers are kept in master control, shift supervisor office, and three also reported in the medical clinic.

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

The center maintained a written mental health crisis intervention services plan. The plan was reviewed and signed by the designated mental health clinician authority (DMHCA) and the superintendent, on July 29, 2019. The center's plan included notification and alert system, providing a means of referral including self-referral, communications, supervision, documentation, and review.

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

The center maintains an emergency care plan, which was reviewed and signed by the designated mental health clinician authority (DMHCA) and the superintendent, on July 29, 2019. The center's plan included immediate staff response, notifications, communication, supervision of youth, authorization to transport for emergency mental health or substance abuse services, transportation for emergency mental health evaluation treatment under Florida Statutes Chapter 394 Baker Act, documentation, and training. The center utilizes New Horizons of the Treasure Coast for Baker Act and Marchman Act.

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

The center maintains a written policy and procedures established to address mental health crisis intervention services. Five youth mental health records were reviewed and none of the youth were applicable for a crisis assessment. The center provided the annual compliance review team with two crisis assessments completed in the last twelve months. Reviewed documentation confirmed one of the two youth crisis assessment was completed by a licensed clinician. One youth's crisis assessment included reasons for the assessment, mental status

examination and interview, determination of danger to self/others, initial clinical impression, supervision recommendations, treatment recommendations, and notification of the parent/guardian of necessary follow-up treatment. One of the two youth's precautionary observation logs were reviewed and signed by the non-licensed therapist and shift supervisors. Both of the youth's mental health alerts were entered into the Department's Juvenile Justice Information System (JJIS). The second youth's crisis was dated March 8, 2019. Documentation indicated the center staff observed youth messing with her hair and reporting to the staff she could not stop crying and was having a hard time breathing. Documentation showed the youth was transported for off-site care based on a panic attack, trouble breathing, shaking, and headache. On March 9, 2019, a medical assessment and diagnosis documented youth was resting comfortably without anxiety in the emergency room and oxygen saturation stable. The youth was medically cleared and returned to the center. The youth was not placed on constant supervision prior to the off-site care visit and was not placed on constant supervision upon returned to the center until a mental health clinical staff reviewed the off-site assessment and determines the mental health status of the youth. The crisis assessment was not completed until the youth was referred by the senior behavior analyst south region on March 11, 2019, during a Central Communications Center (CCC) investigation. Mental health staff received the referral on March 11, 2019 around 3:30 p.m. Mental health staff started the youth's evaluation around 5:20 p.m. and youth's crisis assessment was completed on March 12, 2019. Reviewed documentation confirmed the youth's crisis assessment was completed by a non-licensed therapist and reviewed by a licensed clinician, within twenty-four hours of completion. The non-licensed staff was trained to conduct crisis assessments. There was no documentation to support the youth's parent/guardian was notified of follow-up assessment/treatment. Five staff were interviewed, and all reported the knife-for-life, wire cutters, and needle nose pliers are maintained in master control, in the shift supervisor's office, and three also reported in the medical clinic.

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

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

Standard 4: Health Services

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

The center maintains a written policy and procedures to ensure clinical services are provided to youth who are in the center. The center has a contract agreement with Maxim Healthcare Services, Inc. A licensed physician serves as the designated health authority (DHA) and performs administrative duties. The DHA holds an unrestricted clear and active license which meets all requirements for independent and unsupervised practice in the State of Florida. The DHA has specialized training in pediatrics. The DHA is on-site on Wednesdays from 6:45 a.m. to 8:45 a.m. and is available twenty-four hours a day, seven days a week to communicate with staff regarding youth medical needs, acute medical concerns, emergency care, and to coordination of off-site care. The center also has an advanced practice registered nurse (APRN) who holds an unrestricted clear and active license to practice in the State of Florida and is on-site six hours a week. The APRN is on-site on Tuesdays and Thursdays from 2:00 p.m. to 5:00 p.m. In addition, the center has one registered nurse (RN) and two licensed practical nurses (LPN) who also holds an unrestricted license to practice in Florida. The APRN has a collaborative practice protocol in place filed with the Department of Health and approved by the DHA. A review of the medical sign in and out log for the past six months verified this practice. When the DHA is on vacation or scheduled absence Maxim Healthcare Services provides for back-up coverage. Reviewed documentation found Maxim Healthcare Services scheduled a license physician who holds an unrestricted clear and active license during the DHA's absence.

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 maintains a written policy and procedures for all health-related procedures and protocols utilized at the center. A review of the center's facility operating procedures (FOP) for all health-related procedures and treatment protocols utilized at the center found they were signed by the DHA on July 3, 2019. This process is followed each time a new policy, procedure, or protocol is developed and/or an existing one is changed. Reviewed documentation supported nursing staff reviewed, signed, and dated a cover page on which all FOPs, treatment protocols, and other procedures are listed. New policies or changes in policies made during the year are reviewed, signed, and dated by each nurse on each individual policy. A review of the protocols found the center's superintendent did not sign and date the protocols. This was brought to the center's attention and the superintendent signed and dated the protocols at during the week of the annual compliance review. All newly employed health care personnel receive a comprehensive clinical orientation to the Department's health care policies and procedures conducted by the registered nurse (RN). The center had two new RNs hired since the last annual compliance review. A review of both RNs personnel records indicated a clinical orientation was conducted.

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.	

The center maintains a written policy and procedures to ensures 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 five youth individual healthcare records (IHCR) verified each record contained a valid AET signed by the parent/guardian and witnessed by a Department representative. Each reviewed AET was a copy and contained a legible stamp with the word “COPY.” None of the youth healthcare records were applicable for a Limited Consent for Evaluation and Treatment. During an informal interview, the nursing staff reported an AET is obtained in court. If a signature cannot be obtained, the parent/guardian is asked to come to the center to complete the form. If the parent/guardian is unavailable to come to the center, the juvenile probation officer (JPO) is asked to provide a copy of the signed AET or obtain a signature form the parent/guardian.

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.	

The center maintains a written policy and procedures to inform the parent/guardian of significant changes of the youth’s condition and obtain consent when new medications and treatments are prescribed. Five reviewed youth individual health care records (IHCR) found four applicable. None of the reviewed records were applicable for over-the-counter (OTC) medications or vaccinations not covered by the Authorization of Evaluation and Treatment (AET). There were no Religious Exemption from Immunization forms submitted since the last annual compliance review. Three records were applicable for new medication. One of the three records were applicable for emergency off-site care. In each instance, the correct health services form was utilized, the parent/guardian was notified by telephone, and a certified letter was forwarded explaining the changes of each youth’s health status. Each applicable youth prescribed new medication parent/guardian were contacted by telephone and gave verbal consent for the youth to be administered the medication. A follow-up letter by way of certified mail was signed and returned by the parent/guardian. Two of the three applicable youth were admitted with psychotropic medication which continued; therefore, parental notification was not required. None of the reviewed IHCR required the parent/guardian to be notified of discontinued medication or youth being hospitalized.

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.	

The center maintains a written policy and procedures to ensure the Department’s Medical and Mental Health Admission Screening form is completed for each youth at the time of admission into center. Five youth individual healthcare records (IHCR) were reviewed. Each record contained a Medical and Mental Health Admission Screening form completed by a juvenile

justice detention officer (JJDO) on the date of admission and each screening was reviewed by a licensed practical nurse (LPN) within twenty-four hours of the screening being completed. None of the reviewed youth had a change in physical custody since their arrival to the center. One applicable youth who is sexually active missed her mensural cycle received a qualitative urine pregnancy screening test, with her approval, upon admission. An interview with the superintendent indicated the designated health authority (DHA), advanced practice registered nurse (APRN), registered nurse (RN), and staff complete the healthcare admission screening form.

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

The center maintains a written policy and procedures to ensure each youth in the center receives an orientation to healthcare services and health education. A review of five individual healthcare records (IHCR) supported a general healthcare orientation was completed on the Department's Health Education form within twenty-four-hours of each youth's admission. Each reviewed IHCR supported the youth received the required orientation topics to include access to medical care, sick call process, emergency situations, medication process, right to refuse care, what to do in case of sexual assault or attempt sexual assault, non-disciplinary role of healthcare staff, and a review of a list of healthcare contacts.

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

The center maintains a written policy and procedures to ensure the designated health authority (DHA) is notified when youth admitted require emergency care or routine notification. The center's practice is for the nursing staff to notify the DHA within twenty-four hours of the youth being admitted either through a telephone call or e-mail. A review of five individual healthcare records (IHCR) indicated none were applicable for emergency care upon admission. Three additional records were requested and reviewed. All three applicable youth IHCRs supported the DHA was notified within twelve hours of admission of any youth with a chronic medical condition. Notification was documented on the nursing admission chronological notes and an e-mail was filed in the IHCR for each youth. Each applicable youth was referred to the advanced practice registered nurse (APRN) or the DHA.

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

The center maintains a written policy and procedures regarding the Health-Related History (HRH) form, which indicates the HRH form shall be completed no later than seven days following the date of admission. A review of five individual healthcare records (IHCR) validated three contained a new HRH form and two contained an updated HRH form. Each form was completed on the most recent HRH form by a licensed nurse within seven days of the youth's admission and reviewed by the advanced practice registered nurse (APRN). Each reviewed HRH was completed before the Comprehensive Physical Assessment (CPA).

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

The center maintains a written policy and procedures to ensure each youth in the center has a completed Comprehensive Physical Assessment (CPA) upon admission into the center. A review of five youth individual healthcare records (IHCR) verified each contained a valid CPA completed within seven days of admission, were reviewed, and initialed by the advanced practice registered nurse (APRN). The medical grade was documented on each CPA and an alert was generated in the center's alert system for youth assigned a medical grade between two and five. Each CPA was completed in full and included all elements. None of the five reviewed records documented the youth refused any part of the exam and the Department's Problem List was updated as required. Each of the five records documented the Tuberculosis Skin Test (TST) was completed within seventy-two hours of admission and documented in the IHCR. None of the reviewed youth required further evaluation prior to entering general population. The center's internal alert system coincides with the Department's Juvenile Justice Information System (JJIS) and each applicable alert was updated, as required.

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

The center maintains a written policy and procedures to ensure each youth in the center is evaluated and treated for sexually transmitted infections (STI). The center provides human immunodeficiency virus (HIV) counseling by a certified counselor for youth who consent to HIV testing. The center has one medical clerk who is a certified counselor contracted with Maxim Healthcare Services, Inc. Five individual healthcare records (IHCR) were reviewed and documented the youth admitted to being sexually active. Three youth were screened for STIs and received further evaluation. Two youth refused testing in writing. One of the three youth received a gynecological evaluation off-site by their personal gynecologist. None of the reviewed youth were out of the Department's custody for more than thirty-days. Each applicable youth required screening results to be documented on the youth's Infectious and Communicable Disease form located in the IHCR. Each of the five reviewed youth was offered counseling, testing, and treatment for HIV. Three youth consented to HIV testing and two youth refused in writing to have HIV testing. Each of the three applicable IHCRs verified written consent was obtained by the center and documented the pre-test and post-test counseling were conducted by a certified HIV counselor. A review of the medical clerk's credentials verified they were trained to provide the service. A review of the three applicable records validated the HIV results were placed in a sealed envelope stamped "Confidential" and filed in the youth's IHCR. Five youth were interviewed, and each stated they were offered HIV testing at the center.

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

The center maintains a written policy and procedures regarding sick call requests. The center conducts sick call seven days a week to respond to a youth's medical illness or injury of a non-emergency nature by a healthcare professional. The shift supervisors are trained in the sick call procedures and will review the sick call request within four hours in the absence of the healthcare professionals. The center's sick call hours are Monday through Friday from 9:00 a.m. to 11:00 a.m. and 4:00 p.m. to 5:00 p.m. Saturday and Sunday from 9:00 a.m. to 11:00 a.m. Youth who requires a sick call will inform staff of their complaint and staff will generate a sick call request in the Department's Juvenile Justice Information System (JJIS). A review of three applicable youth individual healthcare records found sick call forms documented the nature of the complaint, assessment, and plan to include subjective, objective, assessment, and plan format (SOAP). Each of the three applicable sick call requests was conducted by the licensed nurse practitioner (LPN) and were reviewed by the designated health authority (DHA) within twenty-four-hours of the sick call request. Each of the reviewed sick calls were documented on the center's Sick Call Referral Log. None of the reviewed youth presented a similar sick call complaint three or more times within a two-week period. One applicable youth medical condition was unable to be determined and the DHA was notified. None of the youth complained of any severe pain which staff were unfamiliar. Sick call was observed during the annual compliance review period. Prior to the observation, consent was obtained from the youth. The youth was escorted by direct care staff to the clinic. The nurse identified herself and inquired why the youth was there. The youth signed the sick call request log prior to being examined. The youth was examined in a private area where direct care staff was able to maintain supervision. Five staff were interviewed, and each stated the doctor and nurse conduct sick call requests. Five youth were interviewed on how quickly they can be seen by the nurse. Two stated immediately and three indicated have never requested a sick call. Four youth stated the medical services at the center is very good and one stated the medical service is good.

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 maintains a written policy and procedures for the provisions of episodic care and first aid. The center utilizes an episodic care log to document episodic care and first aid treatment. The log documents the date and time of the treatment, nature of the complaint, person rendering aid, treatment, and if an off-sit care is needed. Five youth individual healthcare records (IHCR) were reviewed. Four of five applicable youth IHCRs identified the youth in need of episodic care or first aid. Each reviewed record contained a progress note identifying first aid or emergency care, the date and time of care, nature of the complaint, findings regarding care, and treatment rendered. Two of the four applicable youth had an off-site care referral and follow-up plans for future care. None of the applicable youth were required to be placed on the center's alert list or required parental notification. Each youth's progress note identified the staff rendering aid, signature of the staff, the center's name, and was entered on the episodic care log. None of the reviewed youth received episodic care from a non-healthcare professional; therefore, a follow-up evaluation was not required by the licensed healthcare professional.

The center has a total of fifteen first aid kits strategically located in areas frequented by youth. Observations of four first aid kits verified each kit was stocked with approved supplies, none of the contents were expired, monitored monthly by the nursing staff, and were replenished as needed. The center has two automated external defibrillators (AED) located in the clinic and master control with automated instructions. The nurse checks the AED weekly to ensure the battery and pads are operable. A review of the AED check log for the past six months verified this practice. During the annual compliance review, observations were conducted while the nurse completed a self-test and checked the expiration dates of the battery and pads for both AEDs. The battery and pads in both AEDs expire August 2026 and March 2020 respectively. The center conducts emergency drills at least quarterly on each shift and emergency drills including cardiopulmonary resuscitation (CPR)/AED are conducted once a year on each shift. Emergency and cellular telephone numbers are located in master control and accessible to all staff. A review of emergency drills for the past six months verified the center conducted drills, as required. Five staff training records verified staff received CPR and AED training. A review of the licensed healthcare records verified each healthcare staff maintains a current certification in CPR/AED. Five staff were interviewed, and each stated they are able to call 9-1-1, if 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 maintains a written policy and procedures to provide timely referrals for off-site healthcare. None of the five reviewed records were applicable for off-site care; therefore, an additional three records were reviewed. The three applicable youth individual healthcare records (IHCR) indicated a summary of off-site care form was completed and discharge documentation was filed in the IHCR. One youth was taken off-site for emergency care and two youth were take off-site for routine follow-up care. The designated health authority (DHA) was notified for each emergency event. Each youth record contained a Summary of Off-Site Care form, discharge documentation, and instructions. Reviewed documentation confirmed the designated health authority reviewed and signed all off-site care findings, instructions, and information. All off-site emergency care was documented on the Episodic Care Log. None of the applicable youth required follow-up care.

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

The center maintains a written policy and procedures to ensure youth with chronic conditions receive regular scheduled evaluations and follow-up care. A review of five youth healthcare records found three youth were applicable for the existence of chronic conditions and each were taking medication. Each youth was classified with a medical grade between two and five. None of the youth were diagnosed with a communicable disease, considered obese, or taking medication for tuberculosis. In each of the three records, periodic evaluations were conducted prior to renewing of prescription medication. One applicable youth was pregnant and was undergoing treatment for a physical health condition. The youth was evaluated, as required, by their primary doctor. Two of the three applicable youth received on-site care which is documented in the individual healthcare records (IHCR) chronological progress notes with

clearly written treatment orders. One youth had an off-site evaluation which was documented on the Summary of Off-Site Care Form, filed in the youth's IHCR, and updated on the Department's Problem List. There were no indications of missed or lapsed periodic evaluations.

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

The center maintains a written policy and procedures for medication management. Verification of medication is conducted by the center's nurse whenever a youth is admitted with medication. Youth who are taking medication while in the care of the center are administered medications by the healthcare professionals. Supervisors are trained in medication administration and administer medication in the absence of the healthcare professionals. A review of three supervisor training records verified they were trained in medication management. A review of five youth healthcare records identified three youth were taking prescribed medication upon admission and were applicable for medication management. Each record contained documentation their medication was verified by a licensed pharmacist or the youth's primary physician. All medication was stored in a container intact with the original label and approved medication. In each instance, the physician or psychiatrist was contacted to obtain an order to resume the medication and consent was documented in the youth's individual healthcare records (IHCR). There were no youth in restricted housing requiring over-the-counter medication not listed in the Authorization for Evaluation and Treatment (AET). There were no undocumented explanations for lapses or errors in administered medication in any of the three records. An interview with the center's nurse verified there were no standing orders of psychotropic medication, no emergency treatment orders for psychotropic medication, and no pro re nata (PRN) orders for psychotropic medication.

A review of three youth IHCRs verified the medication administration was documented on the Department's Medication Administration Record (MAR) which documented the youth's name, Department identification (DJJID) number, date of birth, allergies, precautions, medical grade, medical alerts, youth current picture, start and stop dates, and monitored side effects. Further review of the MARs indicated the youth received the medication as ordered, and staff and youth initialed the MAR after the administration of the medication. None of the three youth refused medication. During an informal interview, the nurse stated if a youth refuses medication, an "R" is documented on the MAR where the youth would have initialed if the medication was administered and a refusal form is signed by the youth. A review of three additional youth records confirmed this practice. None of the youth required parenteral medication or were prescribed psychotropic medication while in the center. However, two youth were on psychotropic medication prior to admission. In each instance, the designated health authority (DHA), psychiatrist, and the designated mental health clinician authority (DMHCA) were notified upon admission, and the medication was continued until a diagnostic psychiatric interview was conducted. There was one applicable youth who remained in the center over thirty days and received a review of medication monitoring by the psychiatrist.

An observation of the medication management indicated the six rights of medication administration was verified for each youth, the nurse verified any allergies to the medication, the nurse observed the youth swallowing the medication, and the nurse and youth initialed the MAR. None of the medication was pre-poured from the original packaging or placed in another container. Observations of medication storage indicated all medications were stored separately

by type, stored in a locked area designated for storage, and inaccessible to youth. The center maintains a list of staff who are required to have access to the clinic and medications. Medication requiring refrigeration was stored in a secured refrigerator used for medication only. Medication which cannot be returned to the pharmacist for a credit or medication requiring disposal is documented on the Medication Disposal form and disposed of using RX Destroyer. The center maintains a contact with a provider who disposes of all biohazard material once a month. Five staff were interviewed and stated they do not administer medication to youth and only supervisors, nursing staff, and the doctor administer medications. Five youth were interviewed on who gives youth medication. Four youth stated the nurse and one youth does not take medication.

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

The center maintains a written policy and procedures to ensure medical equipment and medications are secured and inventoried. The center maintains a perpetual daily inventory of medications to include prescribed and over-the-counter medications. Documentation of each individual dosage of medication administered to youth is maintained on the Medication Administration Record (MAR) to demonstrate the distribution of medications. Medical equipment, to include sharps, is secured and inventoried using a perpetual inventory count subtracting from the count as a sharp is used. Observations of the clinic indicated it is secured with limited access to the healthcare professional, supervisors, superintendent, and assistant superintendent. The healthcare professionals maintain a locked medication cart which contains prescribed and over-the-counter (OTC) medications, as well as sharps. Controlled medications are maintained within the locked medical cart within a separate locked storage box. A random review of three prescribed medications, three controlled medications, and three OTC medications verified. All counts during the annual compliance review period were accurate. A review of the daily inventory of prescribed and OTC medications matched the random count. The center has an inventory of all sharps to include items such as sutures, butterfly, scissors, needles, and syringes. A review of the perpetual inventory for the past six months verified the inventory count was accurate.

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

The center maintains a written policy and procedures to ensure proper procedures are followed to prevent the spread of infectious diseases or illnesses and provide staff with the knowledge of appropriate prevention, containment, treatment, and reporting requirements of infectious diseases. The center also maintains an Exposure Control Plan/Infection Control Plan approved by the designated health authority (DHA) on July 4, 2019. A review of five youth individual healthcare records (IHCR) indicated each youth received infection control training within twenty-

four hours of admission to include hand-washing techniques, universal/standard precautions, prevention/transmission of communicable diseases, vaccinations, and the Centers for Disease Control and Prevention (CDC) guidelines for infection control. Reviewed documentation indicated the Exposure Control Plan/Infection Control Plan was written in accordance with Occupational Safety and Health Administration (OSHA) guidelines to include risk assessment and methods of compliance. The plan also included common childhood infectious diseases, self-limiting, episodic contagious illnesses, viral or bacterial infectious diseases, tuberculosis, Hepatitis A, B and C, human immunodeficiency virus (HIV), bloodborne pathogens, other outbreaks and epidemics, and outbreaks of pediculosis. In addition, the plan included methicillin resistant staphylococcus aureus (MRSA) and other antibiotic-resistant micro-organisms, food-borne illnesses, bioterrorism agents, chemical exposures in the workplace, and protocols for needlestick post-exposure intervention and treatment. The center ensures Hepatitis B immunization is made available for staff and all staff have access to protective equipment. A review of five staff training records indicated each staff received pre-service and in-service training on the center's Exposure Control Plan/Infection Control Plan. There were no reportable incidents for which the local county health department, CDC, and the Department's Central Communications Center (CCC) should have been notified since the last annual compliance review.

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 maintains a written policy and procedures for the care of pregnant youth to include procedures for medical issues, nutrition, education, and medication. During the week of the annual compliance review, the center had one pregnant youth in secure detention. A review of the youth's individual healthcare record (IHCR) indicated the youth was receiving prenatal care as recommended by her primary doctor, including off-site medical prenatal, obstetrical, or gynecological appointments. Reviewed documentation supported the designated health authority (DHA) and/or advanced practice registered nurse (APRN) conducted a focused medical evaluation at least once every thirty days. A review of the healthcare chronological notes indicated daily monitoring of danger signs of pregnancy complications. A review of the healthcare education record indicated the youth received pre-natal education to include alcohol and drug use, smoking, nutrition, sexually transmitted infections, contraception, prenatal care, birthing process, postpartum care, basic baby care, child/infant development, and parenting skills. While at the center, nursing staff monitored the youth for weight and nutritional status. The youth also receives nutritious meals in quantities appropriate for a pregnant youth. A pregnancy alert was entered into the Department's Juvenile Justice Information System (JJIS). A review of five staff training records verified each staff received Girls Health training specific to working with pregnant youth. One applicable pregnant youth was interviewed and stated she received 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.

The center maintains a written policy and procedures for active supervision of youth in the center. Movements in the areas of education, medical, dining room, mental health, hallways, and living modules were observed during the week of the annual compliance review. There was at least one staff with each group. Observations verified staff maintained sight and sound supervision of the youth at all times and positioned themselves to ensure the safety of youth and staff. Staff communicate by way of two-way radio with master control and requested permission from master control prior to any youth movement. Staff were observed to have positive interaction with youth throughout the week of the annual compliance review. The center uses a bound logbook in each living module and one in master control. A review of the master control logbooks for the past six months prior to the annual compliance review documented all youth headcounts were completed consistently at the beginning and end of each shift, and prior to each youth movement, and any major incident occurring in the center. Observations made during the week of the annual compliance review found the center maintains an erasable white board to track daily census in master control and on each living module. The census is updated as needed. The center follows a daily activity schedule which is used to govern all free time of the youth in the center. Five staff were interviewed regarding whether or not they thought there were enough staff to provide for the safety and security of the staff and youth at the center. Five staff were interviewed, and five confirmed they believe there is enough staff at the center to provide for the safety and security of the youth and staff. All interviewed staff reported youth counts are completed at the beginning of each shift, the end of each shift, before/after school, and before/after meals. All interviewed staff were able to explain the steps taken to reconcile incorrect counts.

5.02 Ten-Minute Checks (Critical)	Satisfactory Compliance

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

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

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

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

The center maintains a written policy and procedures to ensure ten-minute checks are conducted when youth are in their rooms for sleeping or other reasons. The center has a total of fifty-seven operable cameras with a recording capacity of nineteen days instead of a minimum recording capacity of thirty-days. This discrepancy was brought to the superintendent and administration staff attention immediately. The superintendent provided an active work order to validate the issue was being handled. When conducting room checks, staff must pause at each room door and look into the room to ensure there are no issues with the youth. The center utilizes an electronic system to document room checks. Staff utilize the electronic wand by tapping the wand on the check point sensor located on the outside of each youth's room door. Each day, data from the wand is downloaded to ensure no data is lost. The superintendent was interviewed and confirmed this practice. Observations of ten-minute room checks on five different modules, from three different shifts, and five different days and times along with corresponding ten-minute log indicated checks were being conducted every ten-minutes, or less, and in real time. Staff were observed pausing at each room to observe the youth. However, on one occasion a staff was conducting ten-minute checks and not consistently looking into the rooms throughout the nightly ten-minute checks. This information was brought to the superintendent's attention during the week of the annual compliance review. Five staff were interviewed, and all staff indicated room checks are conducted every ten minutes.

5.03 Census, Counts, and Tracking	Satisfactory Compliance

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

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

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

The center maintains a written policy and procedures to ensure headcounts are conducted as required. Staff must know the exact number and location of all youth under their supervision at all times. Head counts are conducted throughout the day and called into master control and documented in the center's master control and living module logbooks. No youth movement is authorized until master control confirms the count. A review of the master control logbooks and living module log books for the past six months verified headcounts are documented at the beginning and end of each shift, for any mock or emergency drills, following any emergency situation, whenever a population change occurs, and randomly on each shift. Five staff were interviewed regarding when the center conducts youth counts. Each staff indicated emergency counts are conducted when a youth is believed to be missing, when visibility is hindered, such as an electrical outage, and after a major disturbance.

5.04 Logbook Maintenance	Satisfactory Compliance

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

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

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

The center maintains a written policy and procedures to ensure the maintenance of all the logbooks. The center has separate logbooks for master control and each living module, visitors and staff. A review of each logbook found they were bound with numbered pages. A review of logbooks for the past six months for each living module and master control verified all entries were legible and written in ink. All entries included the date and time of the event, name of the

staff and youth involved, a brief description of the event, initials of the staff making the entry, and the date and time of the entry. However, there were some areas with minor write overs and correction notes documented by the superintendent. Observations showed staff were not consistent with correcting errors. Some entries were scratched out, written over, and some were struck through without being initialed. Logbooks documented medical, special needs, and/or mental health alerts impacting the safety and security of the center and were all highlighted. Master control logbooks, also included all emergency situations, incidents, fire drills, medical and mental health drills, Continuity of Operations Plan (COOP) drills and escape drills, population counts at the beginning and ending of each shift, group movements, admissions and releases, presence of law enforcement, and name of youth placed in confinement, including the time confinement began and the time confinement ended, name of youth placed on precautionary/secure observation, including the time precautionary/secure observation began and the time precautionary/secure observation was discontinued.

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

The center maintains a written policy and procedures regarding logbook reviews. The superintendent or designee reviews the logbooks on a weekly basis. The supervisor, master control operator, and juvenile justice detention officer supervisor (JJDOS) review the logbooks and documents any discrepancies and/or issues. The master control and living unit logbooks for the past six months were reviewed and verified JJDOSs from each shift documented a review of the master control logbook prior to accepting the shift. A review of the living module logbooks verified the JJDO coming on-duty documents a review of the logbook. An interview with the superintendent reported shift supervisors are required to review the logbooks for each shift. A review of the center's logbooks verified the practice.

5.06 Key Control	Satisfactory Compliance

Each center is responsible for maintaining inventory and control of all facility keys.

All keys shall be placed on a tamper-resistant key ring designed to inhibit the removal of keys.

Emergency key rings shall be maintained separately from other facility keys, in master control, in a secure location designated by the Superintendent. These keys shall be notched or otherwise identifiable by touch.

The key(s) on these rings shall provide egress through facility exterior doors providing access to evacuation areas.

A key inventory shall be maintained by the Superintendent or designee at all times.
(For the entire indicator statement, please reference the Monitoring and Quality Improvement FY 2019-2020 Detention indicators.)

The center maintains a written policy and procedure to ensure and maintain an inventory of all the center keys. The center keys are maintained on a tamper-resistant ring with a brass tag identifying the ring number and the number of keys on the ring. The center keys are locked and secured in the juvenile justice detention officer supervisor (JJDOS) office, the key box is only accessible by the shift supervisor, captains, and superintendent. All restricted keys are secured in the JJDOSs key box. Emergency keys providing egress through exterior doors are stored in master control and the supervisor's office. A key inventory is maintained in the supervisor's office and superintendent's office for each key. When staff enter the center, personal keys are placed in a locked key box located in the supervisor's office prior to entering the secure area of the center. All staff sign the key control log and tells the shift supervisor which key peg is needed. The assigned key peg is issued which identifies the on-duty staff members' keys. Once the shift is over, the staff returns their work keys to the on-duty supervisor and the staff member's personal keys are returned. The staff member signs the key control log by providing the time and date of their departure next to their name. A review of the key log indicated keys were distributed, as required, by the shift supervisor. Observations conducted during the annual compliance review confirmed this practice. A review of the master key control inventory during the annual compliance review confirmed the inventory report matched the actual keys in use. Observations were made of staff carrying their assigned keys at all times. Youth did not have access to the keys. All center keys were accounted for during the annual compliance review. There were no reported incidents during the review period of lost keys. A review of five staff training records confirmed each staff received key control training. Five interviewed staff reported staff not having personal keys, and youth were not permitted to handle center keys. Each staff was in possession of their assigned center keys. Five staff were interviewed on the procedures for missing, damaged, and lost keys. All staff were able to explain the procedures during the annual compliance review. During an interview, the superintendent reported a key log binder is maintained in the superintendent's office and all staff assigned keys must sign acknowledging the key peg was issued. Five staff were interviewed regarding restricted keys. All staff reported medical record keys, youth property keys, mental health record keys, case management record keys, and kitchen keys were restricted. Five staff were interviewed regarding the center's daily process for tracking keys. Five staff reported center keys are assigned to staff. Three staff reported youth do not have access to keys. The center reported there have been no incidents of lost keys or staff leaving with center keys at the end of their shift in the last six months.

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

The center maintains a written policy and procedure for transportation, operation and maintenance of each vehicle used to transport youth. The center has one maintenance mechanic who is responsible for the weekly and monthly vehicle inspections. The transportation supervisor has also been designated to complete the vehicle checks daily to ensure all vehicles are equipped and readily available to drive. The center has a total of six vehicles used to transport youth. Each vehicle had an annual safety inspection conducted by a certified automobile mechanic. Observations of four vehicles verified each was locked when not in use. All four vehicles have the appropriate number of seat belts, a seat belt cutter, a window punch, up-to-date fire extinguishers, and a first aid kit with approved items by the designated health authority (DHA). Two vans were out at the shop during the annual compliance review. The center maintains a binder for each vehicle which contains the vehicle mileage log, mechanical restraint key, gas card, vehicle registration, and vehicle policy and daily check list. Weekly visual vehicle inspection checks are conducted on all vehicles as required and documented on the preventive maintenance check sheets. A review of the inspection checklist revealed there was no documentation to support if emergency equipment of the vehicle is checked. This was brought to the administration's staff attention during the review. The center updated the inspection checklist to reflect emergency equipment during the annual compliance review. Prior to each transport, a pre-trip vehicle inspection by two staff and documented in the vehicle logbook. An observation of a pre-transport activity verified the vehicle was searched by staff prior to the transport, staff searched the youth prior to placing the youth in the vehicle, staff assisted the youth in securing the seatbelt, and the assigned cellular telephone was charged and turned on prior to leaving for court. A review of the center's logbook reflected the vehicle was searched prior to being utilized and upon returning back to center.

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

The center maintains a written policy and procedures to ensure all tools and equipment are properly maintained, stored, and inventoried. A perpetual tool inventory list is maintained by the center and inventoried monthly. The inventory log, list what tools are being used by the maintenance staff including the times the tools were checked-out, the location of the tools, and times the tools were returned. An interview with the maintenance mechanic reported inventory is conducted monthly by the maintenance staff. Tools are maintained on a shadow board and marked with an identification number. A review of the inventory log verified there were no missing tools. However, there was a damaged tool which was replaced by the center. Tools in need of disposal or replacement is requested by completing a tool disposal/replacement form which the maintenance mechanic signs and request the approval of the assistant superintendent or superintendent. An interview with maintenance mechanic indicated when items are lost, or it is assumed to be left in an area youth were in the shift supervisor and administration is made aware and a searched is initiated. An interview with the maintenance

mechanic and assistant superintendent indicated there were no instances of tools being missing within the past six months. All vendors are identified prior to entering the center and are accompanied by a designated staff when in the secure area. Youth are removed from the area being serviced and not allowed to re-enter the area until it has been searched and cleared by staff. The vendor checks for all their tools to ensure they leave with what they entered with. A review of the kitchen tools found the center maintains a perpetual inventory log to track daily counts of kitchen tools. Any maintenance or kitchen tool in need of disposal or replacement is requested by completing a tool disposal/replacement report which the maintenance or food service manager signs and gives to the superintendent for approval. A review of the monthly inventory sheets confirmed there were no missing maintenance or kitchen tools.

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

The center maintains a written policy and procedures to ensure youth do not have access to or use any tools, including kitchen and/or medical equipment. Youth may use mops, brooms, and buckets under the direct supervision of staff. Observation conducted during the annual compliance review confirmed two youth were using only the dust mops, mops, and buckets. Five youth were interviewed and five indicated they use mops and brooms. Two youth also reported using a scrub brush and one stated using a screw driver.

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

The center maintains a written policy and procedures to ensure the proper inventory of flammable, toxic, caustic, and poisonous items. Reviewed documentation supported all items are inventoried weekly and securely stored when not in use. All items observed had a Safety Data Sheet (SDS) on record for each chemical. Observation of the storage area indicated all items matched the inventory list and are stored in a locked shed located outside the secure area of the center.

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

The center maintains a written policy and procedures to ensure limited access to flammable, toxic, caustic, and poisonous items. These Items can only be used by authorized staff. The center maintains a list of authorized staff who has approved access to the chemical storage area. The chemical storage area is located outside the secure area of the center. Youth are not permitted to use or handle hazardous chemicals. Observations conducted during the annual compliance review week found there were no toxic materials stored in any place accessible to youth. An interview with the superintendent confirmed this practice. Five youth were interviewed one stated they clean with cleaning agents such as bleach, laundry soap, window, or toilet cleaner which is sprayed by the staff. Four youth indicated they do not use any chemicals. Five staff were interviewed and stated youth do not clean with any type of cleaning agent such as bleach, laundry soap, window or toilet cleaner

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

The center maintains a written policy and procedure to ensure flammable, toxic, caustic, and poisonous items are disposed of according to the manufactures Safety Data Sheet (SDS). The maintenance mechanic reported there have been no chemicals disposed of within the last six months. The center's food director reported she does not utilize grease for cooking. All kitchen liquid waste is disposed in the kitchen drain. The center utilizes a provider to clean the drain trap and lift station. A review of invoices for the past six months verified the trap is cleaned quarterly. An interview with the center's maintenance mechanic indicated there have been no chemical spills within the last six months. If a chemical spill occurs, the center's policy requires staff to notify master control of the location, the shift supervisor or master control will contact the maintenance mechanic for directions

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

The center maintains a written policy and procedures ensuring confinements under twenty–four hours are used as an immediate, short-term response strategy during volatile situations with a youth's sudden or unforeseen onset of behavior imminently and substantially threatens the physical safety of others or self. The center has two designated confinement rooms. However, the center utilizes the youth's assigned sleeping room for confinement. If a youth's behavior

escalates while in confinement, or if staff are unable to place the youth in their assigned room, the youth will be placed in one of the designated confinement rooms. An observation of the designated confinement rooms and youth rooms found the rooms were free from obstruction and each room contained no non-fixed items. Youth who are in confinement have no contact with the general population. The center documents confinements under twenty-four hours in the Facility Management System (FMS). A review of seven confinement reports validated youth who were placed in confinement were afforded the same services as youth in the general population. Confinement reports indicated all rooms were searched prior to youth being placed in confinement. Each report reflected visual observation was conducted in accordance with the Department's policy. Each reviewed confinement report indicated all reports were completed within one hour. Each confinement report indicated the juvenile justice detention officer supervisor (JJDOS) completed reviews, evaluating youth every three hours, and documented the need for confinement based on the severity of the rule, violations, past disciplinary history, or behavior while in confinement. Each of the seven confinement reports indicated the superintendent and/or designee reviewed the confinement report within forty-eight hours. An interview with the superintendent confirmed this practice. The superintendent also reported if youth has been placed in confinement and the youth's behavior doesn't warranted the youth is immediately removed and placed back into general population. Five staff were interviewed and stated when a youth is placed in confinement, the staff must complete a confinement report, conduct and document ten-minute room checks, and search the confinement room. Supervisors must review and approve the confinement report within two hours of the youth being placed, and every three hours after. A room search is conducted, and the youth is informed of the right to file a grievance. If a youth confinement was not appropriate, the youth will be immediately released. The superintendent or designee must review the report within forty-eight hours of release, and all confinement events are monitored by regional and headquarter staff.

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

The center maintains a written policy and procedures for confinement over twenty-four hours which requires confinement reports to be submitted within one hour of the incident and reviewed within two hours by the superintendent or designee. The superintendent must review any

request to exceed twenty-four hours of confinement. During an informal interview, the superintendent reported confinements under twenty-four hours are reviewed by the superintendent or designee within forty-eight hours of the end of each confinement, excluding weekends and holidays. Confinements over twenty-four hours must be approved by the superintendent or designee. Anything over twenty-four hours, the regional director and assistant secretary for detention services must approve. All confinements are tracked in the Department's Facility Management System (FMS). Six confinement reports over twenty-four hours was reviewed and each was approved by the center superintendent or designee. Each confinement report documented the regional director or chief was notified and granted approval. Five confinement reports showed the juvenile justice detention officer supervisor (JJDOS) completed reviews, evaluating the youth every three hours. One reviewed confinement report found it was not reviewed by the JJDOS and went over by an hour from the last supervisors review and documented the need for continued confinement based on the severity of the rule violation, past disciplinary history, or behavior while in confinement. None of the confinements extended beyond three days; therefore, no confinement hearing was required.

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

The center maintains a written policy and procedure to ensure a plan is in place to manage various emergencies and disaster events. The center's Continuity of Operations Plan (COOP) was approved by the reginal director on July 26, 2019. Center documentation showed there were two COOP drills conducted, as required. Hurricane drills on January 23, 2019 and May 6, 2019. Observations made of the drill forms indicated each contained written scenarios and drill forms, critique forms and e-mails used to document the drills. Five staff were interviewed and asked what drills they have participated in the last six months. Three staff reported participating in a chemical spill, weather drill, hostage drill, and in a major disturbance. All staff reported participating in an escape and fire drill. Drills are also reviewed during monthly management meetings and during shift briefings. An interview with the center's superintendent reflected the center conducts various safety, emergency and medical drills on a monthly basis. All drills are conducted on each shift, documented on the drill forms, and sign-in rosters are utilized to capture the signatures of all staff who participated in the drills. The COOP drills are required to be conducted twice a year. The evacuation plan is included in the COOP plan. The center conducts monthly safety meetings to address any and all safety concerns.

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

The center maintains a written policy and procedures to ensure it is prepared to address youth escapes. A review of the prevention plan indicated all required elements outlined in the Department's policy. Documentation provided indicated escape drills are required to be conducted once each quarter. A review of the center's escape drill for the last six months, along with corresponding logbook entries verified the center exceeds the requirements and conduct drills monthly. Additionally, staff sign a roster acknowledging they participated in the drill. A review of five staff training records verified annual escape training was completed by each

reviewed staff. Five staff were interviewed regarding drill participation within the last six months; and reported they had all participated in an escape drill.

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

The center maintains a written policy and procedures for addressing fire prevention and safety. The center's fire prevention and safety plans were reviewed and approved by the state fire marshal on October 23, 2018. The center has evacuation egress plans posted throughout the center. Each egress plan defined primary and secondary exit routes, and the locations of emergency equipment; such as fire extinguishers and first aid kits. A review of the emergency drill documentation and the logbook documentation for the past six months found the center conducted fire drills each month, on each shift, during different times except for the month of April 2019. Drills are also reviewed during staff meetings and shift briefings. Five staff were interviewed, and each staff confirmed they have participated in fire drills monthly. Five youth were interviewed, and each reported they have been instructed on what to do in the case of a fire.