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): December 10-13, 2019

Promoting Continuous Improvement and Accountability
in Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Amy Hutto, Office of Program Accountability, Lead Reviewer (Standard 1)
Mike Marino, Office of Program Accountability, Regional Monitor (Standard 4)
Christi Stua, DJJ Detention Services, Senior Management Analyst (Standard 3)
Craig Swain, Office of Program Accountability, Regional Monitor (Standard 2)
Warren Garrison, Office of Program Accountability, Regional Monitor (Standard 5)

Program Name: Volusia Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: Volusia County / Circuit 7
Review Date(s): December 10-13, 2019

MQI Program Code: 139
Contract Number: N/A
Number of Beds: 50
Lead Reviewer Code: 157

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
4.02 Facility Operating Procedures	5.07 Vehicles and Maintenance
4.15 Medication Management	

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

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

Standard 2: Youth Management
Detention Rating Profile

Indicator Ratings

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

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

Indicator Ratings

Standard 3 - Mental Health and Substance Abuse Services		
3.01	Designated Mental Health Clinician Authority (DMHCA)	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 *	Non-Applicable

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Standard 4: Health Services
Detention Rating Profile

Indicator Ratings

Standard 4 - Health Services		
4.01	Designated Health Authority/Designee*	Satisfactory
4.02	Facility Operating Procedures	Limited
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	Limited
4.16	Medication/Sharps Inventory and Storage Process	Satisfactory
4.17	Infection Control/Exporsure Control/Education	Satisfactory
4.18	Prenatal Care/Education	Satisfactory

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Standard 5: Safety and Security
Detention Rating Profile

Indicator Ratings

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

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Program Overview

Volusia Regional Juvenile Detention Center is a state-owned detention facility, operated by the Department, located in Daytona Beach, Florida. The center serves youth in Flagler, St. Johns, and Volusia 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, seven juvenile justice detention officer (JJDO) supervisors, and forty-five JJDOs. Mental health and healthcare services are provided through the contracted provider, Camelot Community Care, Inc. Mental health services are provided by a licensed marriage and family therapist (LMFT) serving as the designated mental health clinician authority (DMHCA). 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 through the contract provider, Maxim Health Services, Inc. Medical services are provided by a medical doctor who serves as the designated health authority (DHA), one advanced registered nurse practitioner, one registered nurse, and three licensed professional nurses. 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, of which forty-eight were operational. At the time of the annual compliance review, the center had four vacancies, which included one JJDO supervisor, and three JJDOs.

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 contract provider may hire an employee to a position which requires background screening before the screening process is completed, but only for training and orientation purposes. However, these employees may not have contact with youth or confidential youth records until the screening is completed, the rating is eligible and the employee demonstrates he or she exhibits no behaviors which warrant the denial or termination of employment. An Annual Affidavit of Compliance with Level 2 Screening Standards is completed annually.	

Since the last annual compliance review nineteen new employees were hired. Each had a background screening prior to hire. Two were deemed eligible with charges and received exemptions prior to hire. Eighteen of the nineteen employees were direct care workers and had a pre-employment assessment tool completed. Each had a passing score with the exception of one. This employee received an exemption from headquarters to be hired with no additional training required. Three contracted employees were hired, and each was background screened prior to hire. Twelve volunteers or interns started at the detention center since the last annual compliance review and each received a background screening prior to their start date. The Annual Affidavit of Compliance with Level 2 Screening Standards was completed and sent to the Background Screening Unit on January 10, 2019. An Annual Affidavit of Compliance with Level 2 Screening Standards for teachers was completed January 7, 2019.

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.	

Five employees were eligible for a five-year background rescreening. Each of the five year rescreens were completed five years from the agency hire date and submitted to the Background Screening Unit (BSU) at least ten days prior to the five-year anniversary. There was one contracted employee who required a five-year rescreen. This occurred as required and was submitted to the BSU at least ten days prior to the five-year anniversary. One volunteer was due for a five year rescreen, but it has not occurred. This volunteer has not volunteered at the center since the background screen expiration. This volunteer is currently out of state and upon return will sign the rescreen form to have it submitted.

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 detention center adhere to a code of conduct which prohibits any form of abuse, profanity, threats, harassment, intimidation, "horseplay", or personal relationships with youth. Seven staff were reviewed, and each signed a code of conduct upon hire. Three staff were reviewed for disciplinary actions regarding violations to the code of conduct. Each received a written warning. The center also recognizes employees and provides commendations such as employee of the month. Three employees were reviewed who had received the commendation of employee of the month. Seven youth were interviewed regarding their ability to report abuse since they have been at the detention center. All seven indicated they have never had to report abuse. Seven youth were asked if staff are respectful when talking to youth. Six reported yes, and one reported no. This youth indicated some staff are very rude, call youth names, and take the level three food or snacks. Upon further questioning it was revealed food is not actually taken from youth, but rather they are not making the level to receive the additional incentive. The seven youth were also asked how often they have heard staff use curse words when speaking with youth. Three stated never, one stated once, one stated occasionally, and two stated often. Six youth reported they have never heard staff threaten themselves or other youth. One youth indicated he had heard staff threaten other youth, the youth he stated he heard staff threaten was also interviewed, and denied he was ever threatened by staff. Six youth stated they feel safe at the detention center; one indicated he did not feel safe due to a particular staff member. His concerns were reviewed and discussed with the superintendent. The superintendent has arranged for the staff to be assigned to not supervise the group this youth is in. Seven staff were interviewed and six reported never hearing a staff use profanity when speaking with youth, and one reported once. All seven 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, one staff indicated it has been very poor, three stated fair, one said good, and two reported very good. The superintendent confirmed the center's facility operating procedure outlines the code of conduct with the purpose of ensuring staff communicate and interact with youth as role models. Violations of the code of conduct will be investigated, and the officer may face disciplinary action up to 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, there were twenty reports to the Central Communications Center (CCC) and five were reviewed. Each was reported within two hours of the incident. All five were documented in the master control logbook. There were no additional internal incidents or grievances which should have been documented to the CCC. Since the last annual compliance review, there were thirty-six incidents reported to the CCC. The program has not experienced an increase in the number of reportable incidents to the CCC. Seven 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 notify a supervisor, three stated the supervisor would make the call, one stated staff are allowed to call, all seven reported the youth is allowed to make the call.
The superintendent confirmed the center calls in 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 completed and filed in accordance with the Florida Administrative Code.	

Since the last annual compliance review, there were seventy-six Protective Action Response (PAR) incidents. A review of seven incidents was conducted by the annual compliance review team member. Each of the reports were completed by the end of the staff members workday. The reports each included statements from all staff who were involved. None of the seven required the use of mechanical restraints. None of the PARs resulted in a serious injury to youth or staff and none of the youth alleged abuse. Each of the seven incident reports were reviewed by a supervisor and a PAR instructor determining the use of force was consistent with policy. In each report, the post-PAR interview was conducted with the youth by an administrator, or designee, no longer than thirty minutes after the incident occurred. None of the seven reviewed indicated the youth was in distress and a medical review was necessary. In each case the superintendent or designee reviewed the report, after all other reviews, and made comments within seventy-two hours. 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 19.78 which is below the statewide Detention PAR rate of 23.40. The PAR rate has increased since the last annual compliance review. Seven staff were asked if staff try to talk to youth prior to using physical restraints or mechanical restraints; six indicated yes, and one stated no. The superintendent stated the process for monitoring PAR incidents is completed by supervisors and administrators reviewing video and reports for all PAR incidents, and commenting on the staff's use of PAR.

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.	

Seven staff were reviewed for pre-service requirements. All seven were certified within 180 days of hire. All seven received Protective Action Response (PAR) training within ninety days of hire. All seven also received the following essential skills prior to being in the presence of youth: 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 of Juvenile Justice (DJJ) detention facility operations including unit log, admissions, and releases. In addition, as part of phase one training the following trainings were completed by each of the seven staff reviewed: essential skills, orientation, information security awareness, legal, DJJ: the organization, gang awareness, interpersonal/communication skills, detainee behavior and consequences, and active shooter training. Each completed phase two training through completion of the academy which consisted of 120 hours. All training was documented in Department's Learning Management System (SkillPro).

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

Seven staff records, including three supervisors, were reviewed for in-service training which reviewed the training completed in the 2018 calendar year. All had completed over twenty-four hours of training. Of the seven staff, five had completed the Protective Action Response (PAR) update. All seven had completed cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), and first aid training. Six of seven had completed suicide prevention training to include two hours of the Department's Learning Management System (SkillPro) training and four hours of instructor-led or webinar training. One staff did not receive the four-hour instructor-led or webinar portion of the training. All seven had completed ethics and active shooter training. Three supervisory staff records were reviewed for training. Each had completed between eight and twelve hours of supervisory training which covered the following topics: management, leadership, personal accountability, employee relations, and communication skills. All supervisory in-service training was documented in SkillPro. The superintendent indicated he has completed all of the SkillPro management training, and staff at the center complete mandatory training such as PAR, CPR and first aid, and the required courses in SkillPro. The last annual compliance review was conducted in January 2019 and reviewed calendar year 2018 for training also. Deficiencies were identified during the last annual compliance review regarding in-service training and the detention center has implemented corrective action to ensure all staff are receiving the required annual trainings.

1.08 Entering Alerts (JJIS) and Sharing of Alert Information (Critical)	Satisfactory Compliance
Superintendents shall ensure Critical and Special Alerts are reviewed and responded to appropriately. *Upon completion of the Admission Wizard, the officer shall ensure all Critical and Special Alerts are listed in JJIS.* *The JJIS alert report shall be reviewed daily by supervisors and administrators to ensure it correctly reflects the status of youth.* *If the electronic system is inoperable, for any reason, the JJDO Supervisor shall ensure the last hard copy of the alerts shall have a written notification or update of the recent admissions or changes to existing alerts on the alert sheet and distribute to all staff within the center immediately.* *Medical and mental health staff shall review alerts to ensure each alert is correctly tracked and managed.* *The responses and updates by medical, mental health and other staff should be documented in JJIS alerts as they pertain to the specific alert.* *JJDOS's shall inform staff of alerts during shift briefing. When a JJDOS receives changes to the alert list, he/she shall notify the staff affected by changes and add the information to the shift briefing for the oncoming shift upon receipt of the information.*	

Seven youth records were reviewed regarding alerts. Each alert was entered into the Department's Juvenile Justice Information System (JJIS) immediately when a youth entered the center and was identified to have suicide risk, mental health, substance abuse, physical health, or a security risk factor. The JJIS alert report is reviewed daily by supervisors and administrators. During shift briefing alerts are reviewed with staff members and staff are provided an alert list. Seven staff were interviewed to determine how they are informed of alerts. All reported they are informed during shift debriefing and provided an alert list. All staff stated shift debriefings are how management informs staff about issues within the center, one stated through alerts, one through meetings, and one stated through emails. The superintendent reported all medical alerts are placed in JJIS and alerts are reviewed at the beginning of each shift during shift briefing. He further stated alerts 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, frisk searched, and stripped searched by an officer of the same sex as the youth.* 3. *All youth shall be allowed to place a telephone call at the center's expense to his/her parent/guardian and the call shall be documented on all applicable forms, or document refusal to make a telephone call.* 4. *If the admission process is completed two hours or more before the serving of the next scheduled meal, youth shall be offered something to eat.* 5. *All youth shall be screened to identify medical, mental health, and substance abuse needs.*	

The center has a written policy and procedures concerning youth being admitted to the center. A review of seven youth records revealed, each contained an arrest affidavit and Suicide Risk Screening Instrument (SRSI). Six youth records also contained a Detention Risk Assessment Instrument (DRAI); however, the remaining youth was transferred from another center on a court order and the DRAI was in the Department's Juvenile Justice Information System (JJIS). Each youth record contained assessments for medical concerns, substance abuse, and mental health issues documentation of the youth being electronically searched, frisk searched, and strip searched by an officer of the same gender, a meal was provided along with a phone call to the youth's parent/guardian. An admission was observed, the youth was provided the opportunity to make a telephone call to their parent/guardian and the youth was provided a snack given by the juvenile justice detention officer (JJDO). A review of the JJIS Admission Wizard indicated it was updated, as required. The JJDO also completed the orientation process with the youth and had the youth sign all the required documentation.

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 written policy and procedures regarding youth orientation. A review of seven youth records revealed, each youth was advised both verbally and in writing of the orientation process. Each record contained documentation supporting orientation was provided to each youth on the day of admission. Each record provided documentation of the rules and regulations, grievance procedures, visitation, telephone calls, youth rights, the behavior management system and related consequences, how to access the Florida Abuse Hotline, Prison Rape Elimination Act (PREA), including medical, mental health and substance abuse concerns and how to access the services. Seven youth were interviewed, and all indicated staff provide youth information about the center's rules and regulations, daily schedule, education services, visitation, abuse reporting, and behavior management system. An observation of one youth admission confirmed the orientation process addressed all areas.

2.03 Classification	Satisfactory Compliance

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

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

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

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

The center has a written policy and procedures concerning youth classification upon admission to the center. The policy requires staff to evaluate youth based on age, physical characteristics, level of aggression, special needs, behavior, gang, criminal behavior, history of sexually aggressive behavior or potential for victimization, suicide risk, and human trafficking involvement. Seven youth records were reviewed, and documentation reflected each contained the supporting documentation needed to ensure youth safety and security while in secure detention. The center assigns a juvenile justice detention officer (JJDO) to the intake unit to conduct the admission, orientation, and classification process. The staff completed the admission wizards in each of the seven youth records reviewed. Documentation supports staff took into consideration the requirements outlined in the policy prior to making room assignments.

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 written policy and procedures concerning juvenile probation officer circuit gang representative notifications. A review of seven youth records revealed none of the youth were suspected gang member or gang associates, the center was not able to provide any records of youth suspected of gang involvement. According to the center's gang liaison, it is his responsibility to email the juvenile probation officer (JPO), the JPO supervisor, and the superintendent detention officer when a youth is suspected of gang involvement. The emails are required to contain documentation or potential evidence supporting the suspicion of gang involvement. According to the gang liaison, law enforcement can only validate a youth a gang member or associate.

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 written policy and procedures concerning youth property upon admission to the center. Upon admission to the center, youth's property is taken and staff and youth complete and sign a Property Receipt form. The youth's Property Receipt form is attached to the property. If the youth has valuable property, it is removed and placed in a clear tamper-proof bag with the youth's name, date, identification number, and items placed in the corresponding valuable property locker located in master control. A drop safe is maintained where any money is placed with a logbook to account for the youth's name, date, and amount of money and staff who dropped the currency placed in the drop safe. Seven youth records were reviewed, each contained a signed Property Receipt form and a letter of acknowledgment regarding unclaimed property. An admission was observed during the annual compliance review. The staff took the youth's clothes and shoes then placed the items in a brown paper bag. The paper bag was then placed in a mesh bag and placed in the property room. The youth did not have any valuables or cash. Seven interviewed youth reported when they arrived at the center, the staff checked their personal property and they signed a form stating the personal property was correct. An interview with the superintendent revealed the staff are trained on securing property and clothing is kept in the property closet, personal items are kept in master control, and money is placed in a safe.

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 written policy and procedures concerning storage of youth property upon admission to the center. A review of seven youth records, the storage of their personal property, and storage of their valuables was conducted. Each room containing youth items was secured and under video surveillance, access to the property is limited to supervisors and center administration. Each bag contained the inventory of items within. The center utilizes a drop box where money is placed with a logbook to account for the youth's name, date, amount of money, and staff who dropped the currency placed in the drop safe. Valuable property is placed in a clear tamper-proof bag with the youth's name, date, identification number, and items placed in the corresponding valuable property locker located in master control. There has not been any Central Communications Center (CCC) incidents involving youth personal property during the annual review period. The superintendent reported only administration staff has access to money and the supervisors have access to the personal property in master control. The unclaimed property is disposed of after thirty days of not responding to the notification letter. The superintendent provided documentation confirming unclaimed money is exchange for a money order and the money order is sent to detention headquarters.

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 written policy and procedures concerning youth being release from the center. The release of two youth was observed, and review of one closed record was conducted. The juvenile detention officer verified all court orders and release paperwork, and the on-duty supervisor reviewed and approved all paperwork related to the release, prior to youth's release. Each of records indicated the youth identification was verified, the parent/guardian identification was verified, and a copy of the identification card was placed in the youth records. All applicable forms were signed prior to the actual release from secure detention. Youth was also provided information concerning future court dates and requirements. A review of the Central Communications Center (CCC) reports and informal interviews with staff confirmed there were no unauthorized releases since the last annual compliance review.

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

The center has a written policy and procedures concerning the release of youth's personal property upon youth's release from the center. Three closed youth records were reviewed for release procedures. Each record contained a copy of the identification of the person taking custody of the youth, a copy of the release wizard checklist, and a signed property receipt acknowledging the youth's property was returned. All the youth's personal property not picked up within thirty-days is considered abandoned. The program holds youth money for ninety days in an attempt to return youth their money. After thirty days, the program mail letters to the known address in attempts to get the family to pick up property. Unclaimed personal property such as clothes are donated to Goodwill and valuables such as money is forward to the detention headquarters in the form of a money order. The program maintains a property record of disposed cash forwarded to headquarters. If the youth is on probation, the assigned juvenile probation officer is asked to sign for and deliver the property to the youth. A review of three applicable closed youth records reflected the youth and the parent/guardian signed a receipt of property form upon release. The superintendent and administrative staff were interviewed, and they are aware of how unclaimed property is to be handled. A release was observed and during the release, the youth and parent/guardian signed the property receipt form acknowledging the return of the youth's property.

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 written policy and procedures concerning youth being released from the center with medication. A review of three applicable closed youth records contained documentation verifying the parent/guardian signed documentation acknowledging they received the youth's medication from staff. In addition, the parent/guardian was reminded of health, mental health, and substance abuse concerns including pending appointments.

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 written policy and procedures concerning review of youth in secure detention. During the annual compliance review, the weekly detention review was observed. Nineteen stakeholders were represented which included, but not limited to, the Department of Juvenile Justice probation officers, school board staff, and the Department of Children and Families. The center's staff discussed each youth's detention placement, release dates and placement upon release, and information needed regarding placement. The staff also reviewed alert information, each youth's future court dates, and/or transportation needs. Weekly treatment team meetings were incorporated into the detention reviews. An agenda, sign-in sheets, and any pertinent issues discussed with follow-up questions were maintained in the treatment team/detention

review documentation. An interview with the superintendent confirmed the weekly detentions reviews take place at the center on Wednesdays in the conference room.

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

The center has a written policy and procedures concerning the daily activity schedule. A review of the daily activity schedule confirmed the center provided the opportunity to participate in constructive activities which will benefit all youth at the same time, allowing the maximum use of staff for proper supervision. The schedules are posted in all of the modules, and general use areas in the center. The master schedule includes hygiene times, meal times, visitation dates, phone calls, education, and center activities to include recreation, volunteer activities, group therapy such as restorative justice, and gender-specific programming. Seven interviewed youth reported the center has a daily activity schedule. Four youth reported the schedule is followed. One youth reported meal times vary from day to day, one youth reported youth stay in their mod until it is time to go to sleep after school, the remaining youth reported some days they miss school. A review of the logbooks, schedule, education, and staff interviews did not support the youth's statements.

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 written policy and procedures concerning the daily activity schedule. Observation of the daily activities and a review of master control logbook confirmed the center is following the daily activity schedule; however, in some instances they were a few minutes late to the activities. Shift change was observed during the annual compliance review, in which the supervisor engaged staff in an open dialog. The topics discussed included which youth conflict with others, grievance process, abuse reporting, 9-1-1 calls, alerts, visitation, ten-minute checks, movement, changes in the schedule, and the behavioral management system. Seven staff were interviewed reporting the center follows the daily schedule.

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 incorporates a daily school schedule including 300 minute blocks a day, with classes being held Monday through Friday. This schedule, which has been approved by the school district, reflects twenty-five hours of instruction a week and is distributed over 250 days throughout the year. The original approved schedule included ten days for teacher planning and

training; however, three of those days have been converted into school days to make up for days missed during Hurricane Dorian. An interview with the lead educator revealed all youth are provided a schedule when they arrive and are enrolled in academic courses which can lead to course credit upon completion. Seven youth interviewed responded they attend school Monday through Friday and education is offered to them, mainly the core courses, but also a General Educational Development (GED) option. The superintendent and seven staff interviews indicated the daily schedule is followed and there is minimal interference of the school day. The master control log book was reviewed from March 12 through April 2, 2019 and from August 6 through August 16, 2019. Most days the program adhered to the school schedule, although there were several days one group did not arrive at school by the 8:00 a.m. start time. This was not indicative of one specific group and did not occur on a regular basis.

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 programming which incorporates communication, interpersonal skill and decision-making skills, as well as goal setting skills. Interviews with education staff revealed the center is providing the requirements for Type One Career Education to include life skills groups, activities, and instruction for the youth.

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

The center has a written policy and procedures concerning the behavior management system (BMS). The center utilizes a system of rewards, privileges, and consequences to encourage youth to follow the guidelines within the BMS. The behavioral norms and expectations for the youth are posted in all living areas outlining appropriate and inappropriate behaviors. Staff were observed interacting with youth while engaged in their daily activities in a professional and encouraging manner. Seven youth were asked to rate the center's BMS, three youth rated the system as good, three rated it as poor, and one rated it as very good. Six interviewed youth reported the BMS consequences were fair, the remaining youth reported never receiving consequences. Seven staff were interviewed, six stated the center's BMS is effective, the remaining staff does not believe it is effective due to youth in the center who are going to commitment programs do not care about the BMS. Four staff reported points can be taken as a consequence, three staff reported levels can be taken, and one staff reported snacks can be taken. Seven staff reported supervisors provide feedback to them regarding the implementation of the BMS. Seven staff reported receiving feedback concerning the BMS from their supervisor.

2.16 Unauthorized Use of Punishment (Critical)	Satisfactory Compliance

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

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

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

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

The center has a written policy and procedures concerning the behavior management (BMS) system which addresses the unauthorized use of punishment. The center's policy prohibits corporal and group punishment. The center has the phone numbers to the Florida Abuse Hotline and the Central Communications Center (CCC) posted throughout the center. Seven youth were interviewed concerning when consequences were given and what was taken away as a consequence; one youth responded points and two youth responded BMS levels were taken away, the remaining youth responded none or stated they never received consequences. All seven youth reported they are not allowed to punish other youth in the center. Five youth reported being sent to their rooms as punishment and all reported the door was closed and locked. Four youth reported handcuffs or leg irons are not used to prevent youth from hurting themselves or others, three youth reported not witnessing handcuffs or leg irons being used on youth. All seven staff reported, speaking with youth to discuss the consequences being imposed and allowing youth to explain their behavior and alternative acceptable behaviors. All staff reported youth meals, snacks, sleep, clothing, education and medical care cannot be taken from youth as a form of consequence, and have not witnessed youth being denied these things.. All staff reported never observing other staff encourage a youth to punish another youth.

2.17 Grievances	Satisfactory Compliance

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

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

The center 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 three phases, informal, formal, and appeal. 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. Appeal phase allows the youth to appeal the outcome of the formal phase to the superintendent or designee. A review of the center's grievances was conducted, the center had a total of five formal grievances of which four were reviewed. Each grievance was addressed within the required timeframe and handled appropriately with the exception of one, the grievance was not documented in the Facility Management System. Seven interviewed youth reported never submitting a grievance. Seven staff were interviewed concerning the grievance process and each demonstrated knowledge and awareness of the grievance process.

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

The center has a written policy and procedures concerning trauma-informed care practices. Staff receive training in trauma-informed care as part of their pre-service and in-service requirements. A tour of the center during the annual compliance review week confirmed the center has a soft room and numerous areas throughout the center painted in soft, soothing colors. The center has painted murals, and art work posted throughout the center which includes paintings, pictures, and drawings. The center also has a multi-purpose room where youth are allowed to play video games, watch television, play cards, and ping pong.

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 detention center. The DMHCA is responsible and accountable for ensuring appropriate coordination and implementation of mental health and substance abuse services in the facility and shall promote consistent and effective services and allow the facility superintendent and staff a specific source of expertise and referral.	

The 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 DMHCA is on-site forty hours a week and is on-call twenty-four hours a day which was confirmed by reviewing the center's logbooks. The DMHCA works for Camelot Community Care, Inc. and is contracted through Maxim Health Services, Inc. to work 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 as non-applicable.

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

The center is licensed under Chapter 397. The center has one non-licensed mental health professional (MHP). The non-licensed MHP has a master's-level degree in psychology from an accredited university. The non-licensed MHP works for Camelot Community Care and is contracted through Maxim to work for the Department. The non-licensed MHP is on-site thirty hours a week, Monday through Friday, and for ten hours a week on Saturday and Sunday. Documentation reflected the non-licensed MHP received twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. The training included the administration of five assessments of suicide risk conducted on-site in the physical presence of a licensed mental health

professional and documented on non-licensed mental health clinical staff person's training in Assessment of Suicide Risk form. The non-licensed MHP receives at a minimum, one hour a week of on-site face to face supervision provided by the designated mental health clinician authority (DMHCA).

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

The center has a written policy and procedure in place for mental health and substance abuse admission screenings. A review of seven youth records found documentation of each having a Suicide Risk Screening Instrument (SRSI) completed during admission process in the Department's Juvenile Justice Information System (JJIS). Each section of the SRSI was completed by the required parties to include the juvenile probation officer, juvenile detention officer and the mental health and/or medical professional. One youth record had partial documentation in the screening results section of the SRSI. Each record included documentation of the Massachusetts Youth Screening Instrument (MAYSI) and a Vulnerability and Sexually Aggressive Behavior (VSAB) being completed at intake. All records reviewed include responses requiring an Assessment of Suicide Risk (ASR) and placement on suicide precautions. All records contained documentation of mental health referrals. All records documented the ASRs were completed within twenty-four hours or less of the time of admission. The superintendent and designated mental health clinician authority (DMHCA) are 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 as having mental health and substance abuse issues or problems receive in-depth mental health and/or substance abuse assessment shortly after intake to the juvenile justice system.	

The center has a written policy and procedure for completion of mental health and substance abuse evaluations identified as needed at the time of admission. All records reviewed include referrals for evaluation. One record had a completed evaluation conducted by the detention provider, which was uploaded to the youth's Electronic Medical Record. The remaining six were not due at the time of the annual compliance review as the youth were in detention less than thirty days. The designated mental health clinician authority (DMHCA) maintains a comprehensive tracker to ensure the evaluations are received within the established timeframes. When the community provider has not completed an evaluation within thirty days, a mental health professional at the center completes the evaluation.

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

The center has a written policy and procedure for mental health and substance abuse treatment. Three records reviewed were applicable for treatment services. Each record contained a signed Authority for Evaluation and Treatment (AET). Each record contained documentation of referrals and mini-treatment team involvement and individual counseling sessions. All services provided were documented on Department's Office of Health Services (OHS) 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, commitment, education, medical, mental health, facility administration, community providers, and youth. Seven youth were interviewed regarding how they would rate the mental health and substance abuse services they have received at the center. One youth reported very good, one youth reported good, two youth reported fair, two reported very poor, and one youth reported they are 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 OHS forms and in the youth's chronological progress 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.

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

The center has a written policy and procedure in place for treatment and discharge planning. Three records reviewed were applicable for treatment and discharge planning. Each record contained the required referrals, Authority for Evaluation and Treatment, treatment plan (initial or individual) and were completed within seven days of the initiation of treatment. Psychiatric services included the medication(s) and frequency of monitoring. All treatment plans were developed and signed by the designated mental health clinician authority (DMHCA), youth, and mini-treatment team member(s). Parent/guardian notification or attempts to contact were documented on each record. During the review period treatment team was observed. Individualized treatment plans are developed for youth receiving mental health and/or substance abuse treatment in the center by the thirty-first day of the youth's admission. None of the youth

in the original sample were at the center long enough to be due for an individualized treatment plan. There was one example of a youth who was at the center long enough to require an individualized treatment plan. It was signed within ten days of completion by the licensed mental health professional and included the DSM-5 diagnosis, symptoms which were treatment focused, treatment goals, strength, psychiatric services, and pharmacological interventions. Progress notes validated the youth received treatment services as stipulated on the treatment plan. The plan was signed and dated by the following: youth, mental health professionals, treatment team members, and the parent/guardian were involved by phone. The individual treatment plan was reviewed every thirty days by the treatment team and noted no modifications were needed. The review was signed by the clinical staff, youth, and licensed mental health professional. Three closed treatment records appropriate for discharge planning were reviewed. Each record contained a Discharge Summary signed by the DMHCA and a mini-treatment team member. Copies of the summaries are mailed to parents/guardians and e-mailed to juvenile probation officers. If a youth is transferred to a residential facility, a copy is faxed to the program.

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 procedure in place for providing psychiatric services. Three records were reviewed for youth admitted with or reporting use of psychotropic medications. Each record contained a referral and current Authority for Evaluation and Treatment (AET). Each youth was evaluated within fourteen days of admission to the center. The psychiatrist utilizes the Department's Office of Health Services (OHS) forms for each evaluation. A review of the center's sign-in/sign-out logs confirmed the psychiatrist was on-site according to contract weekly and according to Florida Administrative Rule bi-weekly. The initial psychiatric interviews included all 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 on November 7, 2019 by the superintendent and designated mental health clinician authority (DMHCA) and is located in the conference room, where it is 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 as having suicide risk factors or identified through assessment as a potential suicide risk. *Any youth exhibiting suicide risk behaviors must be placed on suicide precautions (precautionary observation or secure observation), and a minimum of constant supervision.* *All youths identified as having suicide risk factors by screening, information obtained regarding the youth, or staff observations must be placed on suicide precautions and receive an assessment of suicide risk.*	

The center has a written policy and procedures in place for suicide prevention services. Seven records were reviewed, all required the completion of an Assessment of Suicide Risk (ASR). Each record contained a referral and ASR competed in twenty-four hours or less. Six of the seven records documented the youth were stepped down to standard supervision from precautionary observation. One record documented a step-down to close supervision. The Department's Juvenile Justice Information System (JJIS) alerts were entered and closed appropriately for all reviewed records. There were logbook entries for each youth being placed and removed from suicide precautions. Seven youth were interviewed regarding being placed on suicide precautions while at the center. All seven indicated they had been on suicide precautions and were observed by staff the entire time. Seven staff were interviewed regarding what to do if a youth expresses suicidal thoughts. All indicated the mental health authority would be notified. Additionally, six reported they would document the level of supervision being provided, two reported they would search the youth and their room for sharp objects, six reported they would provide constant sight and sound supervision, and four stated they would notify the supervisor or master control. All seven staff reported they were aware a suicide response kit was located in each sub control room, six reported there was one in master control, and three reported there was one in medical. None of the selected records were applicable for use of secure observation, additional records were reviewed. The three instances of use of secure observation found placement was authorized by the Superintendent/designee and the designated mental health clinician authority. The secure room assignment was in writing, a health status checklist was 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.

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. Seven youth records were reviewed and all 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 reviewed included documentation of safe housing requirements. Seven youth interviewed reported having been placed on suicide precautions, each stated they were in the presence of staff the entire time they were on suicide precautions.

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 seven staff training records found six had completed the required six hours of training. One staff did not have the required six hours of training. The center maintains a binder to document mock suicide drills. The drills are conducted on a monthly basis on each shift. (twenty-two out of forty-one staff reviewed have participated in four quarterly drills, ten have participated in three quarterly drills and nine have participated in two or less). Review of drills revealed direct care staff participated in at least one mock drill which included the use of cardiopulmonary resuscitation annually. Additionally, staff members who are not present have the opportunity to review each drill scenario and procedures in an effort to understand the process and receive the necessary training to respond to an incident of a suicide attempt or incident of serious self-inflicted injury in the facility. Seven staff were interviewed and six reported there is a suicide response kit in master control, seven reported in sub control and three reported in medical.

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 to include: notification and alert system use, means of referral (including self-referral), communication, supervision, documentation, and review. The plan was last reviewed and approved on December 6, 2019 by the superintendent and designated mental health clinician authority (DMHCA) and is located in the conference room, where it is 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 the center, requires emergency care to be provided in accordance with the center's Emergency Care Plan. The Crisis Intervention Plan and Emergency Care Plan may be combined into an integrated Crisis Intervention and Emergency Services Plan which contains all the elements specified in Rule 63N-1, Florida Administrative Code.	

The center 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 on December 6, 2019 by the superintendent and designated mental health clinician authority (DMHCA) and is located in the conference room, it is accessible to all staff.

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

The center has a written policy and procedures in place for the use of Crisis Assessments. There have been no instances of the mental health provider completing an assessment since the time of the last annual compliance review. The designated mental health clinician authority (DMHCA) has knowledge of the process and the required forms to be used should a crisis assessment be warranted.

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

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

Standard 4: Health Services

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

The center has a contract with Maxim Healthcare Services, Inc., to provide medical services at the center. The center has a board-certified physician who has a clear and active license, which expires January 31, 2020 and meets all the requirements to serve as the designated health authority (DHA). The DHA interview revealed the DHA evaluates and performs physical examinations for youth who require Comprehensive Physical Assessments or have acute or chronic conditions. A review of the sign-in logs for the past six months confirmed the DHA was on-site weekly for at least one hour. The DHA is available twenty-four hours a day, seven days a week by phone to address any medical concerns at the center.

The provider also employs an advanced practice registered nurse (APRN). The APRN holds a clear and active license to practice in Florida, which expires on July 31, 2020. The APRN provides services on-site twenty 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 APRN stated her role at the center is to complete Comprehensive Physical Assessments, conduct sick calls, episodic care when on-site, follow-up with youth who present with chronic or acute illnesses and management of youth with chronic or acute illnesses. A check of all licensed medical staff confirmed all had current State of Florida medical licenses, verified by the Department of Health.

4.02 Facility Operating Procedures [Contract Provider]	Limited 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 health-related services provided at the center. All FOPs and treatment protocols contained the signature of the designated health authority (DHA) and the superintendent, which was completed in August 2019. There was documentation of an annual review of all treatment protocols by the DHA and superintendent. The review of and development of FOPs, or other protocols related to psychiatric services was conducted by the psychiatrist. There was documentation of the two newly employed healthcare personnel receiving a comprehensive clinical orientation to the Department's healthcare policies and procedures; however, one was not signed by the personnel who conducted the training. There was documentation of three of the nursing staff, two registered nurses and the advanced registered nursing practitioner, signing a training document for Nursing Protocols: Use and Documentation. However, the document was signed on December 11, 2019, which was day two of the annual compliance review. There was no documentation of the nursing staff reviewing, signing, and dating a cover pager on which all FOPs, treatment protocols, and other procedures were listed annually. The center's previous annual review of the medical FOPs and protocols by all nursing staff was in April 2018.

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

A review of seven youth Individual Healthcare Records revealed six out of seven had an original signed Authority for Evaluation and Treatment (AET) filed in the record. The remaining youth's record had a legible copy, but it did not have "copy" written or stamped anywhere on the AET. The AETs were obtained prior to medical services being provided at the center.

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

A review of seven youth Individual Healthcare Records (IHCR) found each had documented parent/guardian notification. None of the seven youth required parental notification for over-the-counter medications not covered by Authority for Evaluation and Treatment form. Five youth required parental notification for new medication. Two youth required parental notification for off-site care, which included one instance of emergency care at the hospital. For each parental notification, there was documentation of telephone calls, attempted calls, and verbal approvals, which were witnessed. Written parental notifications were sent to parents/guardians as well, and many were returned signed by the parent/guardian. Two youth required a parental notification for a new psychotropic medication. A parental notification along with a Clinical Psychotropic Progress Note (CPPN) was completed in each case.

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

A review of seven youth Individual Healthcare Records found each youth received a medical and mental health admission screening for their most recent admission. Each screening was completed on the day of admission. Five youth were screened by a juvenile justice detention officer (JJDO). There was documentation of each screening being reviewed by a licensed practical nurse (LPN) or higher within twenty-four hours. The remaining two youth were screened by a registered nurse (RN). None of the youth had a change in their physical custody since their arrival to the center, requiring a healthcare admission rescreening. The superintendent interview revealed the medical and mental health admission screening is completed by the admitting JJDO and reviewed by medical staff within twenty-four hours. Two female youth were included in the sample and each consented to and received a qualitative urine pregnancy test.

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

A review of seven youth Individual Healthcare Records revealed each received 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 (use, how to access), what constitutes an emergency and who to notify, medication process and side effects monitoring, the right to refuse care and how it is documented, what to do in the case of a sexual assault or attempted sexual assault, and the non-disciplinary role of the healthcare providers.

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

A review of seven youth Individual Healthcare Records (IHCR) found three were applicable for notification to the designated health authority (DHA). The DHA received an immediate notification when youth were identified as possessing a medical concern or chronic condition. The notifications were documented in each youth's IHCR.

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

A review of seven youth Individual Healthcare Records (IHCR) found each youth had a Health-Related History (HRH) form completed within seven days of admission. One of the HRH forms was new and the other six were updated. All seven HRH forms were completed by a licensed nurse and reviewed by the designated health authority (DHA) or the advanced practice registered nurse (APRN). Each of the HRH forms were completed before the Comprehensive Physical Assessment (CPA).

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

A review of seven youth Individual Healthcare Records (IHCR) found each contained a current Comprehensive Physical Assessment (CPA) completed by the advanced practice registered nurse (APRN) or designated health authority (DHA). All CPAs were completed or reviewed within seven days of admission. Each CPA was reviewed, initialed, and dated by the designated health authority (DHA). If a youth refused any part of the exam, the clinician documented "Youth Refused." There was documentation of youth signing a Refusal of Care form to reflect the refused portion on the CPA, which matched the date of the exam. 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 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 them to be transported to the nearest hospital for further evaluation.

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

A review of seven youth Individual Healthcare Records (IHCR) found each youth was screened and evaluated for sexually transmitted infections (STIs). Three youth were tested for STIs, which was documented on the Infectious and Communicable Diseases form. A community provider conducts human immunodeficiency virus (HIV) testing at the center. All seven youth were offered HIV testing. None of the selected youth consented to HIV testing. Additional records were requested, and three were provided for review. There was documentation of the three youth consenting to HIV testing, receiving pre-test and post-test counseling, and being tested for HIV. The HIV test results are filed in the youth's IHCR in a confidential manner, until they are released. Upon release, youth are given the results to take with them. The nurse stated youth are asked at the time of intake if they want HIV testing. If a youth consents to testing, the community provider will provide pre-test counseling, draw blood, and provide post-test counseling. Seven youth were interviewed and all stated they could ask for an HIV test.

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

The center has a policy and procedures in place for the completion of sick calls. A review of seven youth Individual Healthcare Records (IHCR) found two youth requested sick calls. A review of the Sick Call Log provided the review team with two additional youth who had requested a sick call. 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. The sick call was conducted within twenty-four hours in each case. Three sick calls were conducted by a licensed practical nurse (LPN), and all were reviewed by a registered nurse within twenty-four hours. Sick calls were found to be documented on the youth's Sick Call Index and the center's Sick Call log. None of the youth presented a similar sick call complaint three or more times within a two-week period. 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 calls are scheduled Monday through Friday at 9:00 a.m. until 10:00 a.m. and 5:00 p.m. to 6:00 p.m., Saturday and Sunday 3:00 p.m. until 4:00 p.m., and as needed. There were no youth complaints regarding any severe pain with which medical staff were unfamiliar. During the annual compliance review, sick call was observed. One youth was escorted to the medical clinic by a Protective Action Response (PAR) trained supervisor. The youth was examined by a licensed medical staff in a private area, with no other youth present to hear or see the examination. Seven youth were interviewed. Three youth reported they never requested a sick call. One youth stated they could be seen within one day once the Sick Call Request was made. One youth stated they are seen within two days, and two youth responded it was three days or longer before being seen by medical staff. Youth who

had a sick call stated a nurse conducts sick calls. The medical department was rated as very good by two youth, good by two youth, fair by one youth, and very poor by two youth. Seven interviewed staff revealed the facility nurses conduct sick calls for youth.

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 the provision of episodic care, first aid, and emergency care. A review of seven youth Individual Healthcare Records (IHCR) found none of the youth received episodic/first aid care from a non-healthcare staff. The center reported there have not been any instances of non-healthcare staff providing episodic care. Seven instances of episodic care provided by medical staff were reviewed. The episodic care was documented in the Subjective, Objective, Assessment, and Plan (SOAP) format, though two did not include documentation of vital signs. Five of the seven instances of episodic care were documented in the Episodic Care Log. First aid kits were located in each sub-control, master control, intake, the kitchen, and each vehicle. There was documentation of the designated health authority (DHA) approving the contents of each first aid kit, as 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. In two of the first aid kits, expired items were replaced with current items, but the expired items were not removed from the first aid kits until the week of the annual compliance review. First aid kits in the vehicles were out of compliance for monthly monitoring and most of the contents were expired. The center reported the maintenance manager conducts the checks on first aid kits in vehicles and he was out for about three months.
The program has two automated external defibrillators (AED), which are located inside of the medical clinic and the B2/3 sub-control room. Both AEDs were tested and functional during the annual compliance review. There was documentation of the AEDs being checked monthly by medical staff. The pads expire on March 28, 2021 and the batteries expire in August 2021. The pads and batteries were installed on August 17, 2018. A review of the center's medical drills confirmed the center conducts emergency medical drills at least quarterly on each shift. The emergency drills included a CPR/AED demonstration at least once each quarter. All direct care staff had participated in emergency drills. Seven staff were interviewed and all reported they are able to call 9-1-1 if they feel necessary. All of the licensed healthcare staff have a current CPR/AED certification. A review of seven pre-service and seven in-service training records found all had current CPR/AED First Aid certification. The center has a list of emergency telephone numbers and cell phone numbers posted in master control, which is accessible to all staff.

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 for youth. A review of seven youth Individual Healthcare Records (IHCR) found three were applicable for off-site care. A Summary of Off-Site form was completed and filed in each IHCR, along with discharge instruction documents, when applicable. There was documentation of the designated health authority (DHA) being notified of the event in each IHCR. There was documentation of the DHA

reviewing the off-site care paperwork for each youth. All three instances of off-site care were documented on the Episodic Care Log. One youth required a follow-up appointment, which will occur after release. Release paperwork showed this youth's parent/guardian was informed of the follow-up appointment.

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

The center has a written policy and procedures for the delivery of treatment to youth identified as having a chronic medical condition. A review of seven youth Individual Healthcare Records (IHCR) found one youth was identified with a chronic medical condition and/or taking prescribed medications. Additional records were requested, and two were provided to the review team. Each youth was classified with a medical grade two through five. The nurse interview revealed the center monitors youth with chronic conditions by referring them to the designated health authority (DHA) at intake and every ninety days for periodic review, according to protocol. Each record documented an initial assessment of the youth was conducted by the DHA and the youth's chronic condition was monitored. None of the youth required a reevaluation, as none of the youth were in the center for ninety days. The Department's Problem List was updated in each of the IHCRs to identify the youth's chronic condition, as required.

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

The center has a written policy and procedures to ensure medication is received, stored, inventoried, and provided in a safe and effective manner. A review of seven youth Individual Healthcare Records (IHCR) found three youth were prescribed medication prior to their admission to the center. In each of the three IHCRs, the medication was brought to the facility by the parent/guardian, verified by medical staff, and the youth was continued on the medication(s). The center used the standard Department's Medication Administration Record (MAR)/Electronic Medical Record (EMR), to document administration and refusal of medications. The MARs documented all required information including demographic information of youth, medication start and stop dates, and staff and youth initials when medication was administered. There were no lapses or errors in medication administration. The medical staff document weekly side effect monitoring on the MARs. There was one youth refusal of medication, which was documented on the MAR and a Refusal of Care form. None of the youth required parenteral medication. There was documentation of the designated health authority (DHA), designated mental health clinical authority (DMHCA), and psychiatrist being notified upon admission when youth were admitted on psychotropic medication. The initial diagnostic psychiatric interview was conducted within fourteen days of admission. None of the youth required a reevaluation, as none were in the facility over thirty days, though documentation showed the psychiatrist monitored youth on psychotropic medication. A morning medication pass was observed during the annual compliance review. The registered nurse (RN) verified the Six Rights of Medication Administration (right youth, right medication, right dose, right route, right time, and right documentation). For oral medication, the RN verified the youth consumed the medication by checking his/her mouth, as did the staff providing supervision of the youth. In one instance, a youth received his topical acne medication and was allowed to leave the clinic

with the medication in a small cup. The supervisor took the medication from the youth and escorted him back to his group, which was in the dining room, and then gave the medication to the juvenile justice detention officer (JJDO) assigned to the group. The group was moved to the classroom some time later, and the JJDO still had the medication in the classroom. The youth was asked when he would apply his medication, and he stated he would at shower time, which was after school. The medication was then taken back to the clinic. Interviews with staff suggested youth place acne meds on their face after showers, and not in the clinic. The center has trained supervisors to assist in the delivery of medications when licensed staff are not on-site. Seven staff were interviewed, and all reported they do not give any medications to youth. Seven youth were interviewed. Three youth reported nursing staff gives them medication. The other four youth stated they do not take medications.

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

The center has a written policy and procedures ensuring medications and sharps are secured and inventoried utilizing a perpetual inventory. The medications and sharps were found stored and locked in designated areas inaccessible to youth. Medications are stored in a locked medication cart, cabinets, and in the locked refrigerator in the medical clinic. All controlled medications were found stored behind two locks. A shift-to-shift inventory count of all controlled substances was documented on the youth's individualized Controlled Medication Inventory Record. Random inventory reviews of three different sharps, three prescribed medications, and three over-the-counter (OTC) medications was conducted. Weekly and/or perpetual inventories were maintained, and each ending count was accurate. There was one miscount in the Ibuprofen log, but the actual pill count was correct. There was no controlled medication on-site at the time of the annual compliance review. The center provided controlled medication inventories for two youth previously in the center. The controlled medication inventories documented shift-to-shift counts were documented by nursing staff. In one case, the second shift count did not match the first shift for three days, but was corrected at the next inventory count. The other controlled medication inventory was properly completed. The center has a policy and procedures in place to identify and report discrepancies in the inventory. 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 (CDC) guidelines. The comprehensive education plan shall include pre-service and in-service training for all staff. Education for youth infection control shall also be provided at the time of intake and subsequently when the need is identified.	

The center has a written policy ensuring all staff and youth receive education on infection control. A review of the center's Exposure Control Plan confirmed the plan included all required

elements outlined in the Department's standards. The plan was reviewed and signed by the superintendent and designated health authority (DHA) in August 2019. 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. All training and education was provided in accordance with the Center for Disease Control and Prevention guidelines. A review of fourteen staff training records confirmed seven of seven staff received pre-service training on infection control and six of seven received in-service infection control training.

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

The center has a written policy and procedures in place for prenatal care for pregnant youth. The policy and procedures also address health education for youth and training for staff on healthcare issues for female youth. A review of seven pre-service and seven in-service staff training records found three staff did not receive in-service training on girls' healthcare. Seven of seven pre-service staff received training at orientation. There were no pregnant youth at the center at the time of the annual compliance review: therefore, three pregnant youth previously at the center were reviewed. All three youth were given appropriate prenatal care, beginning immediately upon confirmation of pregnancy. Medical reviews by the doctor were recorded within thirty days. All three youth were given the required prenatal education. All three youth were routinely monitored for weight and nutrition, which was recorded weekly on the youth's MAR.

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 the annual compliance review. Activities included youth in their assigned living units, line movements, and education. There was always a minimum of two staff supervising the youth. Notifications were sent to all staff through a two-way radio as staff assigned to master control authorized all movements. Observations determined master control approved all youth movements and was in accordance with Florida Administrative Code. A review of video footage showed staff would often leave the living module when youth were asleep. This occurred on three different days, leaving the youth unattended in their rooms. An interview with the superintendent revealed staff were completing other tasks such as laundry or a youth admission during the time they were required to remain on the module. The center addressed this issue with staff by an email advising staff not to leave the module unattended while youth were present. The e-mail was sent on November 22, 2019, and video footage showed it happened one more time subsequent to the e-mail. A total of six days was reviewed encompassing each module. A review of the logbooks determined counts were conducted at the beginning and end of each shift. A census sheet is utilized as the method for tracking the youth and the center's logbook. A random sample of seven staff were interviewed and each reported staffing was adequate.

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

The center utilizes an electronic wand to conduct ten-minute checks. The electronic wand records a digital record of each ten-minute check conducted by staff. Observations of ten-minute visual observations of youth by the center's staff during youth's sleep time and confinement determined staff conducted the required visual observations within the required timeframe. A total of six days was reviewed encompassing each module. 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. On one of the days reviewed, video footage showed staff were approximately five minutes late on three separate occasions. Seven staff were interviewed and six reported checks are conducted every ten minutes. The remaining staff reported they never worked the night shift. The detention superintendent was interviewed, and stated staff conduct ten-minute checks every ten minutes when youth are asleep.

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

Daily observations determine census counts of the youth were taken. Utilizing two-way radios, the juvenile justice detention officers (JJDOs) in collaboration with master control document the head counts at the beginning and end of each shift, emergencies, routine group movement,

population change, and random head counts. Observations of the center's logbooks determined headcounts, youth movements, and daily census are documented as required. A random sample of seven staff were interviewed and reported emergency counts are conducted when a youth is not accounted for or a disturbance. Documentation did not include any youth not physically present. A random sample of seven staff were interviewed and reported counts are conducted at the beginning and end of each shift. If the count is inaccurate; all movement is stop and a recount count is conducted.

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

Logbooks are utilized in each living unit and master control. The center utilizes four living areas, G one, B one, B two, and B three. Each living area and the master control logbook was reviewed for the past six months. The logbooks included a chronological record of events, incidents, and activities. The logbooks are bound with number pages. Each entry included dates, times, names of staff, youth involvement, brief descriptions of events, and the name of the person making the entry. Medical, special needs, and mental health alerts or issues were highlighted. Logbook entries were reviewed for each living unit for the past six months. Entries were made in black or blue ink and the logbooks were bound with sequential pages. The master control logbook documented all the required entries.

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

Logbooks are utilized in each living unit and master control. The center utilizes four living areas, G one, B one, B two, and B three. Logbook entries were reviewed for each living unit for the past six months. The logbooks (master control and living areas) entries include a review by the

juvenile justice detention officer supervisor (JJDOS) at a minimum at the beginning and end of each shift.

5.06 Key Control	Satisfactory Compliance
Each center is responsible for maintaining inventory and control of all facility keys. *All keys shall be placed on a tamper-resistant key ring designed to inhibit the removal of keys.* *Emergency key rings shall be maintained separately from other facility keys, in master control, in a secure location designated by the Superintendent. These keys shall be notched or otherwise identifiable by touch.* *The key(s) on these rings shall provide egress through facility exterior doors providing access to evacuation areas.* *A key inventory shall be maintained by the Superintendent or designee at all times.* *(For the entire indicator statement, please reference the Monitoring and Quality Improvement FY 2019-2020 Detention indicators.)*	

An observation of the center's key control was conducted. Each key was placed on a tamper-resistant king ring. The center's emergency, medical, confirmed the juvenile justice detention officers (JJDOs) and mental health keys were maintained in master control. The center master control officer maintains the inventory for all keys. The center utilizes key logs to document the shift, to whom each key is issued to, the ring number, and the number of keys on each ring. Seven staff records were reviewed, and each had key control training. An observation of staff during daily activities was conducted. Observations confirmed JJDOs were responsible for their issued keys and keys were accounted for during their shift. Keys signed out by the staff matched the keys the staff was in possession of. The issued keys were with JJDOs at all times during the annual compliance review. Youth were not observed to have control of the keys at any time during the annual compliance review. There were no incidents of the facility keys leaving the grounds during the scope of the annual compliance review. Personal keys were observed as being secured in master control prior to entering the facility. The center's policy delineates the proper key control requirements and training for staff. The policy requires for staff to report all missing or lost keys immediately upon gaining knowledge. Seven direct care staff reported the medical records area, the youth property area, the mental health records area, the case management area, the kitchen, the supervisor office, the maintenance area, and exit doors are all restricted and their keys do not gain access to these areas. Seven staff also reported the center's daily process for keys include tracking keys, denying youth from accessing keys, reporting missing keys, replacing damage keys, and utilizing master control to properly secure and store personal keys.

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

The center has a total of six vehicles to transport youth. Interviews with the one of the two assistants and the superintendent revealed the designated transportation staff was not at work for majority of the annual compliance review period. As a result, vehicles were not inspected prior to use by the juvenile justice detention officers (JJDOs). Documentation did not include each of the six vehicles being searched before and after each transport. Documentation reviewed for the past six months did not include the maintenance staff conducting weekly visual checks and monthly vehicle checks as the maintenance staff was not at work for three of the six months reviewed. After transports, there was no documentation to determine staff searched the vehicle for contraband and any remaining youth. Six vehicles were observed, three of the six had a first aid kit, window puncher, and knife-for-life. The remaining three did not have all required items. The first aid kits contained expired contents in each of the three vehicles. All transports were approved prior to transport. Each of the vehicles were observed to be free of contraband, a secure screen, sufficient gasoline, vehicle logs, gas credit card, and vehicle registration. Invoices included annual safety inspections and any deficiencies identified were corrected prior to use. The was no documentation to verify if the center ensured the safety of staff and youth while in the transport vehicles.

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

The center utilizes a locked secure storage room located inside the center's main hallway. The kitchen also maintains sharp tools in a locked drawer. Each tool was inspected monthly. Maintenance and kitchen staff are responsible for the inventory of tools and equipment and each was completed by the appropriate staff. Documentation determined each tool was accounted for and inventoried daily (sharps) and monthly. The maintenance staff was not at work for three months and therefore the superintendent completed inventory during these three months. The results of these inspections are reviewed by the superintendent. There was no evidence of broken tools or discrepancies upon observations. There were no documented instances of lost tools by the center. All tools and equipment with the potential to cause serious injury are stored under strict control in locked secure areas inaccessible to youth. The maintenance tools are marked and located on a shadow board. The issuance and return of tools were documented. Maintenance staff reported missing tools are documented and reported to the superintendent. A review of the center's policy on maintenance and kitchen tools and the observations of the center's tool inventory determined staff adhere to the required procedures for tool inventory and management. Each tool room was secure and inaccessible to youth. Seven staff were interviewed. All seven reported youth are allowed to use mops and brooms. Seven youth were interviewed and three reported youth use mops and brooms and four reported youth do not use any tools.

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

The center utilizes four living areas, G one, B one, B two, and B three. According to observations, each module was clean. Seven youth and seven staff were interviewed. Each staff reported youth use mops, brooms, and scrub brushes. Three youth reported they could use mops and brooms. Youth were forbidden to use any other tool. Youth are under strict supervision while handling mops and brooms.

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

The center utilizes two locations for storage of flammable, toxic, caustic, and poisonous items. One storage area is located outside on the facility grounds inaccessible to youth and the other is securely located inside the facility in the maintenance tool room. The flammable, toxic, caustic, and poisonous items were inventoried. The documentation provided to the annual compliance review team included all inventoried items which matched the actual items located on-site. The Material Safety Data Sheets (MSDS) to the flammable, toxic, caustic, and poisonous materials and items determined there is a MSDS for all materials. The MSDS sheets were old and not updated for this year. A review of the center's safety plan determined the established procedures appropriate to address a chemical spill or injury while handling dangerous materials.

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

Flammable, toxic, caustic, and poisonous fluids and other dangerous substances were stored in secure areas inaccessible to youth in two locations for storage of flammable, toxic, caustic, and poisonous items. One storage area is located outside on the facility grounds inaccessible to youth and the other is securely located inside the facility in the maintenance tool room. Seven staff and seven youth were interviewed. Each staff reported youth are not allowed to clean with flammable, toxic, caustic, and poisonous fluids and other dangerous substances. Four youth reported they are not allowed to handle flammable, toxic, caustic, and poisonous items and three youth reported staff will handle the cleaning chemicals prior to the youth cleaning an area.

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

Observations of flammable, toxic, caustic, and poisonous fluids and other dangerous substances determined they are stored in a secure area inaccessible to youth located outside in a small metal storage unit. The kitchen does not store any chemicals when they are not in use. A review of the center's Facility Operating Procedures determined the center has a process for storing 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) Standards. Observations confirmed there were no signs of kitchen waste being disposed of inappropriately. An interview with maintenance personnel determined, it is the center's practice to dispose of flammable, toxic, caustic, and poisonous items and materials in accordance with OSHA. Tomoka Land Fill was identified to address the disposal of waste.

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

The center utilizes four living areas for confinement, G one, B one, B two, and B three. The rooms on each module were free of obstruction. Nine confinements under twenty-four hours were reviewed. Each room utilized did not have any safety hazards. Each youth were given their meals/snacks while in confinement. Each youth reviewed had access to medical care and mental health care, education, showers, clothing, large muscle exercise, bedding during sleeping hours, and hygiene as needed. Prior to placing each youth on confinement, each of the youth confinements were approved by the juvenile justice detention officer (JJDO) supervisor.

One youth was placed in a confinement room at a time. The room was searched by a JJDO and each room was free of potential safety hazards. The confinement report was completed in the Facility Management System (FMS). The JJDOS documented any special needs for each youth reviewed. The confinement report was evaluated and the JJDOS documented the youth's status every three hours. The superintendent reviewed each of the confinement reports within twenty-four hours. The JJDOS reviewed each confinement within two hours and continued to counsel the youth. All instances of continued confinement were stated clearly in the confinement report completed in FMS. None of the confinements interfered with visitation. Seven staff reported they search the room, document ten-minute checks, and complete a confinement report when a youth is placed in confinement.

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

A new policy for confinement over twenty-four hours was revised on September 5, 2019. A review of the Facility Management System (FMS) revealed the center did not have any occurrence of confinements over twenty-four hours subsequent to the policy revision.

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

The center utilizes a binder to maintain the Continuity of Operations Planning (COOP) drills. The center had documentation of completing the required COOP drills. The center completed an actual evacuation on September 2, 2019. A COOP drill was completed in June 18, 2019, and June 21, 2019, for each shift. The drills contained the required information. The completed COOP drills were hurricane drills but hurricane the drill was not completed prior to June 1, 2019 (the official start of hurricane season). Drills were documented in the center's logbooks. Seven staff were interviewed and each reported participation in drills.

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

A review of the center's Escape Prevention Plan determined the center has a process to maintain safety and security in the event the center needs to respond quickly and appropriately. The plan delineated appropriate levels of supervision, staff vigilance, and proper building maintenance in escape drills. The center utilizes a binder to maintain the escape drills. The center conducted and documented quarterly mock escape drills for each shift for three quarters. The center did not have documentation of an escape drill being conducted for the quarter of July through September 2019. Drills were documented in the center's log book. Seven staff were interviewed and each reported participation in escape drills. A review of escape prevention training revealed seven of seven staff had not completed the training for calendar year 2018. This deficiency was identified during the center's last annual compliance review which occurred in January 2019. Corrective action was applied and demonstrated for the lack of in service training.

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

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. The center provided documentation of conducting monthly fire drills. Drills were also documented in the center's logbooks. Six fire extinguishers were inspected, and each had not been inspected within their proper time frame. Seven staff were reviewed for in-service training regarding the fire prevention plan/disaster procedure and six had completed the required training. Seven staff were interviewed and each reported participation in monthly fire drills. Seven youth were interviewed and four indicated they had participated in a fire drill. One reported they had not participated in a fire drill as they had only been employed at the center for twelve days, but knew what to do in case of a fire. Six fire extinguishers were inspected, and each had not been expected within their proper time frame. The remaining two reported they had not participated in a fire drill.