STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Volusia Regional Juvenile Detention Center

Department of Juvenile Justice

(State-Operated)
3840 Old Deland Road
Daytona Beach, Florida 32124

Review Date(s): November 3-6, 2020

Promoting Continuous Improvement and Accountability
in Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Kristine Harshaw, Office of Accountability and Program Support, Lead Reviewer (Standard 1)
Gwen Nelson, Office of Accountability and Program Support, Regional Monitor (Standard 2)
Christi Stua, DJJ Detention Services, North Region, Senior Management Analyst II (Standard 3)
Mike Marino, Office of Accountability and Program Support, Regional Monitor (Standard 4)
Kenneth Coleman, Marion Regional Juvenile Detention Center, Assistant Superintendent (Standard 5)

Program Name: Volusia Regional Juvenile Detention	MQI Program Code: 139
Provider Name: N/A	Contract Number: N/A
Location: Volusia County / Circuit 7	Number of Beds: 50
Review Date(s): November 3-6, 2020	Lead Reviewer Code: 187

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
4.16 Medication/Sharps Inventory and Storage Process	

Standard 1: Management Accountability
Detention Rating Profile

Indicator Ratings

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

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

Standard 2: Youth Management
Detention Rating Profile

Indicator Ratings

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

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

Indicator Ratings

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

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Standard 4: Health Services
Detention Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Detention Rating Profile

Indicator Ratings

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

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Program Overview

The Volusia Regional Juvenile Detention Center is a state-owned detention center, operated by the Department, located in Daytona Beach, Florida. The center serves youth in Volusia, Flagler, and St. Johns Counties in Circuit 7. 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 Volusia County School Board.

The center's management team includes the superintendent, two assistant superintendents, one administrative assistant, eight juvenile justice detention officer supervisors (JJDOS), and forty-eight juvenile justice detention officers (JJDO). Mental health and healthcare services are provided through the contracted provider, Camelot Community Care, Inc. Mental health services are provided by a licensed mental health counselor who serves as the designated mental health clinician authority (DMHCA), one licensed mental health professional, and one non-licensed mental health personnel under supervision. A contracted psychiatrist is on-site weekly. Clinical services provided by the center include mental health and substance abuse evaluations, mental health treatment planning, individual, group and family therapy, mental health crisis intervention services, on-site psychiatric services, and availability for substance abuse services for youth with co-occurring disorders. Medical services are provided by a medical doctor who serves as the designated health authority, one registered nurse, two licensed practical nurses, and one advance practice registered nurse (APRN).The medical clinic maintains nursing coverage Monday through Friday, from 6:00 a.m. to 7:00 p.m., and on weekends, from 11:00 a.m. to 7:00 p.m. Food services are provided by Department staff and include menus, meal planning, meal schedules, special diets, nutritional analysis, daily allowance, food preparation, health certifications, food product standards, sanitation, and cleaning.

Staff are responsible for the custody and control of youth in their care, providing youth supervision twenty-four hours a day, seven days a week. The center has three living modules which are divided by male and female youth. There are forty-eight security cameras at the center, all of which were operational. At the time of the annual compliance review, the center had ten vacancies, which included one food service worker position and nine JJDO positions.

Standard 1: Management Accountability

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

Since the last annual compliance review, twelve staff were hired. Each staff had a background screening completed prior to hire and each passed the pre-employment screening assessment. There were no new volunteers at the center since the last annual compliance review. The Annual Affidavit of Compliance with Level 2 Screening Standards was completed and sent to the Department's Background Screening Unit on January 2, 2020. An Annual Affidavit of Compliance with Level 2 Screening Standards for teachers was completed January 6, 2020. The provider for medical and mental health services, Camelot, has current employee rosters in Clearinghouse for medical and mental health staff.

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.	

Three staff were eligible for a five-year background rescreening. Each of the five-year background rescreenings were completed five years from the agency hire date and submitted to the Department's Background Screening Unit (BSU) at least ten days prior to the staff's five-year anniversary date. No volunteers or contractors were applicable for a five year background rescreening.

1.03 Staff Code of Conduct	Satisfactory Compliance
Center staff adheres to a code of conduct prohibiting any form of abuse, profanity, threats, harassment, intimidation, "horseplay," or personal relationships with youth. *Officers shall maintain the confidentiality afforded to all youth and shall not release any information to the general public or the news media about any youth in the center or who has been in the custody of the Department.* *Officers shall not verbally abuse, demean or otherwise humiliate any youth, and shall not use profanity in the performance of their job.* *Officers shall not engage in or allow horseplay, either verbal or physical, with and/or between any youth.* *Officers shall not engage in personal relationships nor discuss personal information related to themselves or other officers with any youth.* *Management takes immediate action to investigate or address all allegations or violations of the code of conduct.*	

Staff at the center adhere to a code of conduct which prohibits any form of abuse, profanity, threats, harassment, intimidation, "horseplay," or personal relationships with youth. Each of the seven reviewed staff records contained a code of conduct which were signed upon hire. Two staff records were applicable for disciplinary actions regarding violations to the code of conduct. Both records documented the staff received re-training. The center recognizes staff and provides commendations such as employee of the month. Two reviewed staff records were applicable for commendations. One staff received employee of the month, and one staff received supervisor of the year. Four of the five interviewed youth reported they have never been denied an abuse call. The remaining youth indicated they have never had to report abuse. All of the youth revealed staff are respectful when talking to youth. Three of the five youth stated staff never use curse words when speaking with and two stated staff occasionally use curse words. None of the youth reported they have heard staff threaten themselves or other youth. All of the youth stated they feel safe at the center. Three of the five interviewed staff reported never hearing a staff use profanity when speaking with youth, one staff reported occasionally, and one staff reported once. All of the staff stated they never heard a co-worker using threats, intimidation, or humiliation when interacting with youth. Regarding the working conditions at the center for the past year, three staff stated conditions were good and two staff reported fair conditions. The superintendent confirmed the center's facility operating procedures outline the code of conduct to ensure staff communicate and interact with youth as role models. Violations of the code of conduct will be investigated, and an officer may face disciplinary action up to and including dismissal.

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.	

In the last six months, the center reported seventy-three incidents to the Central Communications Center (CCC). Sixty-one of the incidents were related to the COVID-19

pandemic. Nine of the remaining twelve CCC reports were reviewed. Each incident was reported to the CCC within two hours of the incident. All nine incidents were documented in the master control logbook. There were no additional internal incidents or grievances which should have been reported to the CCC. The program has not experienced an increase in the number of reportable incidents to the CCC, with the exception of the sixty-one reports related to the COVID-19 pandemic. Five staff were interviewed regarding the process for allowing staff and youth to call the Florida Abuse Hotline or CCC if the youth is eighteen years or older to report suspected abuse. Five reported they would allow the youth to make the call, four stated the supervisor would be notified, three stated the supervisor makes the call, and one said staff are allowed to call. The superintendent confirmed the center reports all incidents included in the CCC policy and notifies the regional office when calls are made to the CCC.

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

Since the last annual compliance review, there were seventy-three Protective Action Response (PAR) incidents. Eight of the nine reviewed PAR reports were completed by the end of the staff members workday. The remaining report was completed one day late. The reports each included statements from all staff who were involved in the incident. None of the incidents required the use of mechanical restraints, resulted in a serious injury to youth or staff, nor did any of the youth allege any abuse. Each of the nine incident reports were reviewed by a supervisor and a PAR instructor, determining the use of force was consistent with policy. Each report documented a post-PAR interview was conducted with the youth by an administrator or designee within thirty minutes after the incident occurred. None of the nine incidents documented the youth was in distress or a medical review was necessary. In all but one instance, the superintendent or designee reviewed the report, after all other reviews, and made comments within seventy-two hours. One report, the one not initially completed on time, was reviewed by the superintendent one day late. There were no internal incidents or grievances which reflected any additional PAR incidents occurred which were not documented.

The center's PAR rate during the annual compliance review period was 12.14, which is below the statewide Detention PAR rate of 16.56. The PAR rate has decreased since the last annual compliance review. All five interviewed staff reported trying to talk to youth prior to using physical or mechanical restraints. The superintendent stated the process for monitoring PAR incidents is completed by supervisors and administrators reviewing video and reports for all PAR incidents.

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

Five staff records were reviewed for pre-service trainings. Four of the five staff were certified within 180 days of hire, and one is currently in training. All five staff completed Protective Action Response (PAR) training within ninety days of hire. Each of the staff completed essential skills

training prior to youth contact. Essential skill training included cardiopulmonary resuscitation, automated external defibrillator, first aid, mental health services, substance abuse services, suicide recognition, prevention, and intervention, safety, security, and supervision including emergency plans/procedures, Prison Rape Elimination Act (PREA), human trafficking, and Department detention facility operations including unit log, admissions, and releases. Each of the staff completed orientation, information security awareness, legal, DJJ: the organization, gang awareness, interpersonal/communication skills, detainee behavior and consequences, and active shooter trainings. All completed training was entered into the Department's Learning Management System (SkillPro) within thirty days of training completion.

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

Five staff records, including three supervisory records, were reviewed for in-service training . All five staff completed more than the required twenty-four hours of training. All staff completed Protective Action Response (PAR) update, ethics, active shooter, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), and first aid trainings. Four of the five staff completed suicide prevention training to include two hours of web-based training in the Department's Learning Management System (SkillPro) and four hours of instructor-led or webinar training. The remaining staff did not receive the four-hour instructor-led or webinar portion of the training. Three supervisory staff records were reviewed for training. Each supervisor completed at least eight hours of supervisory training which included management, leadership, personal accountability, employee relations, and communication skills. All supervisory in-service training was documented in SkillPro. All trainings were entered into SkillPro within thirty days of training completion. The superintendent reported completing all SkillPro management trainings, and staff at the center complete mandatory trainings such as PAR, CPR, first aid, and the required courses in SkillPro.

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

The center has a written policy and procedures concerning the grievance process. The grievance process is posted in each module and explained to each youth during the admission and orientation process. Youth are required to request a grievance form in order to file a grievance. The grievance procedures allow youth to submit a grievance to ensure they are treated fairly, respectfully, without discrimination, and their rights are protected. The grievance

process has an informal, formal, and appeal phases. The informal phase allows the youth and staff to attempt to resolve any issues, complaints, or conditions using communication skills. The formal phase allows the youth to submit a written grievance resulting in a response from a juvenile justice detention officer supervisor by the end of the shift (if possible), or otherwise within twenty-four hours. The appeal phase allows the youth to appeal the outcome of the formal phase to the superintendent or designee.

The center reported no grievances were submitted during the previous twelve months. Four of the five interviewed youth knew the process, and one youth was not sure, as the youth was recently admitted to the center. One youth rated the grievance process as "good," one youth rated it "fair," and three responded they have never filed a grievance. Each of the five interviewed staff demonstrated knowledge and awareness of the grievance process.

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

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

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

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

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

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

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

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

Five youth records were reviewed regarding alerts. Each alert was entered into the Department's Juvenile Justice Information System (JJIS) immediately when the youth were admitted to the center and were identified with a suicide risk, mental health, substance abuse, physical health, or a security risk factor. Each of the alerts entered into JJIS were included on the internal alert system, as required. The JJIS alert report is reviewed daily by supervisors and administrators. During shift briefing, alerts are reviewed with staff and staff are provided an alert list. Five interviewed staff reported they are informed of youth alerts during shift debriefings and are provided an alert list. All staff stated they are informed of issues within the center during shift briefings, three stated through meetings, and four stated through emails. The superintendent reported all alerts are entered in JJIS and alerts are reviewed at the beginning of each shift during shift briefing and are modified, as needed.

Standard 2: Assessment and Performance Plan

2.01 Admission	Satisfactory Compliance

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

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

The center has a policy and procedures for youth admissions. Five youth records were reviewed to determine if the intake processes were conducted in accordance with the Florida Administrative Code. All records contained an arrest affidavit/custody order or courtesy hold order, a Detention Risk Assessment Instrument (DRAI), and Suicide Risk Screening Instrument (SRSI). All five records contained a copy of the admission wizard printed. The Admission Wizard documented the youth were electronically and strip searched, and staff completed medical, mental health, and substance abuse screenings. Reviewed documentation indicated each youth was given an opportunity to make a telephone call to their parent/guardian. Documentation confirmed the youth were offered a snack or meal upon admission. The records indicated the youth showered and were provided clothing.

2.02 Orientation	Satisfactory Compliance

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

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

The center has a policy and procedures for orientating youth to the rules and regulations. Five youth records were reviewed for orientation process. Each record contained documentation indicating an orientation was completed within twenty-four hours of admission, with youth acknowledging the orientation by signature. The orientation process included identification of

key personnel, the daily activity schedule, the center's rules and regulations, youth rights, visitation, telephone calls, grievance procedures, access to medical, mental health, and substance abuse services, access to the Florida Abuse Hotline and Central Communications Center, behavior expectations and related consequences, and possible new law violations for destruction of property. All five interviewed youth reported they received an orientation to the center to include the rules and regulations, daily schedule, education services, visitation, abuse reporting, and the behavior management system.

2.03 Classification	Satisfactory Compliance

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

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

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

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

The center has a policy and procedures to ensure all youth are classified upon admission to provide the highest level of safety and security. Five youth records were reviewed. Admission wizards were completed in each record, which included a review of the youth's history, gender, height, weight, age, level of aggressiveness, identified special needs, history of sexual offenses, the Victimization and Sexually Aggressive Behavior (VSAB) form, and any risks to include medical, suicide (identified or suspected), escape, gang affiliation, and security. Youth were assigned to rooms based on classification procedures. Each of the applicable alerts were entered into the Department's Juvenile Justice Information System (JJIS). Two of the youth were classified with gang affiliation. The gang liaison reported confirmations of the youth's gang affiliations were pending the juvenile probation officer and the local law enforcement's confirmation process. Based on the results of the VSAB, three youth were placed in single rooms, as required.

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

The center has a policy and procedures to identify gang members. A review of five youth records indicated all youth were screened for gang affiliation during intake. Two of the five youth were identified with gang affiliations during the intake process, as reflected in the Department's Juvenile Justice Information System (JJIS). Reviewed documentation confirmed the center shared information with the juvenile probation officer (JPO) designated as the circuit gang representative. The superintendent reported the center shares gang information with the youth's assigned JPO and local law enforcement, as well as the gang representative.

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

The center has a policy and procedures to address taking possession of youth's personal property during admission. Five youth records were reviewed. Each record documented youth property was inventoried by the admitting juvenile justice detention officer (JJDO) and entered into the Department's Juvenile Justice Information System (JJIS). A Property Receipt Form was signed by the youth and JJDO and contained in each record. Youth property was placed in a bag and placed in a secured room. Money and other valuable items were placed in a clear tamper-proof bag and placed in a drop safe, which is under camera surveillance. Each of the bags were labeled with the youth's name, Department identification number (DJJID), a listing of the items in the bag, and youth and staff signatures. The logbook documented the dates, times, youth names, items placed in the drop safe, DJJIDs, the printed names of the officers who secured the property, as well as their initials, as required. All reviewed records contained a signed Letter of Acknowledgement regarding unclaimed property. All five interviewed youth reported staff checked their personal property and they signed a property receipt upon admission to the center. An interview with the superintendent confirmed the process for the receipt of youth property.

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

The center has a policy and procedures for safeguarding youth's personal property. When a youth enters the center, the youth's personal property is stored within two separate areas in the center. Youth clothing is stored in a property room with access restricted to supervisors and intake personnel. Valuable property is turned over to the shift supervisor. Valuable property

items are secured in a tamper-proof bag and secured in the drop safe, which is under surveillance. The administrative staff have access to the drop safe. Property bags are listed in binder according to the date the bags were stored. A notice is sent to a youth's parent/guardian regarding any property left at the center after a youth is released. A review of Central Communications Center (CCC) reports for the past six months indicated there was one incident related to youth property. The superintendent was interviewed regarding youth's personal property storage. The superintendent explained all procedures related to storage of youth personal property.

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

The center has a policy and procedures for releasing youth. Three closed youth records were reviewed for release documentation. The records reflected the center obtained a photocopy of the identification (ID) cards of the parents/guardians or responsible adults to whom the youth were released. For youth released to transporters, ID cards were photocopied, and the transporter's names were documented. Each of the three records documented court orders and other paperwork related to the release were reviewed by a supervisor. Each record documented the youth's identity was confirmed prior to release. The supervisor reviewed the release order and related paperwork. None of youth were on precautionary observation at the time of youth release and no notifications of suicide risk were applicable. The property receipts were reviewed and signed by the youth and parent/guardian. A review of admission and release dates in each youth record correlated with the dates documented in the Department's Juvenile Justice Information System. A review of Central Communications Center reports found there were not any unauthorized releases during the annual compliance review period.

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

The center has a policy and procedures addressing the release of a youth's personal property. Three closed youth records were reviewed. All three records contained a copy of the Property Receipt Form and were signed by the youth and parents/guardians. The valuable property

logbook documented valuable property was released to youth upon release from the center. A letter sent to each youth's parent/guardian regarding the intent to dispose any property not picked up after thirty days. The superintendent interview indicated property not picked up is either donated to a non-profit organization or discarded. Money not claimed within thirty days is forwarded to detention services headquarters.

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

The center has a policy and procedures for releasing a youth's medication, as well as aftercare instructions. One of the five reviewed records was applicable for a youth was released from the center with medication. The center did not have any additional applicable records for review. The record contained a completed Medication Receipt form. All forms were signed and dated by all required parties. Reviewed documentation indicated medical staff completed a review of the medication with the parent/guardian. The parent/guardian, medical staff, and a witness signed the medication receipt.

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

The center has a policy and procedures to conduct weekly reviews for youth in secure detention. The superintendent reported the center has designated a juvenile justice detention officer II (JJDO) to serve as the detention review specialist who coordinates detention reviews weekly. The weekly review team includes representatives from mental health, medical, and education services, as well as detention and probation staff from the circuit. According to the superintendent, the meetings address youth alerts, confinements, behavior issues, current court status, any issues relative to youth's placement (if committed), education, and medical or mental health concerns. Documentation of detention reviews conducted during the past six months was reviewed and a detention review was observed. All youth on detention status were reviewed, which included follow-up information needed from previous reviews, pending court dates, commitment status, release dates, and other pertinent information. The review team members attend the meetings in person or by phone.

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

The center has a policy and procedures to ensure youth are provided opportunities to participate in constructive activities. The daily activity schedule is posted on each module. Reviewed logbooks and observations during the annual compliance review indicated the center follows the daily activity schedule. The schedule includes times for personal hygiene, groups, meals, visitation, education, indoor and outdoor recreation, shift change, faith-based services, groups, shower time, bedtime, and down time for youth. Each of the five interviewed youth indicated the center has a daily activity schedule and the center follows the daily schedule. All

five interviewed staff reported the center follows the daily schedule with minimal interference of educational instruction.

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

The center has a policy and procedures in place to ensure staff adherence to the center's daily activity schedule. All five interviewed youth and five interviewed staff reported the daily schedule is followed. Observations during the annual compliance review confirmed youth moved to and from class, meals, and other activities as scheduled. Logbooks documented the schedule was followed unless an emergency event or disturbance occurred. Changes to the schedule were approved by the shift supervisor or administration.

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 provides educational instruction for the youth. The youth attend school Monday through Friday, for five hours each day. Youth are enrolled in educational programs and can earn course credit for completion of education and training experiences. The center provides education on a 250-day calendar over twelve months. The teachers have teacher training and planning days up to ten days a year. A review of logbooks indicated youth received education services, as indicated on the daily schedule. All five interviewed youth reported they attend school Monday through Friday and each youth identified common subjects/classes taught during school (math, language arts, and social studies). Five interviewed staff, as well as the superintendent indicated there is minimal interference in education activities. Due to the COVID-19 pandemic, the school schedule has been adjusted.

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 provides career education to all youth. The center provides Type 1 programming, which includes life skills groups, activities, and instruction. The youth at the center receive instruction in the areas of communication, interpersonal, and decision-making skills.

2.15 Trauma-Informed Care	Satisfactory Compliance

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

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

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

The center has a policy and procedures relating to trauma-informed care practices. According to the superintendent, all staff are trained on trauma-informed care as part of the pre-service and in-service training requirements. The superintendent interview and a tour of the center indicated the center does not have room specifically named “soft” room. The center has a room utilized by the youth as a calming room. The dormitories and hallways are painted in soft colors. Paintings of murals and artwork are posted throughout the center. The center has a multi-purpose room where youth can play video games, watch television, and play cards and ping pong. Ten staff training records (five pre-service and five in-service) confirmed staff members are trained on trauma-informed care practices.

Standard 3: Mental Health and Substance Abuse Services

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

The designated mental health clinician authority (DMHCA) is a licensed mental health counselor (LMHC) with a clear and active license in the State of Florida. The DMHCA's license expires on March 31, 2021. The DMHA is on-site forty hours a week and is on-call twenty-four hours a day. The DMHCA works for Camelot Community Care, Inc. and is contracted to provide services for the Department. An interview was conducted with the DMHCA to confirm the oversight of the mental health program at the center. The DMHCA reported providing clinical supervision and direction to the mental health professionals at the center, as well as being responsible for the planning, management, and supervision of clinical services. The DMHCA is responsible for ensuring services are provided to the youth to include mental health and substance abuse screenings, comprehensive assessments, mental health and substance abuse counseling, psychiatric services, suicide prevention, crisis intervention, and emergency services.

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

The center does not have any other licensed clinical staff other than the designated mental health clinician authority; therefore, this indicator is rated Non-Applicable.

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

The center has one non-licensed clinical staff. The non-licensed staff holds a master's-level degree in psychology from an accredited university. The non-licensed staff works for Camelot Community Care, Inc. and is contracted to provide services for the Department. The non-licensed staff is on-site thirty hours a week, Monday through Friday and ten hours a week on Saturday and Sunday. Documentation reflected the non-licensed staff received twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. A review of the Licensed Mental Health Professionals and Licensed/Certified Substance Abuse Professionals Direct Supervision Logs confirmed the non-licensed staff received at least one hour each week of on-site face-to-face supervision provided by the designated mental health clinician authority (DMHCA). The center is licensed

under Chapter 397 to provide substance abuse services; however, the center has not facilitated any groups since March 2020 due to the COVID-19 pandemic.

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

The center has a written policy and procedures addressing mental health and substance abuse admission screenings. A review of five youth records found documentation indicating each youth had a Suicide Risk Screening Instrument (SRSI) completed during admission process in the Department's Juvenile Justice Information System (JJIS). Each section of the SRSIs were completed by the required parties to include the juvenile probation officers, juvenile justice detention officers, and the mental health and/or medical professional. One record had partial documentation in the screening results section of the SRSI. Each record contained documentation indicating a Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) and a Vulnerability and Sexually Aggressive Behavior (VSAB) assessments were completed at intake by trained staff. Based on the results from the SRSIs, four youth required and received an Assessment of Suicide Risk (ASR) and placement on suicide precautions. All four applicable records contained documentation reflecting mental health referrals were completed and the superintendent was notified. Each of the ASRs were completed within twenty-four hours of the time of admission. The superintendent and designated mental health clinician authority (DMHCA) were knowledgeable of the screening process conducted during the admission process.

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

The center has a written policy and procedures for completion of mental health and substance abuse evaluations. Four of the five reviewed records reviewed were applicable for evaluations. One of the four applicable records documented the youth received a comprehensive assessment completed by a community provider. The remaining three records were for youth who had been in the center less than thirty days; therefore, there was time remaining to complete the assessment. The designated mental health clinician authority (DMHCA) maintains a comprehensive tracker to ensure evaluations are received within the established timeframes. When the community provider has not completed an evaluation within thirty days, a clinical staff from the center will complete the evaluation.

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

The center has a written policy and procedures in place for treatment and discharge planning. One of the five reviewed youth records was applicable for treatment planning; therefore, two additional applicable records were reviewed. Each applicable record contained the required referrals, Authority for Evaluation and Treatment form, and treatment plans (initial or individual), which were completed within the required time frames. All treatment plans were developed and signed by the designated mental health clinician authority (DMHCA), youth, and mini-treatment team member(s). The treatment plans addressed all required elements, to include the diagnoses, treatment goals, strengths and needs, and psychiatric interventions. Two youth were prescribed psychotropic medication and their plans included pharmacological interventions, which identified the youth's medication(s) and frequency of monitoring. Two youth required thirty-day treatment plan reviews, which were completed, as required. Parent/guardian notification or attempted contracts to get input from parents/guardians for treatment plans were documented in each record. Treatment plans were mailed to the parent/guardian in each case.

Three closed youth records were reviewed for discharge planning. Each record contained a Discharge Summary signed by the designated mental health clinician authority (DMHCA) and a mini-treatment team member. All Discharge Summaries were completed on the required Department form. Copies of the summaries were mailed to parents/guardians and e-mailed to juvenile probation officers. If a youth is transferred to a residential facility, a copy is sent to the program.

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

The center has a written policy and procedures regarding mental health and substance abuse treatment. Two of the five reviewed youth records were applicable for treatment services; therefore, one additional applicable record was reviewed. Each applicable record contained a signed Authority for Evaluation and Treatment (AET) form and substance abuse consents (MHSA forms 012 and 013), as well as documentation indicating referrals were completed, the mini-treatment team was involved, and individual counseling sessions. All services provided in accordance with treatment plans, were documented on the required Department forms, and

uploaded to the youth's electronic medical record. A treatment team meeting was observed during the annual compliance review. Attendees included representatives from probation, education, medical, mental health, and administration. (No youth were required to be present on day of observation.) There are usually representatives from community providers during the weekly meetings; however, due to the COVID-19 pandemic, many were not attending in person during the review period, but participating by phone. A review of sign-in sheets confirmed no more than ten youth were participating in groups. Two of the five interviewed youth reported mental health and substance abuse services at the center are "very good," one youth reported "poor," one youth reported "very poor," and one youth reported not receiving services. An interview with the designated mental health clinician authority (DHMCA) confirmed individual and/or group counseling is provided to youth for mental health and substance abuse, as needed/required. Treatment for individual and group sessions is documented on required Department forms and listed on the youth's chronological notes. The DMHCA uses a tracking method to monitor the number of youth in treatment, as to ensure groups do not exceed the established size limits.

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 has a written policy and procedures in place for providing psychiatric services. A licensed psychiatrist is on-site two hours per week. The psychiatrist has a clear and active license. Two of the five reviewed youth records were applicable for psychotropic medications; therefore, one additional applicable record was reviewed. Each record contained a completed referral and current Authority for Evaluation and Treatment (AET) form. Each youth received an initial diagnostic interview within fourteen days of admission to the center. The psychiatrist utilized the Department's forms for each evaluation. The initial psychiatric interviews included all required elements, and were completed within fourteen days. Psychiatric evaluations were completed within thirty days and included all the required elements. The Clinical Psychotropic Progress Notes (CPPN) reviewed were complete in their entirety with parent/guardian notifications or attempts documented as well as required signatures. The three records reviewed included documentation of monitoring for symptoms of Tardive Dyskinesia.

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

The center has a written Suicide Prevention Plan detailing suicide prevention procedures. The plan incorporates all required topics to include: identification and assessment process of youth at risk of suicide, staff training (including drills), suicide precautions, levels of supervision, referral process, communication, notification, documentation, immediate staff response, and review process. The plan was last reviewed and approved in August 2020 by the superintendent and designated mental health clinician authority. A copy of the plan is located in the conference room, accessible to all staff.

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

The center has a written policy and procedures in place regarding suicide prevention. Four of the five reviewed records were applicable for the completion of an Assessment of Suicide Risk (ASR). Each applicable record contained a referral and ASR competed within twenty-four hours on the Department's form, as required. The ASRs were completed by the designated mental health clinician authority (DMHCA) or by non-licensed staff and reviewed by the DMHCA within the required time frame. All four records documented the youth were stepped down to standard supervision from precautionary observation. Required notification to staff and the superintendent or designee were made and the superintendent or designee agreed with the reduction to standard supervision. Alerts in the Department's Juvenile Justice Information System (JJIS) were entered and closed appropriately for all records reviewed. There were logbook entries for each youth's placement on suicide precaution, as well as for removal.

None of the five reviewed records were applicable for secure observation; therefore, three additional records were reviewed. The three instances of use of secure observation found placement was authorized by the superintendent/designee and the DMHCA. The secure room assignments were in writing, health status checklists were completed, and the suicide precaution logs were completed in their entirety. Each record had documentation of the completion of an ASR within the required timeframe and notification of all required parties.

None of the five youth reported being placed on suicide precautions while at the center, although there was documentation indicating four of the five youth were placed on PO upon entering the center. All five interviewed staff indicated the mental health authority would be notified and they would provide constant sight and sound supervision if a youth expressed suicidal thoughts. Additionally, four staff reported they would document the level of supervision provided, and one reported they would search the youth and their room for sharp objects. All five staff reported they were aware a suicide response kit was located in each sub-control, one is in master control, and one is in medical.

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 has a written policy and procedures in place for documenting suicide precaution observations. Four of the five reviewed records were applicable for use of Suicide Precaution Observation Logs. All Suicide Precaution Logs were complete in their entirety including all

required documentation, reviews, and signatures. All checks were completed within the required timeframes. All logs included documentation of safe housing requirements. None of the interviewed youth indicated having been placed on suicide precautions, although four of the five were on precautionary observation upon admission.

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 has a written policy and procedures in place to ensure staff are trained on suicide prevention services. A review of ten (five pre-service and five in-service) staff training records found staff nine staff completed the required six hours of training to include web-based and instructor-led trainings. The remaining staff did not complete the instructor-led training. The center maintains a binder to document suicide drills. The drills were conducted on a monthly basis on each shift. Each of the ten staff reviewed participated in drills quarterly, as required. All of the suicide drills required the use of CPR as part of the procedure.

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

The center has a written Mental Health Crisis Intervention Plan. The plan outlines the procedures to be followed and includes notification and alert system use, means of referral (including self-referral), communication, supervision, documentation, and review. The plan was last reviewed and approved in August 2020 by the superintendent and designated mental health clinician authority. A copy of the plan is located in the conference room, accessible to all staff.

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

The center has a written Emergency Care plan for mental health and substance abuse emergencies. The plan incorporates all required topics to include immediate staff response, notifications, communication, supervision, authorization to transport, transport procedures for Baker and Marchman Acts, documentation, training and incident review. The plan was last reviewed and approved in August 2020 by the superintendent and designated mental health clinician authority. A copy of the plan is located in the conference room, accessible to all staff.

3.15 Crisis Assessments [Contract Provider] (Critical)	Satisfactory Compliance

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

The center has a written policy and procedures in place for the use of Crisis Assessments. None of the five reviewed records were applicable for a Crisis Assessment, nor have any youth required an assessment during the annual compliance review period. The designated mental health clinician authority explained the process and the required forms required to be utilized should a crisis assessment be warranted.

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

The center has a policy and procedures in place for Baker and Marchman Acts. None of the five reviewed youth records were applicable for Baker or Marchman Act services; however, the only applicable additional record was reviewed. The Baker Act was initiated by the designated mental health clinician authority (DMHCA). Upon re-admission to the center, the youth was placed on suicide precautions. Reviewed documentation confirmed all required actions, as outlined in the center's Emergency Care Plan, were followed to include completion of a mental health referral, mental status exam, and Assessment of Suicide Risk, as well as maintaining the youth on appropriate levels of supervision. An alert was entered into the Department's Juvenile Justice Information System and documented in the logbook. The youth was maintained on suicide precautions upon return to the center and until the time of her transfer to another facility.

There have been no Marchman Acts during the annual compliance review period.

Standard 4: Health Services

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

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

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

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

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

Three of the six youth individual healthcare records (IHCR) were reviewed were applicable for the completion of an Authority for Evaluation and Treatment (AET) and three IHCRs were applicable for the completion of the Limited Consent for Evaluation and Treatment and court order for youth in the custody of the Department of Children and Families (DCF). The three records for youth requiring an AET contained an AET signed by the parent/guardian. A Limited

Consent for Evaluation and Treatment and court order authorizing medical treatment were present for the three DCF youth. The AETs and Limited Consents for Evaluation and Treatment were obtained prior to medical services provided at the center. The interviewed nurse was familiar with procedures for the completion of an AET.

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

Six youth individual healthcare records (IHCR) were reviewed for parental notifications, which included four youth requiring parental notifications and two youth in the custody of the Department of Children and Families (DCF) requiring court-ordered consent for psychotropic medication. The four youth requiring parental notifications included four notifications for over-the-counter medications not covered by the Authority for Evaluation and Treatment (AET), one notification for off-site care, one notification for emergency care, and three notifications for psychotropic medications. Verbal notifications to the parent/guardian were documented in each IHCR. Reviewed documentation confirmed a staff witnessed each notification for psychotropic medication. Written notifications were completed in each IHCR. For psychotropic medications, the notifications included page three of the Clinical Psychotropic Progress Note (CPPN). For the two youth in the custody of DCF, a court order authorizing prescribed psychotropic medications and the Medical Report for Prescribing Psychotropic Medication to a Child in Out-of-Home Care (DCF form 5339) were in place prior to the youth receiving the medication. The nurse interviewed knew parental notification and consent requirements.

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

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

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

Five youth individual healthcare records (IHCR) were reviewed. Each record documented nursing staff provided a general orientation to healthcare services within twenty-four hours of admission to the center. The healthcare topics reviewed during orientation included access to

medical services, sick call, what constitutes an emergency and who to notify, the medication process, side effects monitoring, the right to refuse care and how it is documented, what to do in the case of a sexual assault or attempted sexual assault, and the non-disciplinary role of the healthcare providers.

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

Three of the five reviewed youth individual healthcare records (IHCR) were applicable for notification to the designated health authority (DHA). Reviewed documentation confirmed the DHA was notified when youth were confirmed as possessing a medical concern or chronic condition. Three of the five IHCRs were applicable for youth taking psychotropic medication upon admission. Each of the applicable records documented the psychiatrist was notified upon the youth's admission, as required. The nurse reported the DHA is immediately notified when youth are admitted with serious or chronic conditions.

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

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

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

A review of five youth individual healthcare records (IHCR) found each contained a completed Comprehensive Physical Assessment (CPA). Three of the IHCRs had CPA which were considered to be current at the time of the youth's admission. In these three records, the designated health authority (DHA) or advance practice registered nurse (APRN) documented a review of the CPA and completed a focused evaluation within seven days of admission. The remaining two IHCRs documented a new CPA was completed within seven days of the youth's admission. If a youth refused any part of the exam, the clinician documented "Youth Refused" and the youth signed a refusal of care form. The Department's Problem List was updated for each youth. Each youth had at least one verified Tuberculin Skin Test (TST) documented in the IHCR on the CPA and Infectious and Communicable Diseases form. The Tier 1 Tuberculosis screening was completed within seventy-two hours for each youth. None of the youth had a positive TST or symptoms of Tuberculosis requiring the youth to be transported to the nearest

hospital for further evaluation. The interviewed nurse explained the process for completing the CPA and TST.

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

Five youth individual healthcare records (IHCR) were reviewed. Each IHCR documented the youth was screened and evaluated for sexually transmitted infections (STI) and each screening was reviewed by the advanced practice registered nurse (APRN). Each youth was offered human immunodeficiency virus (HIV) testing, though all declined testing. The APRN ordered STI testing for two youth; however, one youth refused the testing. Results of the STI testing for the one youth were documented on the Infectious and Communicable Disease (ICD) form.

An additional three IHCRs were reviewed for STI testing and HIV testing. STI testing was completed and the results were documented on the ICD form and lab section for all three youth. Each of the three youth were offered and consented to HIV testing. The Department of Health conducts HIV testing at the center. Pre-test and post-test counseling were documented on the Health Education Record for each youth and test results were documented in a confidential manner. The nurse completing the interview described the screening and testing processes for an STI and HIV. All five interviewed youth stated they could ask for an HIV test.

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

The center has a policy and procedures in place regarding the completion of sick calls. None of the five reviewed youth individual healthcare records (IHCR) were applicable for sick calls; therefore, three additional applicable IHCRs were reviewed. All Sick Call Request forms and narrative progress notes conformed to the professional standards, to include all elements of the subjective, objective, assessment, and plan (SOAP) format. Each sick call was conducted within twenty-four hours of the youth submitting the Sick Call Request. One sick call was conducted by a licensed practical nurse (LPN) and was reviewed by a registered nurse (RN) within twenty-four hours. Sick calls were found to be documented on the youth's Sick Call Index and the center's Sick Call Log. None of the youth presented a similar sick call complaint three or more times within a two-week period. There were no youth complaints regarding any severe pain with which medical staff were unfamiliar. Sick calls are conducted in the medical clinic by licensed medical staff at the center. When there is not a licensed nurse on-site, the center has procedures in place for the shift supervisors to review Sick Call Requests no longer than four hours after a request is submitted. Sick call is scheduled daily from 9:00 a.m. to 11:00 a.m., and throughout the day, as needed. There were no opportunities to observe sick call during the annual compliance review.

The nurse completing the interview reported sick call is provided daily by nursing staff. The nurse explained any sick calls conducted by LPNs must be conducted under the direction of a RN or higher level medical professional. The nurse further explained youth presenting with a similar complaint three or more times in a two-week period require a referral to the designated

health authority (DHA) or advanced practice registered nurse (APRN). All five interviewed staff stated nursing staff provide sick call care. Three of the five interviewed youth reported they had never submitted a sick call request, one youth revealed being seen the same day the sick call request was submitted, and the remaining youth reported being seen the day after the sick call was submitted. Each youth reported a nurse conducts sick call.

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

The center has a policy and procedures for first aid, episodic, and emergency care. None of the five reviewed youth individual healthcare records (IHCR) were applicable for receiving episodic/first-aid care from a non-healthcare staff. Medical staff reported there have not been any instances of non-healthcare staff providing episodic care during the annual compliance review period. None of the reviewed IHCRs were applicable for episodic care by healthcare staff; therefore, four additional applicable IHCRs were reviewed. There were eight instances of episodic care provided by medical in the four IHCRs combined. The episodic care was documented in the subjective, objective, assessment, and plan (SOAP) format. All instances of episodic care were documented in the Episodic Care Log Two IHCRs documented education or instruction was provided to the youth. All four IHCRs documented parental notifications, as required. Three IHCRs were applicable for and contained documentation indicating the youth received follow-up evaluation by a licensed healthcare staff, as required.

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

The program has two automated external defibrillators (AED), with one located inside of the medical clinic and the other in the B2/3 sub-control room. Both AEDs were tested during the annual compliance review and showed ready for use. Documentation reflected the AEDs were checked monthly by medical staff. The AED pads expire on March 28, 2021. The AED batteries do not have an expiration date.

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

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

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

The center has a policy and procedures in place for off-site care. None of the five reviewed individual healthcare records (IHCR) were applicable for off-site care; therefore, the only two applicable additional IHCRs were reviewed. Each instance of off-site care was reviewed, finding a Summary of Off-Site form was completed and filed in each IHCR, along with discharge instruction documents. The designated health authority (DHA) and advanced practice registered nurse (APRN) reviewed the discharge instructions. For one youth who required emergency care, the DHA was notified and the event was documented in the Episodic Care Log. One youth required a follow-up appointment, which was tracked by nursing staff. The nurse completing the interview stated orders from off-site care providers are obtained and reviewed by the APRN and DHA. Any follow-up care is tracked and scheduled by nursing staff.

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

The center has a written policy and procedures for the delivery of treatment to youth identified with a chronic medical condition. A review of five youth individual healthcare records (IHCR) found three youth were identified with a chronic medical condition and/or taking prescribed medications. Each youth was classified with a medical grade two through five. Each applicable record documented an initial assessment of the youth was conducted by the designated health authority (DHA) and the youth's chronic condition was monitored. The Department's Problem List was updated in each of the IHCRs to identify the youth's chronic condition, as required. None of the three youth required a re-evaluation, as none of the youth were in the center for ninety days.

Two additional IHCRs for youth with a condition requiring periodic evaluations who had been in the center for over ninety days were reviewed. Each of the youth had an evaluation documented every ninety days. The nurse completing the interview knew the requirement for periodic evaluations for youth with chronic conditions, stating the frequency of the evaluations would be based on the youth's condition and, in no case, would the time between evaluations exceed three months.

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

The center has a written policy and procedures to ensure medication is received, verified, and administered in a safe and effective manner. Five individual healthcare records (IHCR) for youth taking medication were reviewed. One youth was admitted with medication. Nursing staff verified the youth's medication upon arrival to the center. The remaining four youth were identified as being on medication upon admission but did not have the medication with them. Chronological notes indicated nursing staff followed-up with parents/guardians regarding the

medication, and the parents/guardians subsequently delivered the medication to the center. Nursing staff verified the medication upon receipt in each case. Reviewed documentation confirmed the designated health authority (DHA) and/or psychiatrist was notified in each IHCR and ordered the medication be continued, as prescribed.

The center uses the standard Department's Medication Administration Record (MAR) to document administration of medications. Each MAR included the youth's name, Department identification number (DJJID), date of birth, allergies, medical alerts, medication precautions, and a picture of the youth. Four of the five MARs had the correct medical grade listed. The remaining youth's medical grade was updated during the youth's stay, but it was not updated on the MAR. This was corrected during the annual compliance review. There were no lapses or errors in medication administration. There was one documentation error for medication administration, which was a direct care staff not recording his/her initials along with the youth's initials to document the administration of an over-the-counter medication. The medical staff documented weekly side effect monitoring on the MARs. There were no refusals documented. The center's practice is to clearly document refusals on the MAR and Refusal Form, when applicable. The center had not had any youth who required parenteral medication during the annual compliance review period.

All five reviewed IHCRs were applicable for youth taking psychotropic mediations. The psychiatrist was notified when youth were prescribed psychotropic medication. The initial diagnostic psychiatric interview was conducted with fourteen days of admission for four youth. The remaining youth had not been in the center for fourteen days. None of the youth required a thirty-day monitoring for psychotropic medication, as none of the youth had been in the center for thirty days after the initial psychiatric interview. Center policy and procedures required psychotropic medication monitoring every thirty days.

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

The nurse interviewed was able to explain all aspects of medication management, to include receipt and verification, storage, administration, and disposal of medication. Five youth were interviewed. Four youth reported nursing staff gives them medication and the remaining youth said he does not take medications.

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

The center has a written policy and procedures ensuring medications and sharps are secured and inventoried. Medications and sharps were found stored and locked in designated areas inaccessible to youth. Medication storage areas include a locked medication cart, locked cabinets, and a locked refrigerator in the medical clinic. Active medications are stored in the medication cart; sharps and stock medication are stored in cabinets. All controlled medications

are stored in a lockbox within the locked medication cart. The center had one youth on controlled medication at the time of the annual compliance review. A shift-to-shift inventory count of the controlled medication was documented on the youth's individualized Controlled Medication Inventory Record. The medical department reported no other youth on controlled medication during the annual compliance review period.

The center has a policy and procedures for sharps and medication inventories, which includes procedures to identify and report discrepancies in sharps and medication inventories. Sharps inventories reviewed found weekly sharps inventories were not documented for July and August 2020. The weekly inventories were documented weekly since mid-September; however, perpetual inventories were not consistently recorded as sharps were used. Three sharps inventories were selected to review for accuracy. Two of the inventories had accurate counts. The remaining inventory (tuberculin syringes) had counts documented in a binder used to record Tuberculin Skin Test (TST), on the box containing the syringes, and in the inventory binder. None of these inventories matched or had the correct count.

Three over-the-counter (OTC) medications inventories were selected to review for accuracy. Inventories were documented weekly for all OTC medication; however, perpetual inventories were not consistently recorded when OTC medications were transferred from the stock supply in cabinets to the active supply in the medication care. The inventory for one OTC medication was not accurate. The inventory did not reflect a card containing thirty pills transferred to the medication cart and the inventory was off by two for the medication in the medication cart. The inventories for the remaining two OTC medications were accurate.

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

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

The center has a written policy and procedures and an Exposure Control Plan addressing infection control, which includes staff training and education for youth on infection control. The Exposure Control Plan is written in accordance with Occupational Safety and Health Administration (OSHA) standards. The Exposure Control Plan was signed by the designated health authority and superintendent. The program has implemented exposure and infection control procedures for COVID-19, at one point having more than ten percent of youth in the center in quarantine due to youth testing positive for COVID-19. The Central Communications Center (CCC) was notified whenever a youth or staff was tested for COVID-19. The local health department was notified on youth placed in quarantine at the center.

A review of seven youth individual healthcare records (IHCR) found each youth received infection control training within seven days of admission. Training included guidelines for hand-

washing techniques, universal/precautions, prevention/transmission of communicable diseases, prevention of blood borne pathogens, and guidelines for infection control. A copy of the Health Education Record form was maintained in each reviewed IHCR. A review of ten staff training records confirmed all staff received infection control training. All training and education was provided in accordance with the Centers for Disease Control and Prevention guidelines. The nurse completing the interview knew the location of the exposure control plan and knew requirements for infection control training for youth and staff.

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

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

Standard 5: Safety and Security

5.01 Active Supervision of Youth (Critical)	Satisfactory Compliance

Staff are aware of the location of youth assigned to their supervision at all times. Staff monitor the movement of youth in their direct care from one location to another.

Youth are in sight of at least one juvenile justice detention officer (JJDO) at all times (with the exception of sleeping hours or time secured in rooms).

Officers are responsible for the care of youth at all times. At no time shall another youth be allowed to exercise control over or provide discipline or care of any type to another youth.

When a youth leaves the group or program area of the center for any reason, all staff assigned to supervise the youth are informed.

Master control authorizes all movement of youth prior to the actual movement, and no movement occurs until cleared by master control.

Staff moves youth from one area of the center to another in accordance with Florida Administrative Code.

Observations of staff during daily activities was conducted during annual compliance review. Activities observed included youth during outside recreation, line movements, and education. A minimum of two staff supervised the youth during all observations. The master control operator used a two-way radio to conduct all movement of youth throughout facility. A review of five days of video footage of youth and staff on each mod often showed staff positioned properly. Counts were conducted at beginning and end of shifts and noted in logbooks. A census sheet and control logbook are used for tracking youth in facility. Interviews with five staff noted staffing was adequate.

5.02 Behavior Management System	Satisfactory Compliance

The center provides a system of rewards, privileges, and consequences to encourage youth to fulfill the center's expectations.

Each center shall implement and maintain a behavior management system to meet the needs of the youth and the center. The system shall include rewards for positive behavior and consequences for inappropriate behavior.

The behavioral norms and expectations for youth shall be posted in all living areas and shall clearly specify appropriate and inappropriate behaviors.

The center has a policy and procedures on the behavior management system (BMS). A tour of the center found the program has postings in all living areas which clearly specify appropriate and inappropriate behaviors, rules, norms and expectations. The BMS was approved by the regional director for detention. A review of the BMS found it includes rewards for positive behavior and consequences for inappropriate behavior. The center uses a three-level system for rewarding positive behavior. All youth entering the center are placed on level two. Each day, youth have an opportunity to earn points. After three days, youth with good behavior move up to level three. A review of youth point cards revealed rewards and consequences were given in

accordance with the BMS. The superintendent reported detention services utilizes a three-level system to track youth behavior. Regardless of the level a youth is on, all youth will have basic rights and receive three meals a day, snacks, clothing, sleep, health care, mental health and substance abuse services, school, exercise, letter writing, telephone use (minimum of twenty minutes a week), religious programs, parent/guardian visitation, visits with a juvenile probation officer, attorney, or clergy, and access to bathing and hygiene. Five staff interviews revealed the BMS consists of a point/level system. Staff interviews revealed the BMS is posted throughout the center and is included in the orientation process. Two of the five interviewed youth rated the center's BMS as "very good." One youth rated it "good," one rated it "fair," and one rated it "poor." Each of the five youth explained the center's BMS. The youth stated rewards include treats, movies, games, food, and additional phone time. Four youth stated staff use the rewards the consistently, and one youth was not sure.

5.03 Unauthorized Use of Punishment (Critical)	Satisfactory Compliance

The center's behavior management system (BMS) restricts certain types of penalties on youth who demonstrate negative behaviors.

Group punishment shall not be used as a part of the center's BMS. However, corrective action taken with a group of youth is appropriate when the behavior of a group jeopardizes safety or security, and this should not be confused with group punishment.

Corporal punishment shall not be used. All allegations of corporal punishment of any youth by center staff shall be reported to the Florida Abuse Hotline, pursuant to Chapter 39, F.S., and the Central Communications Center (CCC).

The use of drugs to control the behavior of youth is prohibited. This does not preclude the proper administration of medication as prescribed by a licensed physician.

The center's behavior management system (BMS) policy and procedures were reviewed. The center's BMS restricts certain types of consequences for youth who demonstrate negative behaviors. According to policy, group punishment is not used as part of the center's BMS. Corporal punishment is not used in the center. Any allegations of corporal punishment of any youth by center staff are to be reported to the Florida Abuse Hotline and the Department's Central Communications Center (CCC). Five staff interviews revealed only levels and points can be taken away from youth as a consequence. Each of the staff reported they have never seen a co-worker take meals, snacks, clothing, education, or medical care from a youth due to behavior. Four of the five staff revealed they have never observed any staff encouraging youth to beat up another youth. One staff who responded yes stated it was a few years ago, not recently. Five youth were interviewed. One youth stated they had been sent to their room for punishment. The other four youth stated they have not. The youth who had been sent to his room as a consequence stated door was shut and locked. Two of the youth stated consequences at the center were fair, one stated no, and two stated never receiving consequences.

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

The center utilizes an electronic wand to conduct ten-minute checks. The electronic wand records a digital record of each ten-minute check conducted by staff. A video review five days, on each mod, of ten-minute visual observations of youth by the center's staff during youth sleep time and confinement determined staff conducted the required visual observations within the required timeframe. The center utilizes four mods, G one, B one, B two, and B three. Observations included staff completing visual observations during the youth's sleep time. Staff maintained constant sight and sound of youth, as needed. Five staff were interviewed. All staff reported checks are completed every ten minutes. The superintendent stated staff conducts ten-minute checks every ten minutes while youth are sleeping.

5.05 Census, Counts, and Tracking	Satisfactory Compliance
Officers must know the exact number and location of all youth under their supervision at all times. Census counts of youth shall be taken, called into Master Control, and documented, at a minimum: • *At the beginning and end of each shift.* • *Following any emergency to include power outages, evacuation due to emergency drills, and any code called outside the secure walls. In the event a code is called in any location outside the main walls of a facility, it is critical all youth counts are reconciled prior to the movement of any group of youth.* • *Prior to and following routine group movement.* • *Any time a population change occurs.* • *Randomly, at least once on each shift.* *Staff should not include youth in the count who are not physically present with the staff person at the time of the count (e.g., court, clinic, confinement).*	

Daily observations during the annual compliance review determined census counts of the youth were taken. A two-way radio was utilized, the juvenile justice detention officers and master control documented the head counts at beginning and end of each shift, as well as any disturbances, routine group movements, count changes, and random head counts. A review of facility logbooks documented head counts, youth movements, and daily census were documented, as required. All five interviewed staff stated emergency counts are conducted

when a youth is not accounted for or after a disturbance. Staff stated all movement of youth stops until all youth are accounted for.

5.06 Logbook Maintenance	**Satisfactory Compliance**
The center maintains a chronological record of events, incidents, and activities in logbooks maintained at master control and in each living area in accordance with Florida Administrative Code. Each logbook is a bound book with numbered pages. If electronic logbook software is used by the facility, it is password-protected and configured to prevent entries from being deleted or altered after they are saved. *At a minimum, each logbook entry includes the date and time of the event, the names of staff and youth involved, a brief description of the event, the initials of the person making the entry, and the date and time of the entry. Logbook entries are made in black or blue ink, with no erasures or whiteout areas. No logbook entries are obliterated or removed; errors are struck through with a single line and initialed by the person correcting the error.* *Log entries regarding Medical, Special Needs, and Mental Health alerts, or other issues impacting facility safety and security shall be highlighted.*	

The center has a policy and procedures in place related to logbook maintenance. The center has separate written logbooks for master control, each youth module, contracted staff, and visitors. Master control and all module logbooks were reviewed from the past six months. All entries by staff were written in black or blue ink with no erasers or white out used. All errors were struck through with one line and initialed by staff. The master control logbook captured admissions, releases, emergency situations, incidents involving youth, monthly drills, facility counts, confinement, youth movement, Center Communications Center (CCC) calls, and all other information involving the facility. The date, shift, and supervisor on-duty were included in the heading of each page of the logbook. Youth placed on precautionary and/or secure observation and close watch, as well as the time of the precautionary and/or secure observation began and the time the observation ended were documented in the logbooks. The center does not use an electronic logbook.

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

The center has a policy and procedures in place related to logbook reviews. A review of the center's logbooks for the past six months revealed the superintendent or designee reviewed each logbook on a weekly basis. Each module logbook was reviewed daily by each shift supervisor. There was documentation indicating the superintendent or designee toured each of the youth living areas at least once during each consecutive shift. There was documentation

reflecting the juvenile justice detention officers (JJDO) reviewed the logbook maintained in assigned living areas when accepting responsibility for living area at shift change. An interview with the superintendent revealed all logbooks are reviewed at least weekly.

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

The center has a policy and procedures regarding key control. An observation of the center's key control was conducted. The center's keys were maintained in a secure metal storage box located on the wall inside of master control. The administrative staff, which includes education, maintenance, nursing, mental health staff, shift supervisors, superintendent, and assistant superintendents, sign out keys inside master control. Emergency keys are stored in a separate locked cabinet inside master control. Only administration and supervisors have access to emergency keys. Juvenile justice detention officer (JJDO) keys are distributed by the supervisor, issued to staff during shift briefing by the oncoming shift supervisor. All staff keys were maintained on a tamper-resistant key ring and a number was inscribed on the ring to indicate how many keys are on the key ring. Shift supervisors document keys issued on a log and the information is entered into the Department's Facility Management System (FMS). All keys are returned by the JJDO at the end of each consecutive shift. This process was observed during the annual compliance review and found to be conducted correctly, according to policy. The facility emergency, medical, mental health, and detention staff keys are located and maintained in the master control. The center utilizes key logs to document the shift, to whom each key is given to, and the key number.

Ten reviewed staff (five pre-service and five in-service) training records reflected each staff completed key control training. Supervisors are responsible for issuing keys to staff and ensure the keys are accounted for during their shift. Observations confirmed JJDO supervisors were responsible for their issued keys and keys were accounted for during the shift. Youth were not observed to have control of the keys at any time during the annual compliance review. There were no incidents related to keys control at any time during the annual compliance review. If keys are lost or missing, a diligent search is conducted, and the Department's Central Communications Center is contacted within two hours of gaining knowledge of the lost or missing keys. If keys are damaged, the superintendent and maintenance is notified.

The superintendent interview revealed permanent keys are not issued to any staff. Five staff were interviewed in which each explained the center's daily key control, and the damaged, and/or missing key process. Each staff stated the master control operator and the supervisors

are responsible for tracking all keys. Each staff member was able to describe and identify the restricted keys within the center as medical records, master control, youth property area, mental health records, case management records, and the kitchen. The five staff stated youth do not have access to any keys.

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

The center has nine vehicles utilized to transport youth. During the annual compliance review period, there were no transports of youth due to all courts utilizing Zoom during the COVID-19 pandemic. The vehicles were inspected during the annual compliance review. Documentation reviewed for the past six months reflected the maintenance staff conducted weekly visual checks and monthly vehicle checks. The first-aid kits in the vehicles were inspected were up-to-date with no expired contents. All vehicles were free of contraband and the registrations were contained within the vehicle logs. Each vehicle was found locked when not in use. The transportation supervisor stated vehicles are searched before and after each transport. Five interviewed youth revealed they felt staff drive safely when transporting youth. The youth revealed they have never seen anyone place contraband in a transport vehicle.

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

The center has a policy and procedures for tool inventory and management. The policy includes guidelines for the storage of kitchen knives or other hazardous sharps. The center utilizes a locked secure storage room located inside the center's main hall; however, the center is in the process of relocating the tools to an outside storage building. There were no broken tools or discrepancies found during observations. There were no documented instances of lost tools. Reviewed documentation revealed each tool was inspected monthly. The kitchen stores sharp tools in a locked drawer. Reviewed documentation determined each tool was accounted for and inventoried daily and monthly. Maintenance tools were marked and placed on a shadow board. A review of the center's policy on maintenance and kitchen tool, as well as observations of the tool inventory determined staff followed the required procedures for tool inventory and management. Five interviewed youth reported they are allowed to use brooms and mops. Five interviewed staff revealed if a tool is damaged or missing, all youth movements are stopped and a thorough search of all youth, staff, and the center is conducted immediately. The superintendent interview revealed the maintenance mechanic and administration have access to facility tools.

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

The center has a policy and procedures addressing youth access to and use of tools and cleaning items. Youth are prohibited from using any medical equipment, kitchen, or maintenance tools, except for mops and brooms, under direct staff supervision. The center utilizes four living areas, G One, B One, B Two, and B Three. Observations reflected each mod was clean and fresh to the smell. All five interviewed youth stated they are allowed to use mops and brooms. Each of the five interviewed staff stated youth are allowed to use mops and brooms under direct staff supervision. Two staff responded youth may be allowed to use scrub brushes, if available, also under supervision.

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

The center has a policy and procedures which addresses the inventory of all flammable, toxic, caustic, and poisonous items. The center utilizes two locations for storage of flammable, toxic, caustic, and poisonous items. One storage area is located on facility grounds, inaccessible to youth, and the other is securely located inside the facility in the maintenance tool room. The materials and items stored inside the facility are in the process of being relocated. The flammable, toxic, caustic, and poisonous items were inventoried. Reviewed documentation indicated all inventoried items matched the actual items located on-site. The safety data sheets (SDS) were reviewed and an SDS was found for all chemicals present. The center's safety plan includes established procedures appropriate to address a chemical spill or injury while handling dangerous materials.

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

The center has a policy and procedures which addresses access to all flammable, toxic, caustic, and poisonous items. All hazardous chemicals are stored in two secured areas inaccessible to youth. Youth were not observed using any chemicals during the annual compliance review. Five interviewed youth stated they do not use any type of cleaning agents. Each of the five interviewed staff stated youth are not allowed to clean with substances considered toxic, flammable, or poisonous. One storage area is located outside of the facility grounds inaccessible to youth, and the other is securely located inside the facility in the maintenance room which is in the process of being relocated.

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

A review of the center's facility operating procedures determined the center has a process for handling all hazardous items and toxic, materials and procedures, explaining the disposal of flammable, toxic, caustic, and poisonous fluids and other dangerous substances in accordance with Occupational Safety and Health Administration (OSHA). Observations of the flammable, toxic, caustic, and poisonous fluids and other dangerous substances determined substances were stored in a secure area inaccessible to youth located outside in a small metal storage unit. The maintenance personnel are responsible for diluting, handling, and disposing of hazardous waste materials. The center reports there were no chemical spills or disposal of flammable, toxic, caustic, or poisonous items in the past six months. There were no observations indicating kitchen waste was disposed of inappropriately. A local land fill is designated for disposal for any hazardous waste. An interview with the maintenance manager revealed the center's practice is to dispose of flammable, toxic, caustic, and poisonous items and materials in accordance with OSHA.

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

The center has a policy and procedures regarding the use of confinement under twenty-four hours. The center utilizes four living areas for confinement, G one, B one, B two, and B three. Nine confinements under twenty-four hours were reviewed. The juvenile justice detention officer supervisor (JJDOS) approved all confinements prior to the youth's placement in confinement. All confinement rooms were searched and determined to be free of obstructions and were deemed

safe for youth to enter. Each youth was given snacks and/or meals while in confinement. Supervision was documented on the Visual Observation Report forms every five minutes for the first hour, as required. While in confinement, the youth received an initial confinement review with the shift supervisor within the first two hours, as required, and documented the review in the Facility Management System (FMS). The reviews contained all required elements and were entered into FMS within the required time frame. The superintendent or designee conducted a review of all the confinements within twenty-four hours and made the determination to continue or end the confinement. Each youth was counseled with by the superintendent or designee prior to release from confinement. All youth in confinement had access to medical and mental health care, education, showers, clothing, and large muscle exercise. None of the rooms utilized had any safety hazards. Only one youth was placed in a confinement room at a time.

Five staff members were interviewed, and each stated when a youth is placed in confinement, staff complete a confinement report, conduct and document ten-minute checks, and search the confinement room. Three staff reported five-minute checks are conducted during the first hour. Two of five staff interviews revealed youth placed in temporary confinement are provided education materials.

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

A review of the Facility Management System (FMS) revealed the center had one youth confinement over twenty-four hours. An interview with the major determined the supervisor failed to communicate the release of the youth from confinement resulting in the youth remaining in confinement for approximately five minutes past the twenty-four hour mark.

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

The center has a Continuity of Operations Plan (COOP) to ensure the center is prepared to manage emergency and disaster situations. The center utilizes a binder to maintain the COOP Drills. The center had documentation indicating the required COOP drills were completed, as required, and documented all required elements. The drills were documented in the facility logbooks. Five staff were interviewed and state they have participated in facility drills as follows: Five out of five report participation in weather, major disturbances, bomb threat, hostage situations, chemical spills, flooding, escape, and fire drills. Four reported they have also participated in a terrorism drill.

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

The center has a policy and procedures addressing escapes and escape drills. The center has an escape prevention plan which includes all required elements. The center conducted and documented quarterly escape drills for each shift during the annual compliance review period. The drills were documented in the master control logbook, as well as a binder which contained all documentation regarding the drills. Each of the five interviewed staff received escape prevention training annually. All staff stated they participated in an escape drill.

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

The center has a policy and procedure addressing fire drills. A review of the center's fire prevention plan determined the center has implemented a disaster preparedness plan. The center utilizes a binder to maintain documentation of fire drills. Drills were conducted monthly, facility-wide, and on each shift. Drills were documented in the facility logbook. Four fire extinguishers were observed, and all were up-to-date on inspections. All five interviewed staff stated they participated in fire drills within the last six months.