STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Miami-Dade Regional Juvenile Detention Center

Department of Juvenile Justice

(State-Operated)
3300 North West 27th Avenue
Miami, Florida 33142

Review Date(s): October 22 - 25, 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:

Keith Bennis, Office of Program Accountability, Lead Reviewer (Standard 1, Interviews)
Rosa Flores, DJJ Probation, Circuit 11, Senior Juvenile Probation Officer (Standard 2)
Douglas Kane, St. Lucie Regional Juvenile Detention Center, Juvenile Justice Detention Officer Supervisor (Standard 5)
Peter Keelan, DJJ Office of Education, Education Coordinator (Standard 2)
Gary Mogan, Office of Program Accountability, Regional Monitor (Standard 3)
Shakela Minns, Office of Program Accountability, Regional Monitor (Standard 4)

Program Name: Miami-Dade Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: Miami-Dade County / Circuit 11
Review Date(s): October 22 - 25, 2019

MQI Program Code: 490
Contract Number: N/A
Number of Beds: 100
Lead Reviewer Code: 142

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

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

Standard 1: Management Accountability
Detention Rating Profile

Indicator Ratings

Standard 1 - Management Accountability		
1.01	Initial Background Screening*	Satisfactory
1.02	Five-Year Rescreening	Satisfactory
1.03	Staff Code of Conduct	Satisfactory
1.04	Incident Reporting *	Satisfactory
1.05	Protective Action Response (PAR)	Satisfactory
1.06	Pre-Service/Certification Requirements *	Satisfactory
1.07	In-Service Training	Satisfactory
1.08	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 *	Satisfactory
3.03	Non-Licensed MH/SA Clinical Staff	Satisfactory
3.04	MH/SA Admission Screening	Satisfactory
3.05	MH/SA Assessment/Evaluation	Satisfactory
3.06	MH/SA Treatment	Satisfactory
3.07	Treatment and Discharge Planning	Satisfactory
3.08	Psychiatric Services *	Satisfactory
3.09	Suicide Prevention Plan *	Satisfactory
3.10	Suicide Prevention Services *	Satisfactory
3.11	Suicide Precaution Observation Logs *	Satisfactory
3.12	Suicide Prevention Training *	Satisfactory
3.13	Mental Health Crisis Intervention Services *	Satisfactory
3.14	Emergency Care Plan *	Satisfactory
3.15	Crisis Assessments *	Satisfactory
3.16	Baker and Marchman Acts *	Satisfactory

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Standard 4: Health Services
Detention Rating Profile

Indicator Ratings

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

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Standard 5: Safety and Security
Detention Rating Profile

Indicator Ratings

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

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Program Overview

The Miami-Dade Regional Juvenile Detention Center is a state-owned detention facility, operated by the Department, located in Miami, Florida. The center serves youth in Miami-Dade, Broward, and Monroe counties in Circuit eleven. Male and female youth who are detained pending adjudication, disposition, or placement in a residential commitment program are housed in the 100 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 Miami-Dade County School Board. The center's management team includes the superintendent, three assistant superintendents, two administrative assistants, thirteen juvenile justice detention officer (JJDO) supervisors, and sixty-eight JJDOs. Mental health and healthcare services are provided through the contracted provider, Camelot Community Care. Mental health services are provided by one designated mental health clinician authority (DMHCA), one licensed therapist, and two non-licensed therapists. Clinical services provided by the center includes mental health and substance abuse evaluations, mental health treatment planning, individual, group and family therapy, mental health crisis intervention services, on-site psychiatric services, and availability for substance abuse services for youth with co-occurring disorders. Medical services are provided by one designated health authority (DHA), one advanced registered nurse practitioner (ARNP), two registered nurses (RNs), and five licensed practical nurses (LPNs). The medical clinic maintains nursing coverage seven-days a week from 6:30 a.m. to 10:30 p.m. on Mondays through Fridays, and from 7:00 a.m. to 7:00 p.m. on weekends. 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 five living modules which consist of four male modules and one female module. There are 164 security cameras at the center, of which 161 were operational. A complete tour of the center reflected the center was clean and the grounds around the facility were observed to be manicured and maintained as well. At the time of the annual compliance review, the center had eleven staff vacancies, which included five JJDO-I positions, five JJDO-II positions, and one food support staff position.

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.	

The center has a written policy and procedures for completing a background screening prior to hiring an employee or utilizing the services of a volunteer, mentor, intern, or contracted provider with access to youth and confidential youth records. During the annual compliance review period, the center hired a total of fifty-six new staff inclusive of twenty-nine direct care staff, four medical staff, four contracted providers, three school teachers, and sixteen volunteers/interns. The three contracted providers included therapists from Camelot Community Care. Reviewed documentation reflected each initial background screening was completed by the Department's Background Screening Unit (BSU)/Clearinghouse, prior to each hire date. Each staff received an eligible rating and there were no staff applicable for having an ineligible/not eligible rating. Each direct care staff completed a pre-employment assessment tool and received a passing score prior to being hired. A copy of each assessment score was maintained in each staff's personnel record. Supporting documentation was provided from the site administrator of the Miami-Dade County Juvenile Justice Center School confirming newly hired teachers were authorized by the Miami-Dade County Public Schools for employment. The Annual Affidavit of Compliance with Level Two Screening Standards was completed and submitted to the Department's BSU on January 17, 2019, meeting the annual requirement.

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

The center has a written policy and procedures requiring the completion of a background rescreening every five years for applicable staff. There were nine staff applicable for requiring a five-year rescreening since the last annual compliance review. Reviewed documentation reflected each staff received a five-year rescreening within the required time frame, as required. Eight of the nine rescreenings/resubmissions were submitted to the Background Screening Unit (BSU)/Clearinghouse at least ten business days prior to the five-year anniversary date. One was submitted one day prior to the staff member's five-year anniversary date.

1.03 Staff Code of Conduct	Satisfactory Compliance

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

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

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

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

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

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

The center has a policy and procedures regarding staff code of conduct. The center utilizes the Department of Juvenile Justice's employee handbook which contains a code of conduct in which all staff must adhere to. Seven staff personnel records were reviewed and each contained the acknowledgement, receipt, and review of the Department's code of conduct. None of the original seven staff records contained documentation of disciplinary action or commendations. An additional three personnel records were requested and reviewed for disciplinary action to meet the minimum sample size. Reviewed documentation of each record reflected management took immediate and appropriate corrective action to address the staff's code of conduct when staff violated the policies and procedures. These prior corrective actions included oral reprimands and additional training. An additional three personnel records were requested and reviewed for commendations to meet the minimum sample size. An interview with the superintendent confirmed the center recognizes an employee of the month each month to help increase employee morale. Staff selected as employee of the month may receive an award and/or a gift card. A review of the internal incidents, Department's Central Communications Center (CCC) reports, and Protective Action Response reports determined there were no incidents which should have been documented as a violation of a code of conduct and were not. Seven staff were interviewed and each reported never hearing a co-worker threaten a youth or use profanity towards a youth. Each of the seven staff was able to explain the process for allowing staff and youth to call the Florida Abuse Hotline or the Department's CCC to report suspected abuse. Six of seven interviewed youth reported staff are respectful when speaking to them and one youth reported they are not. The one youth reported, it seems as if staff do not want to talk to the youth and the youth has to get the attention of a sergeant on duty by banging on the sub-control glass to speak with staff. Each youth was interviewed on how often they have heard staff use profanity when speaking with them or other youth. One youth reported never, three youth reported once, and three youth reported they occasionally hear this. This was advised to the program's superintendent for follow-up. Each of the interviewed youth indicated they have never heard staff threaten any youth. An interview with the center's superintendent confirmed the center's practice of incident reporting.

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

The center has a written policy and procedures in place regarding incident reporting. The center had a total of eighty incidents reported to the Department's Central Communications Center (CCC) within the past six months. The program maintains a current CCC logbook which documented all reviewed incidents. A complete facility tour was conducted and observations reflected there were signs posted throughout the center of the Florida Abuse Hotline and CCC telephone numbers. A review of eight randomly selected incidents reflected seven of the eight were reported to the CCC within the required time frame while one was reported beyond the two-hour requirement. Reviewed documentation reflected the center documented each incident in the center's CCC logbook. The internal incidents and/or grievances and logbook documentation were reviewed and reflected there were no additional incidents which should have been reported to the CCC and were not. The center also documents the incidents which were not accepted. An interview with the superintendent confirmed the CCC is called within two hours of being notified of applicable incidents. Direct care staff notify master control as well as the shift supervisor and administrative staff are authorized to make the call 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.	

The center has a policy and procedures pertaining to the use of Protective Action Response (PAR). The center had a total of 278 PAR incident reports within the past six months. A review of twenty-eight applicable PAR reports was conducted. Each of the twenty-eight PAR reports contained a review by a PAR certified instructor and a post-PAR interview conducted with the youth within thirty minutes after the incident. Twenty-seven of the twenty-eight reviewed PAR reports contained statements from all staff involved by the end of the staff member's workday while one report reflected a staff member completed their narrative the day after the incident occurred. None of the reviewed reports required a PAR medical review as a result of serious injury to the youth or staff. Each of the reviewed PAR reports contained a review of the PAR incident report by the superintendent or a designee within seventy-two hours of the incident to determine if use of force was consistent with policy. Each report was maintained electronically in the Facility Management System (FMS) within the Department's Juvenile Justice Information System. Due to this, the center does not generate a monthly summary. None of the reviewed reports required a report to the Department's Central Communications Center (CCC) and there was no documentation to support any involved youth made or required a report to the Florida Abuse Hotline. Logbooks, internal incident reports, and grievances were reviewed and documentation did not reveal any additional PAR incidents occurred. The center's PAR rate during the annual compliance review period was 21.27, which is above the statewide Detention PAR rate of 11.75. The superintendent was interviewed regarding the increase in the number of PARs since the last annual compliance review. The superintendent advised the numbers are higher due to increased populations and less modules being used. The superintendent reported only three modules are being used and more youth are housed together within the modules

which creates issues amongst the youth. An interview with the superintendent confirmed the detention center's administrative team reviews reports when incidents occur to determine if PAR moves or techniques were used appropriately and in accordance with Florida Administrative Code 63H-1.004. Seven staff were interviewed and each indicated staff utilize verbal interventions before use of physical restraints or PAR techniques on youth while.

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

The center has a written policy and procedures ensuring all newly hired staff are trained in accordance with Florida Administrative Code within 180 days of hire. Pre-service training is divided into two phases. Phase one consists of instructor-led and web-based courses. Phase two consists of 120 hours of academy instructor-led training. Seven staff training records were reviewed for pre-service training requirements. Each of the seven reviewed records found staff completed the certification process within 180 days of hire. Reviewed documentation reflected each staff completed the required trainings inclusive of Protective Action Response (PAR), first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), mental health services, substance abuse services, suicide prevention, safety and security emergency plans, human trafficking, Department detention facility operations, supervision, active shooter, and Prison Rape Elimination Act (PREA) prior to having any contact with youth. A review of seven training records found documentation to support each staff completed phase one and phase two of the pre-service training requirements. All training was conducted by qualified trainers and documented in the Department's Learning Management System (SkillPro).

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

The center maintains a written policy and procedures which requires staff to complete twenty-four hours of annual in-service training beginning each calendar year after completion of certification with supervisors requiring an additional eight hours of supervisory training annually. The center has an annual in-service training calendar which is updated as changes occur. The in-service training plan was approved by the Department's Office of Staff Development and Training on January 14, 2019. The center provides in-service training for staff through a combination of instructor-led courses and web-based courses in the Department's Learning Management System (SkillPro). Seven staff training records were reviewed for in-service training which was inclusive of three supervisory staff. Each of the training records reflected the staff met and/or exceeded the twenty-four-hour requirement for annual training. Reviewed documentation reflected each staff received refresher training in Protective Action Response (PAR), cardiopulmonary resuscitation (CPR), automated external defibrillator (AED), and first aid. Reviewed training records reflected each staff completed six hours of suicide prevention training which four hours were instructor-led training and two hours were training in the Department's Learning Management System (SkillPro), as well as an active shooter training and

training on professionalism and ethics. Reviewed documentation of the three supervisory staff's training records reflected each completed at least eight hours of supervisory training for the year. Each of the reviewed supervisory staff also completed epinephrine auto-injector training. An interview with the superintendent confirmed the center's practice is to have all staff trained on the epinephrine auto-injector. Reviewed training records supported in-service training was documented in SkillPro.

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

The center has a written policy and procedures in place to ensure an alert system is in place to alert staff when mental health, medical, or safety/security issues exist which may impact the security and safety of the youth in the center. Seven applicable youth alerts were reviewed for mental health, medical, and safety/security alerts. Reviewed documentation reflected alerts were entered, reviewed, and updated as required by an appropriate staff member. Logbooks and shift reports were reviewed and reflected alert documentation. An informal interview with staff confirmed alerts are immediately entered into the center's alert system if a youth is admitted with special needs and/or risks such as suicide, mental health, substance abuse, physical health, or safety/security risk factors. Appropriate staff are notified based on the nature of the youth's alert to include medical, mental health, and food service. The Department's Juvenile Justice Information System (JJIS) alert report is printed/reviewed daily by supervisors and administrators. JJIS alert reports and internal alerts are distributed to and are reviewed daily by the juvenile justice detention officer supervisors and administration. Alerts are reviewed with oncoming staff during daily shift debriefings. The center's practice is to have all direct care staff always maintain a copy of the detailed alert list on their person during their shift. A current alert list is also maintained in the medical clinic and kitchen. A shift briefing was observed during the annual compliance review and alerts were observed to be reviewed with staff, as required.

Seven staff were interviewed and reported they were informed of alerts by way of shift briefings, alert forms, JJIS, and logbooks. An interview with the center's superintendent was conducted and confirmed medical alerts are entered at the time of admission and updated when necessary.

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 in place to ensure proper screening, evaluation, and documentation of each youth detained. Seven youth case management records were reviewed and each had a completed Detention Risk Assessment Instrument (DRAI), Suicide Risk Screening Instrument (SRSI), and arrest affidavit or order to take into custody. Each contained an Admission Wizard from the Department's Juvenile Justice Information System (JJIS) completed for each youth. All seven youth were electronically searched, frisk searched, and stripped searched by an officer of the same gender as the youth. Six reviewed records documented the youth were served a meal or a snack within the required time frame while one record was not applicable. All seven youth case management records documented the youth making a telephone call at the center's expense to the youth's parent/guardian. The center has a booking/admission area located in the administration wing of the program and all youth are admitted inside of this area. During the annual compliance review, the team was able to observe a youth being processed for admission to the center. Observations reflected the admission process was explained to the youth and the youth appeared to understand the process. The youth was electronically searched, frisk searched, and stripped searched by an officer of the same gender. The youth was offered a meal and was permitted to call their parent/guardian. All admission case records are reviewed by the shift supervisor for appropriate placement and for appropriate supervision levels. All seven reviewed records indicated each youth was admitted to the center in accordance with the center's policy and procedures.

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 to ensure all youth admitted into the center are notified of the rules and regulations. All seven reviewed youth case management records indicated each youth received an orientation within twenty-four hours of their admission to the center. The center's expectations for behaviors, rules and regulations, grievance process, dates and times for visitation, how to access medical and mental health services, how to access the Florida Abuse Hotline, letter writing, and behavior management system are all explained during admission/orientation. The admission process is documented during intake/booking and is signed by both the admitting officer and the youth. Copies with signatures are placed and maintained in each youth's active case management record. Each of the seven records reviewed had signed copies of the orientation brochure confirming the receipt of each youth . Seven interviewed youth each confirmed they received information about the center's rules and regulations, educational services, visitations, daily schedule, abuse reporting, and the behavior management system upon their admission.

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 to ensure all youth admitted to the center are classified by the admitting officer to provide the highest level of safety and security. All youth are placed upon their classification and may be reclassified if there are any changes in the status or behavior. All room assignments are documented in the Department's Juvenile Justice Information System (JJIS) and no more than two youth may occupy a room. All youth requiring a single room shall have an alert entered in JJIS. A review of the Vulnerability to Victimization and Sexually Aggressive Behavior (VSAB) results must be documented by the supervisor making the room assignment. All youth are screened to determine if they are a criminal street gang member or affiliated with any criminal street gang. Updated gang information is provided to staff to appropriately classify youth during admission and gang-related problems can be prevented. A review of seven youth case management records coupled with a review of the center's alerts was conducted. Seven youth case management records were reviewed and three were applicable for being identified as gang members or affiliated with a gang. Reviewed documentation reflected the youth were all placed appropriately to ensure their safety. Each of the three applicable records documented gang involvement and one of the three applicable records were placed in the JJIS alert system. Shift supervisors are the only staff authorized to make room assignments. The center also utilizes a booking classification form to ensure all youth are classified properly and to determine the most appropriate placement for each youth. Reviewed documentation reflected each of the seven reviewed case management records contained the VSAB, the youth's JJIS Face Sheet containing the youth's arrest history, an Admissions Wizard, and a photograph of the youth.

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 in place to ensure youth are screened to determine if the youth is identified as a street gang member or affiliated with a criminal street gang. The center has identified one juvenile detention officer as the center's gang representative to communicate suspected gang activity to local law enforcement and the juvenile probation officer supervisor (JPOS) serving as the local gang representative for Circuit Eleven, who communicates with the center's gang liaison. The admitting officers have been trained to identify and document any gang involvement identified during the admission process. The center's gang liaison was interviewed and confirmed when a youth has suspected gang affiliations, an alert is entered in the Department's Juvenile Justice Information System (JJIS). Several e-mails were provided as evidence reflecting the center has a process in place to communicate with the JPOS circuit gang representative. Seven interviewed staff each indicated all updates and information is communicated during shift briefings/debriefings. It is the center's practice for direct care staff to carry the most updated JJIS Alert List on their person during their shift. If the alert list changes due to new admissions or changes in a youth's status throughout the day, direct care staff will be provided a new alert list with updates.

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 in place related to ensuring the proper safe handling and security of each youth's personal property including valuables, which are collected and secured at the time of a youth's admission. A review of seven youth case management records coupled with observations made, confirmed each youth's personal property is collected, inventoried, and secured by the booking officer in the presence of the youth during the admission screening process. Observations reflected all monies and valuables were placed in a tamper-proof clear property bag. The youth acknowledges all valuables are accounted for by signing the tamper proof bag. The shift supervisor signs the property form as well and logs the property in the property logbook before placing it in the drop safe located in the admission area. The safe is the initial drop for youth property and the safe is under camera surveillance with limited access to shift supervisors and administration. The center has a second safe for storing youth property. A review of seven youth case management records coupled with one observed admission revealed each applicable youth and staff signed and dated a Property Receipt Form. The program staff takes the completed list and updates the Facility Management System (FMS). Once the center receives information of the youth will be detained over twenty-one days, the property is relocated to another safe located inside the property room. This safe is also under camera surveillance with limited access. Observations were made of all youth's personal

property stored in a property room. Each bag has an assigned number and the number is documented on the youth's property receipt. During admission, all youth must sign a property letter of acknowledgement. This letter is to acknowledge personal property left unclaimed after thirty days will be deemed as abandoned and subject to disposal according to the applicable State of Florida guidelines. All seven youth case management records reviewed had property receipts and acknowledgements of unclaimed property signed by both staff and youth. The Admission Wizard documented whether the youth had personal property upon their admission. The center reported there were no missing personal property for the past six months and a review of the Department's Central Communication Center (CCC) validated this as well. Seven interviewed youth indicated upon their admission to the center, staff checked their personal property and each youth signed and received a form stating the inventory and listing of their personal property was correct.

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 in place to ensure the youth's personal property is inventoried, maintained securely, and returned to the youth in a timely manner upon their release from the center. A review of seven youth case management records coupled with observations made of the property room reflected safe guards were in place for each youth's personal property until it is returned to the youth and/or parent/guardian. The non-valuable property is placed inside a green property bag with an assigned number and transferred to a property room. Each observed bag had a copy of the youth's personal property inventory attached. The valuable property is placed in on one of two safes available within the center and each under camera surveillance. Personal items of value are inventoried and placed in clear plastic bags with the youth's information located outside of the bag. A review of youth property logbooks, property bags, and a walk through of the property room confirmed the youth's property is inventoried by the booking officer in the presence of the youth and signed by both parties. All seven reviewed youth case management records indicated each youth's property was appropriately logged in the Department's Juvenile Justice Information System (JJIS) Admission Wizard. Removal of the youth property is limited to the shift supervisors and administration. The property room is equipped and monitored by surveillance cameras. A review of the Department's Central Communications Center (CCC) logbook and CCC incident reports from the previous six months found there were no incidents of lost or stolen property during the review period. The center procedures included a clear process related to disposal of unclaimed property. All seven reviewed youth case management records had acknowledgements of unclaimed property signed at the time of their admission. An interview with the center's superintendent reflected any property not picked up within thirty days will be considered abandoned. After thirty days, a Notice of Impending Disposal of Property is mailed to the youth's last known address. If the youth is on supervision, it is also acceptable to have the youth's juvenile probation officer sign for and deliver the property to the youth. A record must exist for property disposed of or cash forwarded to headquarters. If the youth or parent/guardian cannot be located, the superintendent or designee will ensure all money and property are counted and inventoried.

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 in place to ensure all releases from the center occur promptly and accurately. All releases from the center must be approved by the shift supervisor prior to the actual release. Three closed youth case management records were reviewed for release documentation and approval. A review of the three closed youth records revealed each had the appropriate documentation including the Release Wizard signed by the youth's parent/guardian or person taking custody, the court authorization to release, a copy of photo identification of the person taking custody, youth check list, and notifications. The center utilizes a release checklist to prevent negligent releases. In the absence of this documentation, the superintendent or designee determines if the person to whom the youth is being released is a parent, legal guardian, or responsible adult. All three youth case management records had signatures of the youth being released, their parent/guardian, and the staff releasing the youth. The center reported having no unauthorized releases for the past six months. A review of the Department's Central Communications Center (CCC) reports from the previous six months indicated there were no unauthorized releases at the center.

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 in place to ensure all youth's personal property is released to the youth or the youth's parent/guardian. The parent/guardian, youth, and staff must sign a receipt acknowledging all property was returned upon their release. A review of three closed youth case management records revealed each youth's record had the required information and contained the youth and/or parent/guardian or responsible adult and staff member's signatures. The Release Wizard supported the youth's personal property and clothing were returned to each youth and documentation noted each applicable youth received their personal property as evidenced by the property receipt. All three youth case management records had signatures of the youth, parent/guardian, and the staff on the Personal Property Receipt Form. There were no applicable reports made to the Department's Central Communication Center (CCC) for the past six months regarding lost or missing property. The

center's staff provided a sample of documentation to demonstrate the follow-up contact made by the center with youth and parent/guardians to have them retrieve unclaimed property. An interview with the center's superintendent confirmed the center's process for unclaimed personal 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 in place to ensure prescribed medication along with medication instructions are provided to the parent/guardian or responsible adult at the time the youth is released. A review of three applicable closed youth case management records was conducted and reflected the Department's Juvenile Justice Information System (JJIS) Release Wizard indicated the youth had medication upon release. The center utilizes a Medication Wizard, Transfer, and Disposition form to ensure all medications accompany the youth upon their release. Each of the three applicable reviewed records confirmed medication and medical instructions were provided to the youth and the youth's parent/guardian upon the youth's release.

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

The center has a written policy and procedures in place to ensure youth are held in detention for the shortest time possible. The center conducts detention reviews on a weekly basis and are held on Tuesdays. The center has a designated staff appointed to coordinate the weekly detention reviews. The purpose of the detention review meetings is to determine proper placement of the youth currently detained in the detention center or who have been placed on home detention. Reviewed documentation found the reviews to be conducted with the center's staff including medical, education, mental health, a representative from probation, and a representative commitment manager. Documentation from the meetings along with sign-in sheets, confirmed meetings are conducted on a weekly basis and each youth in secure detention and home detention are reviewed. Placement status and updates on youth awaiting placement in a commitment program were also discussed. The center utilizes a follow-up form to ensure all issues or updates from previous meetings have been corrected or addressed. An interview with the superintendent indicated the detention review specialist along with the juvenile probation officer supervisor (JPOS), education personnel, detention staff, and commitment managers attend the meeting.

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 in place to ensure youth are provided the opportunity to participate in constructive activities and keep youth actively involved. The center

provides and maintains a weekday, weekend, and holiday schedule posted in all living areas. Observations of the daily schedule were made and reflected they indicated the time frames of the daily activities provided to the youth on a regular basis including wake-up, meal times, personal hygiene, visitation, education, volunteer programing, large muscle exercise, shift change, bed times, groups, and open program times. Center staff must adhere to the daily schedule including all the required elements including gender-specific programming. A review of the facility logbooks indicated the schedule is followed majority of the time. During the morning and early afternoon hours, youth are participating in education. The center offers the youth the opportunity to participate in activities with mural painting along with the designated muralist who designs and creates the artwork within the courtyard of the center. The center is also equipped with a large gymnasium where most of the large muscle exercises are conducted. Six of seven interviewed youth indicated they were aware the center had a daily activity schedule and one was not aware the center had a daily activity schedule. Seven interviewed staff indicated the center's daily activity schedules are followed. Six of seven interviewed staff indicated the center offers restorative justice activities as part of the daily schedule and one staff indicated the center does not provide restorative justice activities. Interviewed staff revealed the center offers gender-specific programming as part of their daily schedule as well.

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 in place to ensure daily schedules are followed. The daily schedules are openly posted in all youth living units. Any significant changes to the schedules must be approved by the shift supervisor and the reason for the changes must be documented on the shift report. A review of the center's shift reports from the previous six months verified there were no significant changes in the activity schedule. A review of the logbooks indicated there were no changes where the daily activity schedule was interrupted. Six of seven interviewed youth indicated the youth were aware the center had a daily activity schedule and one youth indicated they were not aware of the center's daily schedule. Six of seven interviewed youth indicated the schedules were followed and one youth indicated the schedule was not followed. The center's staff indicated they are made aware of any issues through staff debriefings and meetings.

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's educational program is managed by the Miami-Dade County School District which operates on a year-round basis providing the youth within the center with 300 minutes of instruction daily. An interview with the center's lead teacher was conducted and advised the only restrictions in which school would be canceled would be due to natural/climatic emergencies, inoperable air conditioners, or due to students fighting where the overall

classroom environment would not be conducive to learning. A review of the center's school schedule coupled with an interview with the lead educator, confirmed the teachers have ten dedicated days for professional development as well as one hour a day built into their individual schedules for supplemental daily planning. A review of the center's logbooks reflected school is occurring with minimal interference, as required. The center also provided a detailed student course schedule as well as documented student attendance. Seven interviewed staff each confirmed the center offers educational classes. Seven interviewed youth each reported there is minimal interference of educational instruction at the center. An interview with the superintendent confirmed there is minimal interference of educational instruction at the center.

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

The center provides appropriate career education to its students based upon the youth's age as well as assessed cognitive and educational abilities. The career education component which is offered, is categorized as a Type 1 Career/Vocational curriculum which teaches personal accountability skills and behaviors appropriate for students in all age groups and ability levels and leading to work habits which may help maintain employment and living standards. This classification which stresses "soft skills", includes but is not limited to communication, decision making, as well as interpersonal skills. An interview with the lead teacher confirmed youth enrolled in academic and career education offerings can earn course credit for the completion of said offerings.

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 in place to ensure the center provides a behavior management system (BMS) of rewards, privileges, and consequences to encourage youth to fulfill the center's expectations. The BMS includes rewards for positive behavior and consequences for inappropriate behavior. The expectations and behavioral norms are posted throughout the center's living areas. Observations made during a youth's admission confirmed the youth was informed of the center's BMS. At the time of admission, each youth enters the center at a level two. This level provides youth basic rights and some additional activities and incentives. After three days of positive demonstrated behavior, youth are able to move to level three. This level provides youth all the basic rights and youth are eligible to receive more privileges. Level one is the most restrictive level and is utilized for negative behavior. The youth may move up and down within the level system based on their positive and/or negative behavior and their ability to respond to staff intervention. Level change requests must be made with the authorization from a shift supervisor. Youth levels are updated in the logbooks and youth are informed of their current level. Observations during the annual compliance review included

youth receiving verbal direction and receiving counseling based on their behavior. Seven youth were interviewed on how they would rate the center's BMS. One of seven interviewed youth stated the BMS was very poor; one youth stated it was poor; two youth stated it was fair; one youth stated it was good; and two youth stated it was very good. Four of seven interviewed youth stated the consequences they received were fair while three youth indicated they have never received any consequences. Seven interviewed staff each advised they speak with the youth and discuss the consequences being imposed. Each of the seven interviewed staff indicated they provide the youth with the opportunity to explain their behavior and give youth alternatives for acceptable behaviors. All seven interviewed staff indicated they can only modify the youth's levels as a form of consequence and they receive feedback from supervisors regarding the implementation of the BMS.

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

The center has a written policy and procedures in place prohibiting group and/or corporal punishment of youth. The superintendent was interviewed providing an explanation of the behavior management system (BMS) indicating the center utilizes a level system and upon the youth entering the center are placed on a level two. During their stay, if the youth behavior is good, the level will be raised to 2.1 until they have reached a level 3 status. The center reported there were no incidents indicating any unauthorized use of punishment. The youth are not allowed to discipline other youth in the center. Seven interviewed youth each validated this. Three of seven interviewed youth stated they have never received consequences while four stated they received a level/point drop. All seven interviewed staff indicated they have not witnessed an unauthorized use of punishment nor observed staff encouraging youth to participate in physical altercations. Furthermore, staff have never taken away meals, snacks, clothes, education, or medical care for inappropriate behavior.

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 policy and procedures related to youth grievances to ensure each youth has the right to file a grievance and is treated fairly, respectfully, without discrimination, and their rights are protected. Reviewed documentation found the grievance process is explained to each youth during the orientation process upon intake. A review of the center's formal grievance process indicated it is in accordance with the Florida Administrative Code requirements. The grievance process was observed to be posted in each living unit and throughout the center. The youth cannot be denied the opportunity to file a grievance nor can they be punished for filing a grievance whether it is substantiated or unsubstantiated. Observations of an admission reflected the grievance process was explained to the youth. An interview with the center's superintendent confirmed their understanding of the center's grievance process. The superintendent indicated the grievance process has three phases which includes phase one, the informal phase wherein the juvenile justice detention officers (JJDO) attempts to resolve the complaint or condition with the youth using effective communication skills and enter the grievance into the Facility Management System (FMS) on behalf of the youth. The second phase is the formal phase and reflects if unable to resolve the original complaint, the written grievance is submitted to the shift supervisor within two hours of completion for review and is then documented in the logbook and forwarded to the superintendent or designee. The third phase is the appeal phase which occurs if the youth was not satisfied with the outcome, the youth may appeal the outcome of the formal phase to the superintendent or designee. Seven interviewed staff confirmed to each have knowledge of the grievance procedure and were able to explain the center's grievance process. Each staff indicated the different locations of the grievance forms located in the center for youth accessibility. Seven youth were interviewed and six reported to have never filed a grievance while one youth reported they had filed a grievance. The one applicable youth rated the grievance experience as very good. Reviewed documentation reflected the center had five grievances submitted within the past six months. A review of documentation and Central Communications Center (CCC) logbook revealed the grievance process was completed and complied with the policy and procedures.

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 incorporated trauma informed care practices into their current operations to deliver services and provide care to all youth in custody in the center. The center has recently renovated the youth's living environments throughout the center including majority of the modules. An interview with the superintendent reflected the center's implementation of trauma-informed practices to address youth with a softer approach throughout the center with the decoration of the modules, pet therapy, artwork/murals, and life skills. The center has a soft multipurpose room and a soft room located on the girl's module to address trauma. The center incorporates multiple inspirational wall paintings/murals outside of the modules throughout the courtyard and has a dog therapy program as techniques used by the center to address trauma. A review of the Department's Juvenile Justice Information System (JJIS) daily alerts log identified youth with traumatic history and this information is placed in the center's internal alert system. Seven staff training records were reviewed and reflected each were trained on trauma-informed care.

Standard 3: Mental Health and Substance Abuse Services

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

The center maintains a written policy and procedures ensuring there is a single licensed mental health professional identified as the designated mental health clinician authority (DMHCA) who is responsible for the coordination and implementation of mental health and substance abuse services provided at the center. The DMHCA is on-site forty hours a week, Monday through Friday and sixteen hours a week every other weekend. The DCMHA is also available seven days a week, twenty-four hours a day for consultation. The DMHCA has a clear and active license to practice in the State of Florida which was verified on the Florida Department of Health website with an expiration date of March 31, 2021. The DMHCA is a licensed mental health counselor (LMHC). An interview with the DMHCA confirmed they are responsible for ensuring the clinical quality and integrity of the therapeutic program as required by all applicable standards, regulations, and policies. The DMHCA has management and administrative oversight over mental health and substance abuse services throughout the center. The center has a contract with Maxim Healthcare Services, Inc. which subcontracts with Camelot Community Care, Inc. to provide comprehensive mental health and substance abuse services.

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

The center maintains a written policy and procedures ensuring services are provided by individuals with appropriate qualifications. The designated mental health clinician authority (DMHCA) ensures the center's clinical staff are working under direct supervision and are providing qualified services based on education, training, and experience. The center's contract with Maxim Healthcare Services, Inc. provides for a regional mental health and substance abuse clinical director for the south region, one full-time DMHCA, a licensed mental health counselor (LMHC), and a psychiatrist for approximately six hours each week. The psychiatrist is a medical doctor (MD) and is subcontracted with Camelot Community Care, Inc. Reviewed licenses for all licensed professionals found each maintained a clear and active license to practice in the State of Florida as required by Chapter 491 of the Florida Statutes. The center's DMHCA is a LMHC in the State of Florida with an active license due to expire on March 31, 2021. A review of the psychiatrist's license confirmed the psychiatrist is a licensed MD with a specialty in child and adolescent psychiatry. The psychiatrist's license is free and clear in the State of Florida with an expiration date of January 31, 2020. The psychiatrist is available by telephone twenty-four hours a day, seven-days a week.

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

The center maintains a written policy and procedures to ensure services are provided by individuals with appropriate qualifications. The designated mental health clinician authority (DMHCA) ensures the center's non-licensed clinical staff are working under direct supervision and are providing services based on qualifications such as education, training, and experience. The center employs a licensed DMHCA providing direct supervision to the center's three non-licensed master's-level registered mental health counselors who are employed by Camelot Community Care, Inc. A review of the contract with Maxim Healthcare Services indicates the non-licensed mental health clinical staff shall have either a master's-level degree with a major in psychology, social work, or counseling and the non-license substance abuse clinical staff shall have at least a minimum of a bachelor's-level degree with a major in psychology, social work, counseling, or a related human services field and work under the direct supervision of a licensed qualified professional. Reviewed records found the non-licensed clinicians are qualified to provide services based on their education, training, and experience. A review of training records supported each non-licensed therapist completed the center's Assessment of Suicide Risk form and completed twenty hours of training and supervised experience in assessing suicide risk, mental health crisis intervention, and emergency mental health services. Supporting documentation of clinical supervision logs confirmed the DMHCA provides weekly face-to-face clinical supervision which includes directions, instructions, and recommendations to non-licensed staff. A review of the past six months of weekly direct supervision logs documented all non-licensed staff received weekly supervision. Each reviewed direct supervision note was documented on the Department's Licensed Mental Health Professionals and Licensed/Certified Substance Professionals Direct Supervision Log form and contained all required elements.

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

The center maintains a written policy and procedures ensuring mental health and substance abuse needs of youth are identified through a comprehensive screening process. The center utilizes a standardized screening process which includes a review of the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) and the Suicide Risk Screening Instrument (SRSI). A review of seven youth mental health and substance abuse (MHSA) records validated each youth record had documentation to support the juvenile probation officer (JPO) administered the MAYSI-2 and the SRSI upon the youth's admission/intake at the juvenile assessment center (JAC). All seven reviewed MHSA records documented the SRSI and MAYSI-2 detention section was completed by a juvenile justice detention officer (JJDO) in the Department's Juvenile Justice Information System (JJIS). The nursing and/or mental health staff

completed the required sections of the SRSI in each of the seven reviewed records. Five of the seven reviewed youth records were identified as applicable for a need for further assessment based on the admission assessments. Each reviewed record had the summary and recommendations completed in full in the screening results section. Five of the seven reviewed records were identified with an elevated suicide risk factor. Reviewed documentation validated each applicable youth was placed on precautionary observation (PO) and a mental health referral and notification to the superintendent was completed for each. Reviewed documentation validated each of the five applicable youth had an Assessment of Suicide Risk (ASR) completed by the trained licensed or non-licensed clinical staff. An interview with the superintendent confirmed detention intake staff complete the MAYSI-2 and the SRSI as the screening instruments used.

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

The center maintains a written policy and procedures ensuring the mental health and substance abuse evaluations identified through preliminary screenings with youth as having mental health and substance abuse issues receive in-depth mental health and substance abuse assessment shortly after intake. The center is responsible for establishing procedures to track the receipt of comprehensive assessments. A review of seven youth mental health and substance abuse records reflected three of the seven youth were referred by staff for a mental health and substance abuse evaluation. Reviewed documentation confirmed each of the three applicable records had a comprehensive evaluation completed by outside agencies within fourteen days of the youth's admission to the center. Further documentation supported the evaluations were completed by a community provider within thirty days of the referral.

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

The center maintains a written policy and procedures in place to ensure mental health and substance abuse treatment planning focuses on providing identified youth with mental health and/or substance abuse treatment services. Youth determined to have a serious mental disorder or substance abuse impairment and are receiving mental health and/or substance abuse treatment at the center must have an initial or individualized mental health or substance abuse treatment plan based upon the Comprehensive Mental Health and/or Substance Abuse Assessment/Evaluation or Psychiatric Evaluation/Diagnostic Interview. Each youth determined to need mental health treatment including treatment with psychotropic medications or substance abuse treatment while in the center must be assigned to a mini-treatment team. The mini-

treatment team meets monthly to discuss each youth receiving services. Reviewed mini-treatment team documentation supported each applicable youth was assigned to a mini-treatment team which consists of the designated mental health clinician authority (DMHCA), the center's administration staff, mental health and substance abuse staff, nursing staff, an education representative, and a juvenile justice detention officer (JJDO) staff. Observations of a mini-treatment team meeting during the annual compliance review week coupled with an interview with the DMHCA validated the center's consistent practice. A review of seven youth mental health and substance abuse records (MHSA) indicated three youth were applicable for mental health treatment services. Each of the three reviewed MHSA records were applicable for the youth receiving individual, group, and/or family mental health and/or substance abuse counseling. Each reviewed record reflected the youth participated in treatment planning and treatment team meetings. Each of the reviewed records documented the service to be received and outlined the frequency of counseling services. Each of the three reviewed records contained a properly executed Authority for Evaluation and Treatment (AET) form and an additional AET consent for mental health, substance abuse, and/or psychiatric medications as required. A review of treatment notes reflected all were documented on the Department's Counseling/Therapy Progress Notes form and maintained within the youth's electronic medical record. A review of the center's group therapy sign-in sheets for the past six months confirmed groups were being held daily. Sign-in sheets confirmed the center was holding both mental health and substance abuse groups. Sign-in sheets supported all groups were limited to ten or fewer youth with mental health diagnoses for mental health treatment groups and fifteen or fewer youth with substance abuse diagnoses for substance abuse treatment groups. An interview with the DMHCA confirmed the center offers mental health and substance abuse services. Substance abuse groups are facilitated by a licensed clinician. The DMHCA reported they follow Florida Administrative Code (FAC) 63N to ensure substance abuse services are provided as required. The youth receive three individual counseling sessions and five group counseling sessions each week. Services are reviewed consistently by the DMHCA during the weekly supervision meetings to ensure fidelity and they are being delivered in a manner consistent with contractual requirements. Seven youth were interviewed regarding mental health and substance abuse services. Only one youth reported receiving mental health and substance abuse services. The youth rated the services as very good. The remaining six youth reported they never received mental health or substance abuse services while at the center.

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

The center maintains a written policy and procedures ensuring mental health and substance abuse treatment planning focuses on providing mental health treatment and/or substance abuse services. The center's superintendent and designated mental health clinician authority (DMHCA) or mental health and substance clinical staff are responsible for ensuring the development and review of an initial and individualized mental health/substance health treatment plan of each youth receiving mental health/substance abuse treatment in the center.

All youth receiving mental health and substance abuse treatment 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 the youth's release. A review of seven youth mental health and substance abuse records (MHSA) reflected three youth were applicable for requiring an initial treatment plan completed within seven days of initiation of treatment. Each reviewed record documented an initial treatment plan was completed on the Department's Initial Mental Health/Substance Abuse Treatment Plan form and contained all required elements. Each reviewed initial treatment plan documented the reason for treatment, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, initial treatment methods, and initial treatment goals. Three of the seven reviewed MHSA records were applicable for psychiatric services. Each of the three reviewed records documented signatures by the mental health staff, youth, and team members involved in the development of the plan. There was no documentation in any of the MHSA records to confirm any of the youth were alleged victims of a Prison Rape Elimination Act (PREA) event. A review of seven youth MHSA records found three youth were applicable for individual treatment plans. Each reviewed plan supported the plans were developed within thirty days of the youth's admission and were signed by the licensed mental health clinician (LMHC) within the ten-day time frame, as required. Each was signed the same day the plan was developed. Each reviewed individual plan identified the youth's DSM-5 diagnosis, symptoms which are treatment focused, treatment goals, strengths, and abilities. Three of the seven reviewed youth records were applicable for psychiatric services and/or psychotropic medication monitoring and pharmacological interventions. A review of the three youth records which were applicable for psychiatric treatment found documentation to support psychiatric treatment and services are provided by a licensed psychiatrist. Documentation supported each reviewed record had progress notes which validated youth were receiving treatment services as outlined on the treatment plan. In addition, each reviewed treatment plan had supporting documentation which validated each plan was signed and dated by the youth, mental health staff, treatment team members, and parent/guardian. During visitation, clinical staff meet with the parent/guardian to discuss the treatment plan and obtain their signatures. When parent/guardians do not visit, attempts are made upon the youth's release and the parent/guardian picks up the youth. Clinical staff mail a copy of the plan to the parent/guardian requesting their review and provide a signature. The center conducts mini-treatment team meetings monthly for applicable youth receiving mental health and substance services. Treatment teams consist of the DMHCA, the center's administration staff, mental health and substance abuse staff, nursing staff, an educational representative, and a juvenile justice detention officer staff. A mini-treatment team meeting was observed during the annual compliance review week which confirmed the center's participants and practice. All three applicable youth records reflected a mental health/substance abuse discharge summary completed on the required Department's form. The discharge summaries were found not to have been provided to the parent/guardian as all three youth were still in secure detention.

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

The center maintains a written policy and procedures ensuring psychiatric services are provided to youth in need. The center provides psychiatric services which includes psychiatric evaluations, psychiatric consultations, medication management, and medical supportive

counseling. The center maintains a contract with Maxim Healthcare Services, Inc. to provide mental health and substance abuse services. Maxim Healthcare Services, Inc. subcontracts with Camelot Community Care, Inc. who subcontracts with a State of Florida licensed psychiatrist. Additionally, Maxim Healthcare Services, Inc. subcontracts with Camelot Community Care, Inc. to provide comprehensive mental health and substance abuse services as well as psychiatric services. The center's psychiatrist is a licensed medical doctor (MD) with a specialty in child and adolescent psychiatry. The psychiatrist's license was free and clear in the State of Florida with an expiration date of March 31, 2020. The psychiatrist's contract requires on-site services six hours a week and each applicable youth is evaluated within fourteen days of admission. A review of the sign-in and sign-out logs from the previous six months validated the psychiatrist was on-site providing services; however, the number of hours on-site could not be confirmed due to no sign-in or sign-out times indicated in the logs. Seven youth mental health and substance abuse (MHSA) records were reviewed. Four of seven youth MHSA records were applicable for psychiatric services. One reviewed record was applicable for arriving with psychotropic medication prescribed and received a psychiatric evaluation within fourteen days of admission, as required. The center completed an in-depth psychiatric evaluation for all applicable youth. Each reviewed psychiatric interview documented the reason for referral, history, mental status examination, the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) diagnosis, treatment recommendations, applicable prescribed medication, explanation of the need of psychotropic medication, and frequency of medication monitoring. Each reviewed psychiatric evaluation also included developmental history, psychiatric history, individual, contributing family or environmental factors, and the signature of the practitioner. The center completed an in-depth psychiatric evaluation which contained all required elements on each of the four applicable youth. Three of the youth were applicable for a newly prescribed medication and the Clinical Psychotropic Progress Note (CPPN) form was completed for all the youth. The CPPNs were marked as "copy" to indicate the form had been forward to the home of the parent/guardian when telephone contact was not confirmed. Each of the four MHSA records were applicable for the continuation of a prescription of psychotropic medication and each documented the medication's identifying data, medication target symptoms, evaluation and description of effect of prescribed medication on target symptoms, prescribed medication, side effects, youth's adherence to the medication regime, youth's height/ weight, laboratory findings, applicable parent/guardian contact, and the signature and date of the psychiatrist. Each of the four applicable records contained documentation to support the monthly monitoring of Tardive Dyskinesia. Each reviewed record contained an active Authority for Evaluation and Treatment form. None of the reviewed records were applicable for youth in foster care or reaching eighteen years of age while at the center and requiring additional consents. There were no applicable youth for significant changes in dosage of the prescription of medications after admission. An interview with the center's registered nurse (RN) and psychiatrist reflected the conservative practices were due to the extremely short-term care of the youth at the center. An interview with the center's psychiatrist confirmed their twenty-four hours a day on-call availability, active communication with the center's mental health and medical staff, as well as fulfilling the role and responsibilities for the oversight of psychiatric care at the center. The center's designated mental health clinician authority also reported the psychiatrist sees all youth admitted on psychotropic medication within two weeks of admission and is responsible for monitoring concerns, side effects, and medication management.

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

The center maintains a written policy and procedures ensuring there is a suicide prevention plan in place to safely assess and protect youth with elevated risk of suicide in the least restrictive means possible, in accordance with Florida Administrative Code (FAC) 63N. The center's suicide prevention plan includes identification and assessment of youth at-risk of suicide, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response, and review process. The plan was revised and approved by the center's superintendent and designated mental health clinician authority (DMHCA) on September 19, 2019. Copies of the plan were located in the center's mental health office, superintendent office, and in the facility operating procedures (FOPs) manual in each sub control unit in all modulars. At the time of the annual compliance review, the center had eighty-one direct care staff who have contact with youth on their respective shifts. Training records for fifty percent of the direct care staff was reviewed for compliance with the annual training and mock drills for suicide precautions. A review of training records such as sign-in sheets and meeting agendas coupled with the Department's Learning Management System (SkillPro) data base confirmed all staff had completed the four hours of instructor lead classroom training followed by two hours of web based on-line training in suicide prevention. A review of the supporting records for mock suicide drills dating back to the last annual compliance review reflected mock drills were completed for each shift with varying suicide scenarios. Staff who were not on duty or missed the mock drill exercise were appraised of the training during their next shift meeting and the drill synopsis was posted in the staff breakroom for their review.

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

The center maintains a written policy and procedures ensuring a suicide prevention plan is in place to safely screen, refer, assess, monitor, and protect youth with an elevated risk of suicide in the least restrictive means possible. All youth identified as having suicide risk factors by screening, information obtained from the youth, or staff observations must be placed on suicide precautions and receive an Assessment of Suicide Risk (ASR). Seven staff training records were reviewed and confirmed the center's mental health staff met the required training hours. A review of seven youth mental health and substance abuse records revealed five were applicable for a youth being placed on suicide precaution status upon their admission to the center as a result of the completed admission screenings. Each of the five youth MHSA records documented the completion of an ASR by a non-licensed master's-level clinician. Each record documented the immediate notification to the center's superintendent and/or designee and the

completion of a Suicide Precaution Observation Log. No records were applicable for the youth being released from the center on precautionary observation (PO) status. Each record documented a referral was made to a mental health professional, an alert was entered into the Department's Juvenile Justice Information System (JJIS), and the youth was maintained on precautionary observation until assessed by a licensed mental health staff. Each of the records documented the youth was transitioned to standard supervision after the completion of an ASR, consultation with the designated mental health clinician authority (DMHCA), and the consultation with the center's superintendent and/or designee as outlined in the center's suicide prevention plan. None of the reviewed records were applicable for disciplinary confinement. A review of the center's master control logbook reflected beginning and end times were documented for youth placed on precautions. There were no instances of a youth attempting suicide or self-inflicting injury since the last annual compliance review; however, there is an established review process in place. Seven staff were interviewed regarding suicide prevention in the center. Each of the seven staff stated they would contact mental health staff, maintain constant sight and sound supervision, document supervision, and search the youth and their room for sharp objects. An interview with the center's superintendent reported the center only utilizes secure observation if a youth is displaying combative behaviors towards other youth or themselves. An officer will be placed in front of the youth's door for constant sight until a mental health staff deems otherwise. Two of the reviewed records were applicable for youth being placed on secure observation status during this annual review period. An interview with the center's DMHCA confirmed the reporting procedures for youth placed on PO at the center. The DMHCA explained assigned juvenile probation officers and parent/guardians are notified of PO status and the mental health practitioner notates the contact in the chronological log. Additionally, it was reported the superintendent and/or designee are notified of any youth requiring PO status through face to face contact or by email. One of seven youth were interviewed and reported being placed on suicide precautions while at the center. The youth further added they was never left alone while on PO status.

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

The center maintains a written policy and procedures ensuring 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. Seven youth mental health and substance abuse records were reviewed and five were applicable for being placed on suicide precaution status upon their admission to the center. Each of the applicable reviewed records contained the Department's Suicide Precaution Observation Log with documentation of the youth's behavior in real time coupled with the documentation of safe housing requirements. Each reviewed log documented all observations at or below thirty-minute intervals. None of the reviewed records were applicable for having warning signs which required notification to administration and/or mental health consultation. Each reviewed applicable record had logs which were reviewed and signed by the juvenile justice detention officer supervisor (JJDOS) and mental health clinical staff daily. Informal interviews were conducted with the five youth and each stated staff never left them alone while they were on suicide precaution status.

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 maintains a written policy and procedures ensuring 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. All staff who work with youth must receive a minimum of six hours of annual training on suicide prevention and implementation of suicide precautions. A review of seven in-service staff training records found all seven staff received the required four hours of instructor-led training and two hours of computer-based training of suicide prevention and implementation of suicide precautions training in the Department's Learning Management System (SkillPro). The center is required to conduct mock suicide drills on each shift at least quarterly. All staff with direct youth contact must participate in at least one mock suicide drill semi-annually. A review of seven staff training records found each staff completed the required mock suicide drill and emergency response training as required. Staff members who are not present during a quarterly mock drill must have the opportunity to review each mock drill scenario and procedures during shift meetings. According to the center's training director, staff who are unable to participate in the mock drills are briefed at their next shift meeting and the scenario evaluation form is posted in the staff breakroom for their review. A review of the quarterly mock suicide drills conducted since the last annual compliance review found drills were conducted quarterly on each shift, as required. Documented use of life saving techniques such as the use of the knife for life from the suicide response kit, automated external defibrillator (AED), and the vital sign machine were the only types of equipment identified to have been used within the drills. The center's training director reported the use of other medical life savings equipment such as cardiopulmonary resuscitation (CPR) and first aid procedures are conducted and documented within the medical drill evaluation forms. Mock suicide drills were documented to have taken place on the Alpha shift four times, the Bravo shift four times, and three times for the Charlie shift. Each reviewed drill documented action by staff, provisions of contacting center staff and 9-1-1 when applicable, and provisions for life saving measures. The center's practice is to review all completed drills during monthly all staff meetings. The mock suicide drills were further being documented in the center's master control logbook and were highlighted in yellow. An informal interview with the designated mental health clinician authority (DMHCA) confirmed there are four suicide response kits maintained at the center located in master control, the medical clinic, and in both sub-control offices. Seven staff were interviewed regarding the suicide response kits and each confirmed the locations of each kit.

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 maintains a written policy and procedures ensuring all staff 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 center. 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. The center's Crisis Intervention Plan was inclusive of a notification and

alert system, means of referrals including self-referral, crisis assessment and follow-up mental health status examination, communication, supervision, mental health supportive services, documentation, and review. The center's combined emergency services plan was reviewed and approved by the superintendent and the designated mental health clinician authority (DMHCA) on September 17, 2019. The plan is maintained in the center's mental health office, master control, and in the juvenile justice detention officer supervisor's office.

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

The center maintains a written policy and procedures ensuring there is an Emergency Care Plan outlining the mental health and substance abuse emergency procedures. The center is required to ensure youth who are believed to be an imminent danger to themselves or others due to mental illness or substance abuse impairment receive emergency mental health or substance abuse services. The center's Emergency Care Plan was approved and updated on September 17, 2019 by the superintendent and the designated mental health clinician authority (DMHCA). The Emergency Care Plan outlines the procedures for immediate staff response, notification and communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment under Chapter 394 Florida Statute (Baker Act), transportation for emergency mental health evaluation and treatment under Chapter 397 Florida Statute (Marchman Act), return from emergency mental health or substance abuse services, documentation, training, and review. The center utilizes Citrus Health Network for Baker Act crisis stabilization and for Marchman Act. The plan is maintained in the center's mental health office, master control, and the juvenile justice detention officer supervisor's offices. Seven staff training records were reviewed and confirmed each staff received training in emergency care.

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 maintains a written policy and procedures ensuring the center responds to youth in the least restrictive means possible to protect the safety of the youth and others while maintaining control and safety of the center. An interview was conducted with the designated mental health authority clinician authority (DMHCA) who confirmed the center had two applicable youth requiring a crisis assessment since the last annual compliance review. A

review of supporting documentation reflected all phases of the center's facility operating procedures (FOPs) within the Emergency Care Plan were followed. Documentation supported the reason for the crisis assessment, the youth's mental status, the risk to self and/or others, the initial clinical impression, supervision recommendations, treatment recommendations, and a follow-up evaluation. One youth's parent/guardian were informed and had an alert entered into the Department's Juvenile Justice Information System (JJIS). The second youth's parent/guardians were not informed nor was their alert entered into JJIS. The crisis assessment was completed by a licensed mental health professional within the required two hours. Seven staff training records were reviewed and confirmed all staff received mental health crisis training as required.

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

The center maintains a written policy and procedures ensuring staff immediately respond to youth who are believed to be an imminent danger to themselves or others due to mental illness or substance abuse impairment requiring emergency mental health or substance abuse services to protect the youth and others from harm. An interview conducted with the designated mental health clinician authority (DMHCA) indicated the center had five applicable youth requiring Baker Act procedures since the last annual compliance review. A review of the five applicable youth mental health and substance abuse records reflected staff ensured youth safety and supervision pending the Baker Act. The records reflected the DMHCA completed the required forms for the Baker Act proceedings. The mental health staff, juvenile probation officer (JPO), and parent/guardians were notified of the emergency. All five youth were placed on precautionary observation (PO) upon re-admission from Baker Act. A Mental Status Examination was also competed. The Department's Juvenile Justice Information System (JJIS) was updated as required with the appropriate alerts. The youth remained on PO until released from the center. There were no applicable Marchman Act procedures since the last annual compliance review.

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 written policy and procedures to ensure clinical services are provided to all youth admitted into the center. The center has a contractual agreement with Maxim Healthcare Services, Inc. to provide comprehensive medical, mental health, substance abuse, and psychiatric services at the center. A licensed physician serves as the designated health authority (DHA) and performs administrative duties. The DHA holds an unrestricted clear and active license which meets all requirements for independent and unsupervised practice in the State of Florida. The DHA's license expires on January 31, 2021 and has specialty training in pediatrics. The DHA is contracted to be on-site once a week for a minimum of five hours and is on-call twenty-four hours a day, seven days a week. A review of the center's logbook for the past six months in comparison with the DHA timesheets found the DHA was on-site in accordance to contractual requirements. When the DHA is on vacation or has scheduled absence, Maxim Healthcare Services provides for back-up coverage. Reviewed documentation found Maxim Healthcare Services scheduled a licensed physician who holds an unrestricted clear and active license once during a week of the DHA's absence. In addition, the contract requires for an advanced registered nurse practitioner (ARNP). The ARNP holds an unrestricted clear and active license which meets all requirements for independent and unsupervised practice in the State of Florida and expires on April 30, 2021. The APRN has a collaborative practice protocol in place filed with the Department of Health and approved by the DHA. The collaborative agreement was issued on January 24, 2018 and was renewed on February 20, 2019.

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

The center maintains the statewide facility operating procedures (FOPs) for detention centers. The FOPs include health-related procedures and protocols designed for the center. The designated health authority (DHA) reviewed, signed, and dated the FOPs, nursing protocols, and non-healthcare protocols on July 9, 2019. The center's contracted psychiatrist documented a review, with signature and date for applicable FOPs. Reviewed documentation supported the registered nurse, licensed practical nurses, and DHA documented their review of the center's healthcare FOPs and protocols on a cover page in June 2019 and in October 2019. New policies or changes in policies made during the year are reviewed, signed, and dated by each nurse on each individual policy. A review of the protocols found the center's superintendent did not sign and date the protocols. This was brought to the center's attention and the superintendent signed and dated the protocols during the week of the annual compliance review. A review of the healthcare policies and procedures cover page found all newly employed healthcare staff received a comprehensive clinical orientation to the Department's healthcare policies and procedures.

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

The center has a written policy and procedures to 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 (IHCRs) reflected four contained a signed Authority for Evaluation and Treatment (AET), two contained a Limited Consent for Evaluation and Treatment (LCET), and one youth was eighteen years of age or older and did not require an AET. Three youth IHCRs contained an original AET and three contained copies. All three copies contained a legible stamp with the word "COPY." Each AET or LCET was obtained prior to providing medical services.

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

The center has a written policy and procedures ensuring the parent/guardian is informed of significant changes in the youth's condition and obtains consent of new medications or treatment prescribed. A review of seven youth individual healthcare records (IHCRs) reflected two had significant changes to existing medications and/or changes in chronic conditions. None of the reviewed IHCRs were applicable for over-the-counter (OTC) medications or vaccinations not covered by the Authorization of Evaluation and Treatment (AET). There were no Religious Exemption from Immunization forms submitted since the last annual compliance review. Two youth received off-site emergency care and supported nursing staff notified the parent/guardians by telephone and subsequently, in writing. Three youth were applicable for parent/guardian notification to obtain consent for the prescription of new psychotropic medications and/or adjustments or discontinuations to existing medications. Supporting documentation in each applicable IHCR confirmed telephone consent was obtained prior to initiating or making changes to psychotropic medications and written notification in the form of the Acknowledgement of Receipt of Clinical Psychotropic Progress Note (CPPN) was forward to the parent/guardian by way of certified mail and included the third page of the CPPN.

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

The center has a written policy and procedures to ensure the Department's Medical and Mental Health Admission Screening form is completed for each youth at the time of their admission into the center. A review of seven youth individual healthcare records (IHCRs) found each contained a Medical and Mental Health Admission Screening form completed on the date of the youth's admission by the juvenile justice detention officer and was reviewed by the licensed practical nurse within twenty-four hours. None of the reviewed youth had a change in physical custody

since their arrival to the center. Each screening form was completed in the Department's Juvenile Justice Information System (JJIS) Admission Wizard.

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

The center has a written policy and procedures to ensure all youth are oriented to the general process of healthcare delivery services at the center. Seven youth individual healthcare records (IHCRs) were reviewed for youth orientation to healthcare services. Each reviewed IHCR included documentation to support the youth received a general healthcare orientation within twenty-four hours of their admission to the center. The healthcare topics included access to medical care, sick call process, emergency situations, medication process, right to refuse care, what to do in case of sexual assault or attempted sexual assault, non-disciplinary role of healthcare staff, a review of healthcare contacts, and the 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.	

The center has a written policy and procedures to ensure the designated health authority (DHA) is notified when youth admitted to the center require emergency care or routine notification. The center's practice is to notify the DHA of the admission of any youth with a chronic medical condition, psychotropic medication, or medical concern. Notification is documented by a licensed medical staff on the intake progress note and is maintained in the youth's individual healthcare record (IHCR). Six of seven reviewed youth IHCRs supported the DHA was notified within twelve hours of admission of any youth with a chronic medical condition, psychotropic medication, or medical concern while one youth was not applicable. None of the reviewed youth were applicable for emergency care upon their admission to the center. One youth was admitted on prescribed psychotropic medications and the DHA was notified, as required. Each applicable youth was referred to the advanced registered nurse practitioner (ARNP) or the DHA. During an informal interview, the superintendent reported the nursing staff and ARNP complete the healthcare admission screening.

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

The center has a written policy and procedures regarding the Health-Related History (HRH) form which indicates the HRH form shall be completed no later than seven days following the date of the youth's admission. A review of seven individual healthcare records (IHCRs) reflected three contained a new HRH form and four contained an updated HRH form. Each form was completed on the most recent HRH form by a licensed nurse within seven days of each youth's admission. Each HRH form was reviewed by the designated health authority (DHA) or advanced registered nurse practitioner (ARNP) and was maintained in each youth's IHCR. The HRH form was completed before or at the same time as the Comprehensive Physical Assessment for each youth.

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

The center has a written policy and procedures to ensure each youth in the center has a completed Comprehensive Physical Assessment (CPA) upon their admission into the center. A review of seven youth individual healthcare records (IHCRs) reflected three youth had a current CPA on file at the time of their admission and four youth required the completion of a new CPA. Reviewed documentation found one of the CPAs was reviewed by the designated health authority (DHA) and six were reviewed by the advanced registered nurse practitioner (ARNP). Each CPA included the medical grade, cardiovascular, body mass index, visual acuity field, and most recent tuberculosis skin test (TST). None of the CPAs included the tanner stage. Each IHCR included a signed refusal form when part of the exam was refused by the youth. One youth's IHCR documented the term "Deferred by Clinician," five youth's IHCRs documented "Not clinically indicated," and one youth's IHCR documented the term "Deferred" only. When applicable, an alert was generated in the center's alert system for youth assigned a medical grade between two and five. Four youth's IHCRs documented the TST was completed within seventy-two hours of admission and was documented in the IHCR. Three youth had a current TST administered within the past twelve months. There were no applicable youth with any symptoms of active TB in the center at the time of the annual compliance review. The Department's Problem List was updated for each, as required.

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

The center has a written policy and procedures ensuring all youth are evaluated and treated, if necessary for sexually transmitted infections (STI). A rescreening is required to be completed if any youth has been out of the Department's custody for more than thirty days. Seven youth individual healthcare records (IHCRs) indicated each youth was screened for STIs and one required further evaluation. Each applicable youth required screening results to be documented on the youth's Infectious and Communicable Disease form located in the IHCR. None of the reviewed youth were applicable for a gynecological evaluation. None of the reviewed youth were out of the Department's custody for more than thirty days. The center has a written policy and procedures ensuring each youth is provided the opportunity to receive counseling, testing, and treatment for human immunodeficiency virus (HIV). The center also maintains an agreement with and utilizes the University of Miami's Hospital for HIV counseling and testing. All seven reviewed youth records supported each youth was offered HIV screening/testing. Two of the seven youth consented while five did not consent, as documented on the Department's Human Immunodeficiency Virus Antibody Test Youth Consent form. One additional record of a youth consenting was requested and reviewed. Reviewed documentation confirmed the youth was offered testing and provided consent to have the test completed. HIV results are securely sealed in an envelope marked "confidential" and are filed in the applicable youth's IHCR. The center also maintains a HIV and sexually transmitted infection (STI) testing log. Reviewed documentation in each applicable youth's IHCR confirmed pre-test counseling and post-test counseling was provided by the University of Miami's Hospital. Seven interviewed youth each reported they can request a 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 written policy and procedures regarding sick call requests. There are approved treatment protocols appropriate to the level of the provider conducting sick call. The center utilizes the Department's Facility Management System (FMS) to enter a sick call request made by a youth. In addition to the electronic system, the center maintains printed copies of sick call request forms available to the youth throughout the center. The licensed practical nurse (LPN) and registered nurse (RN) conducts sick call. The designated health authority (DHA) and advanced registered nurse practitioner (ARNP) will conduct sick call when on-site. The center provides sick call seven days a week, two times a day. The sick call hours are Monday through Friday from 9:00 a.m. until 12:00 p.m. and from 5:00 p.m. until 9:30 p.m. Sick call is held on Saturdays and Sundays from 8:00 a.m. until 12:00 p.m. and from 2:00 p.m. until 6:00 p.m. The shift supervisors are trained in the sick call procedures and will review the sick call request within four hours in the absence of the healthcare professionals. A review of seven youth individual healthcare records (IHCRs) reflected two youth submitted sick call requests. An additional record was requested and reviewed. Each sick call form documented the nature of the complaint, assessment, and plan to include subjective, objective, assessment, and plan (SOAP) format. Each of the three applicable sick call requests were conducted by the LPN and were reviewed by the DHA or ARNP within twenty-four-hours of the sick call request. Each of the reviewed sick calls were documented on the center's Sick Call Index and Sick Call Referral Log. None of the reviewed youth presented a similar sick call complaint three or more times within a two-week period. None of the youth complained of any severe pain which staff were unfamiliar. An observation of the sick call process was observed during the week of the annual compliance review. The youth was escorted by the juvenile justice detention officer (JJDO) to the medical clinic. Verbal and written consent was obtained from the youth prior to the observation. The youth signed the sick call request log prior to being examined. The youth was screened by the LPN prior to being seen by the ARNP. The LPN followed all elements outlined in accordance to the Department's policy. The youth was examined in a private area and the JJDO was seated at the entrance of the examination room entrance. Seven youth were interviewed regarding the sick call process. Four youth stated they can be seen immediately, while two youth reported they can be seen within one day, and one youth reported they have never requested a sick call. All seven youth indicated the nurse conducts the sick calls and two also stated the doctor conducts sick call. Seven interviewed staff indicated sick call is conducted by nursing staff and the doctor.

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 written policy and procedures for the provision of episodic care and first aid treatment inclusive of requirements for episodic care performed by non-healthcare staff. The center utilizes an episodic care log to document episodic care and first aid treatment. The log documents the date and time of the treatment, nature of the complaint, person rendering aid, treatment, and if off-site care is needed. Three youth's individual healthcare records (IHCRs) were applicable and reviewed. Each applicable IHCR documented problem-oriented elements

which were used to chart pertinent information pertaining to the nature of the youth's ailment including identification of the subjective, objective, assessment, and plan (SOAP) to address the complaint. None of the episodic care incidents were conducted by non-healthcare staff. None of the applicable youth were required to be placed on the center's alert list or required parental notification. Each youth's progress note identified the staff rendering aid, signature of the staff, the center's name, and was entered on the episodic care log. The center maintains seventeen first aid kits located in areas frequently used by youth. An observation of three randomly selected first aid kits was conducted. All first aid kits contained a label on the outside of the kit confirming the designated health authority (DHA) checked all content and none were expired. An observed first aid kit reviewed from module two had all required contents. An observed first aid kit from module three was found to be missing a roll of bandage tape. An observed first aid kit from module four was found to be missing a one-way cardiopulmonary resuscitation (CPR) barrier mask and sterile gauze pads. These findings were advised to the nursing staff as well as the Department's nurse consultant of the south region to replenish these items. The center maintains one automated external defibrillators (AED) located in the medical clinic with procedures located in the AED box as well as audio instructions. The nursing staff checks the AED weekly to ensure the battery and pads are operable. A review of the AED check log for the past six months verified this practice. During the annual compliance review, observations were conducted while the nurse completed a self-test and checked the expiration dates of the battery and pads for the AED. The battery in the AED expires on August 20, 2022 and the pads expire on April 28, 2021. The center conducts emergency drills and emergency drills including CPR/AED at least quarterly on each shift. Emergency and cellular telephone numbers are located in master control and the medical clinic accessible to all staff. A review of emergency drills for the past six months verified the center conducted drills, as required. A review of seven staff's training records supported each staff received the required training on emergency care and the supervisory staff received training on epinephrine auto-injector. Only healthcare and trained supervisory non-healthcare staff can administer the epinephrine auto-injector for youth requiring administration, when indicated. Seven interviewed staff each reported they are able to call 9-1-1 if necessary.

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

The center has a written policy and procedures to provide timely referrals and coordination of medical services for youth requiring off-site care. A review of seven youth individual healthcare records (IHCRs) found one was applicable; therefore, two additional IHCRs were requested and reviewed. The designated health authority (DHA) was notified for each emergency event. Each youth's IHCR contained a Summary of Off-Site Care form, discharge documentation, and instructions. Reviewed documentation confirmed the DHA reviewed and signed all off-site care findings, instructions, and information. All off-site emergency care was documented on the Episodic Care Log. None of the applicable youth required follow-up care. An informal interview with the center's registered nurse (RN) indicated the DHA follows up with all youth after any off-site incident occurs.

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. Youth are screened during the intake process for medical conditions warranting periodic evaluations and follow-up care. A review of seven youth individual healthcare records (IHCRs) found two youth were identified with a chronic medical condition and/or taking prescribed medications. One additional record was requested and reviewed. None of the youth were classified with a body mass index (BMI) greater than thirty. None of the youth were applicable for taking anti-tuberculosis medication or were pregnant. When applicable periodic evaluations were completed, there were no indications of lapses in care or missed periodic evaluations. The Department's Problem List was updated as needed for each applicable youth. Each of the three identified youth with chronic conditions were placed on the center's chronic conditions list and alert list.

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

The center has a written policy and procedures ensuring all medication and pharmaceutical products are stored safely, accurately, and in accordance with state, federal, and industry standards. The center's practice is for the nursing staff to verify medication with the parent/guardian delivering medication to the center. Youth who are taking medication while in the care of the center are administered medications by the healthcare professionals. Supervisors are trained in medication administration and administer medication in the absence of the healthcare professionals. The center maintains a list of staff who permitted have access to the clinic and medications. A review of seven youth individual healthcare records (IHCRs) reflected one youth was prescribed psychotropic medication prior to admission to the center, one youth was prescribed psychotropic medication subsequent to admission, while the remaining youth was prescribed medication on an as-needed basis subsequent to admission. One additional record was requested, reviewed, and reflected the youth was prescribed psychotropic medication prior to admission to the center. When applicable, the IHCR documented the medication was brought to the center by the parent/guardian and was verified. All medication was stored in a container intact with the original label and approved medication. When applicable, the physician or psychiatrist was contacted to obtain consent and an order to resume the medication until a diagnostic psychiatric interview was conducted. There were no applicable over-the-counter (OTC) medications not listed on the Authority for Evaluation and Treatment (AET) form administered. There were no undocumented explanations for lapses or errors in administered medication in any of the reviewed records. None of the youth required parenteral medication while in the center. The center utilizes the Department's standard Medication Administration Record (MAR) for each youth receiving either prescription medications on a routine basis or OTC medications. A review of youth's IHCR verified medication administration was documented on the Department's MAR which documented the youth's name, Department identification (DJJID) number, date of birth, allergies, precautions, medical grade, medical alerts, youth's current picture, start and stop dates, and monitored side effects. Further review of the MARs indicated each youth received their medication as prescribed and staff and youth initialed the MAR after the administration of the medication.

When a youth refused the medication administration, the refusal was clearly documented on the MAR and the Department's Refusal of Treatment Form was completed. An observation of the medication administration process was conducted during the week of the annual compliance review. The licensed practical nurse (LPN) conducted the medication administration. The juvenile justice detention officer (JJDO) escorted the youth to the medical clinic. The Six Rights of Medication Administration as well as any any allergies to the medication were verified by the nurse for each youth. The nurse observed each youth swallowing the medication and the nurse and youth initialed the MAR when complete. None of the medication was pre-poured from the original packaging or placed in another container. The center also has a secure refrigerator in the medical clinic which contained Tuberculin vaccinations during the annual compliance review. Nursing staff track daily temperatures of the refrigerator on a temperature log. Observations of medication storage reflected all medications were stored separately by type, stored in a locked area designated for storage, and were inaccessible to youth. During an interview with the registered nurse (RN), it was reported the center utilizes the RX Destroyer for the disposal of medications. The center maintains an agreement with a consultant pharmacist to provide a registered consultant pharmacist on-site once a month. The registered consultant pharmacist is jointly responsible for the disposal of controlled medications and narcotics. All other unused blister-pack medications are sent back to Diamond Pharmacy for a credit. The center maintains a contract with Diamond Pharmacy Services for procurement of medications with an expiration date of September 2020. Seven youth were interviewed and five indicated they do not take medication while two indicated the nurse administers medication. Seven staff were interviewed and five indicated they do not administer medication while two staff indicated they administer medication. When further questioned, each staff reported only those supervisory staff who are trained may administer medication when medical staff are unavailable.

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 medical equipment classified as medications/sharps are secured and inventoried by using a routine perpetual inventory. Documentation of each individual dosage of medication administered to youth is maintained on the Medication Administration Record (MAR) to demonstrate the distribution of medications. Any medical equipment classified as sharps is secured and inventoried utilizing a routine perpetual inventory descending count as each sharp is utilized and disposed. An observation of the medical clinic found medications are stored in a locked medication cart, within locked cabinets, and within the locked refrigerator which are all inaccessible to youth. All medications are stored separately. All controlled medications are stored in a second-locked medication box located inside the medication cart. Trained non-healthcare supervisory staff may assist in the delivery of medications only when licensed staff are not on-site. A random review of three prescribed medications, two controlled medications, and three over-the-counter (OTC) medications were observed and verified. The center only had two controlled medications during the week of the annual compliance review. All counts during the annual compliance review period were found to be accurate. A review of the daily inventory of prescribed and OTC medications matched the random count. The center maintains an inventory of all sharps and medical equipment considered as sharps. An interview with the center's registered nurse (RN) confirmed the center has a method for detecting and responding to inventory discrepancies. A review of the log utilized for tracking sharps for the past six months in comparison with an informal interview with

the RN found the tuberculosis syringe counts were documented incorrectly on the log on September 18, 2019. The inventory count was off by one hundred syringes (one box of syringes) and the error was found during the same month. When interviewed, the RN advised the medical staff accidently miscounted one less box on this date and the box of syringes was later accounted for immediately when noticed and the correct count was documented. The RN reported the staff member who caused the discrepancy was addressed with informal retraining regarding this matter.

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 and procedures to ensure proper procedures are followed to prevent the spread of infectious diseases or illnesses in the center and provide staff with the knowledge of appropriate prevention, containment, treatment, and reporting requirements of infectious diseases. The center also maintains an Exposure Control Plan/Infection Control Plan approved by the designated health authority (DHA) on July 30, 2019. Seven youth individual healthcare records (IHCR)s were reviewed for infection control education. All seven youth IHCRs documented the youth received infection control training within seven days of their admission to the center. The Infection Control Plan outlines prevention, containment, treatment, and reporting requirements related to infectious diseases, as outlined in the Occupational Safety and Health Administration (OSHA) federal requirements and guidelines. A review of seven staff's training records indicated each staff received pre-service and in-service training on the center's Exposure Control Plan/Infection Control Plan. There were no reportable incidents for which the local county health department, Centers for Disease Control and Prevention (CDC), and/or the Department's Central Communications Center (CCC) should have been notified since the last annual compliance review.

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

The center has a written policy and procedures ensuring pregnant youth are provided nutritious foods in enough quantities meeting the standards of the minimum daily allowances for pregnant youth. Each pregnant youth receives prenatal, post-partum, and parenting education including topics directly related to healthcare issues and medical risks for pregnant adolescents. Seven youth individual healthcare records (IHCRs) were reviewed for prenatal care and education. None of the originally reviewed youth IHCRs were applicable. An interview with the nursing staff indicated the center had one pregnant youth since the last annual compliance review. The youth's IHCR was not available for review due to the youth no longer being in the center. The electronic medical records (EMR) documentation supported the youth was admitted to the center with a positive confirmation of pregnancy and prenatal care protocols were implemented immediately. Prenatal care was delivered at recommended intervals including off-site medical prenatal, obstetrical, or gynecological appointments. The youth had daily monitoring of the danger signs of pregnancy complications. Reviewed documentation supported the designated

health authority (DHA) and/or advanced registered nurse practitioner (ARNP) conducted a focused medical evaluation at least once every thirty days. A review of the Healthcare Education Record indicated the youth received prenatal education to include alcohol and drug use, smoking, nutrition, sexually transmitted infections, contraception, prenatal care, birthing process, postpartum care, basic baby care, child/infant development, and parenting skills. A review of seven staff training records verified the center's registered nurse (RN) provided training for Girls Health to staff involved in the supervision or treatment of pregnant youth.

Standard 5: Safety and Security

5.01 Active Supervision of Youth (Critical)	Satisfactory Compliance

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

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

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

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

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

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

The center has a written policy and procedures to address active supervision of youth. During the annual compliance review, youth supervision was observed each day of the review. Youth and staff observations were conducted on the modules, in the classrooms, in the cafeteria, and in the transportation area while preparing for transport. Line movements were observed throughout the facility throughout the week. There were always two or more staff with each group of youth. Detention staff maintained continuous sight supervision of all youth in their assigned area. The interactions between staff and youth demonstrated active supervision. Staff were positioned in the areas and line movements supported active supervision. The juvenile justice detention officers and master control operators communicate to receive authorization for all movement within the center. The master control logbooks for the past six months were reviewed and reflected there was documentation to support headcounts were being conducted on a consistent basis during the beginning and ending of each shift and prior to youth movement. Seven staff were interviewed and all seven responded they think there are enough staff at the center to provide for the safety and security of the youth and staff.

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 has a written policy and procedures addressing ten-minute checks. Staff utilize the electronic Guard One wand to conduct these checks by tapping the wand on the check point sensors located on the outside of each youth's assigned room. The data from the wand is downloaded daily to ensure no data is lost. When conducting checks, the juvenile justice detention officer (JJDO) must observe the youth behind the closed door before the check point sensor is activated. A review of the documentation and surveillance video was conducted for eight randomly selected dates across three shifts and on four different youth living modules. The review reflected the ten-minute checks were consistently conducted at intervals of ten minutes or less as required. Informally interviewed staff reported they are knowledgeable of the requirements and policy for ten-minute checks and room checks. Seven interviewed staff each advised room checks are conducted every ten minutes when a non-suicidal youth is placed in their room.

5.03 Census, Counts, and Tracking	Satisfactory Compliance

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

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

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

The center has a written policy and procedures in place to ensure staff always know the exact number and location of all youth under their supervision. Staff do not include youth in the count who are not physically present with the staff person at the time of the count. A review of the

master control logbooks from the previous six months confirmed the census counts of youth are written at the beginning and at the end of each shift. Furthermore, counts are conducted and documented at a minimum, one additional time randomly per shift. Counts were documented following emergencies, disturbances, and drills. Census counts were documented upon any change in population. Living module counts were recorded in their assigned module logbooks. Seven interviewed staff each advised emergency counts are conducted when a youth is believed to be missing, when visibility is hindered such as an electrical outage, and after a major disturbance. Three staff responded emergency counts are conducted following drills, emergencies, or evacuations. Each of the seven staff reported counts are conducted at the beginning and end of each shift, prior to and following school, and prior to and following meals. All seven staff were able to articulate the process to be followed if counts were not reconciled.

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

The center has written policy and procedures regarding logbooks. The center maintains separate logbooks in master control and for each living module as well as a logbook for visitors and a logbook for contracted staff. A review of logbooks for the previous six months revealed each logbook was bound with numbered pages, entries were made with blue or black ink and included the date and time of the event or incident with the name of the staff and youth involved as well as a brief description of the event, and the initials of the staff making the entry. Reviewed documentation for the past six months revealed the safety and security of the facility, including medical, special needs, and mental health alerts were highlighted. Reviewed logbooks reflected all errors are struck through with a single line and are dated and initialed by the person correcting the error. Reviewed master control logbooks included emergency situations, incidents, fire and escape drills, population counts at the beginning and end of each shift, group movements, admissions and releases, presence of law enforcement, name of youth placed in confinement including the time confinement began and the time confinement ended, and name of youth placed on precautionary/secure observation including the time precautionary/secure observation began and the time precautionary/secure observation was discontinued.

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

The center has a written policy and procedures regarding logbooks. The master control and living unit logbooks for the past six months were reviewed. Reviewed documentation confirmed juvenile justice detention officer supervisors reviewed the logbooks each shift including the master control logbook when accepting the shift to ensure they are aware of alerts, security risks, and other pertinent issues at the center. Reviewed documentation confirmed the superintendent or designee reviewed the logbooks on a weekly basis and the juvenile justice detention officer assigned to the modules reviewed the logbook upon accepting the 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.)*	

The center has a written policy and procedures regarding key control. This policy addresses key control, issuance of keys to staff, inventory and tracking of keys, key restrictions, storage of keys, missing or lost keys, and reporting and replacement of damaged keys. All keys are stored on a tamper-resistant key ring which inhibits the removal of keys. The center maintains a master key inventory which accounts for all key rings by ring number, the number of keys on each ring, the capability of each key, and to whom the keys are assigned and issued to. Emergency keys which provide egress through exterior doors are stored in master control and on the module in a secured lock box affixed to the wall which only staff can access with a key. A review of the Key Control Logs and observation of the distribution and collection of keys confirmed the issuance of keys and key ring numbers, which were documented on the Key Control Logs on each shift with the date and time of issuance, name of the person issuing the key, name of person receiving the key ring, and time returned. During the week of the annual compliance review, staff were always observed carrying the keys on their person and youth did not have access to handle

facility keys. A review of the master key control inventory revealed the inventory report matched the actual key rings in use and inactive key rings were included on the master inventory and were maintained in a secured key box accessible to the shift supervisor. An inventory of active and inactive keys is to be conducted on each shift. An interview with the center's superintendent reflected there were no reported incidents during the review period of lost keys. The superintendent also confirmed if a staff does take keys home with them, the keys are returned to the facility within two hours of discovering the keys were taken home. Personal keys are stored in staff lockers in the non-secure area and visitor's personal keys are stored in master control. Seven interviewed staff each reported they received training on the center's key control policy and procedures and each were knowledgeable of the daily process for tracking keys, what program keys were considered restricted, and what to do if a key is damaged or lost. There were no missing or lost keys in the past six months. An informal interview with master control staff confirmed the center's practice.

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

The center has a written policy and procedures in place for transportation and operation of Department vehicles. The center has a total of six vans used to transport youth. All vehicles were observed to have the appropriate number of seat belts, a seat belt cutter, a window punch, a fire extinguisher, and a first aid kit with approved items. Use of tobacco products is prohibited by the facility operating procedures and is supported by, "No Smoking," stickers posted in the driver cabin of each vehicle. An observation of post-transport activities was completed during the week of the annual compliance review. Observations reflected the vehicle was searched for contraband by staff after the transport. Staff searched the youth after removing the youth from the van. Youth and staff used their seatbelts. The transport staff were in possession of the vehicle's logbook and a binder containing the Vehicle Log, gas credit card, and vehicle registration. A security check was conducted of all vehicles and confirmed the center's vehicles were locked when not in use. Reviewed documentation found each vehicle is inspected prior to transport. Reviewed documentation supported the maintenance mechanic completed weekly and monthly vehicle checks on each vehicle. A review of the vehicle maintenance invoices confirmed all vehicles received an annual inspection within the previous year, as required.

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 has a written policy and procedures addressing tool inventory and management. All tools were secured in a locked and secured maintenance workshop which is only accessible to the maintenance staff and administrators. Tools are stored on shadow boards and are etched with a number which is identified as the Department's property. The center maintains a perpetual inventory of tools. All tools are signed-out prior to use and are signed-in after they are returned. Interviewed maintenance staff indicated inventory is conducted monthly and is forwarded to the center's superintendent or designee for review. Kitchen tools including knives

which are stored in a locked box in the kitchen are always locked and secured. Staff maintains a perpetual inventory of kitchen tools and counts are documented at the beginning of each day, midday, and at the end of the day. Reviewed inventory sheets reflected all tools were accounted for without discrepancy. There were no tools missing or documented as being missing from the center. There were no tools in the center not listed on the inventory. Seven interviewed staff each could articulate the center's practice for when tools are missing or damaged.

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 has a written policy and procedures addressing youth's access to and the use of tools and cleaning items. The youth only have access to mops, brooms, buckets, and cleaning rags. An observation of youth performing cleaning detail also supported the policy is implemented and youth do not access any inappropriate tools or cleaning items. Observations further reflected these approved cleaning tools are used under the direct supervision of staff. Seven interviewed youth each responded they use mops and brooms only. Seven interviewed staff each reported youth are only allowed to use mops and brooms. Three staff responded youth may use scrub brushes to clean the toilets.

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 has a written policy and procedures to address the inventory of flammable, toxic, caustic, and poisonous items. Flammable, toxic, caustic, and poisonous items are maintained in secured areas with access limited to maintenance and supervisory staff only. Safety Data Sheet (SDS) logbooks are maintained in the same location the chemicals are stored. Inventories of flammable, toxic, caustic, and poisonous items are maintained by the center's maintenance mechanic. The SDS and inventories were compared for the items on-site and were found to be accurate and complete.

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.*	

This center has a written policy and procedures for toxic materials which prohibits youth access to flammable, toxic, caustic, or poisonous items. Youth are not permitted to access any materials which are flammable, toxic, caustic, and/or poisonous. No toxic materials were observed to be stored in the center in any place accessible to youth during the week of the annual compliance review. An interview with the superintendent confirmed flammable, toxic, caustic materials are stored in the maintenance department and laundry area under lock and key and are only accessible to supervisors, administrators, and maintenance staff. Seven interviewed youth each responded they use cleaning agents such as bleach, toilet, or window cleaner; however, the staff sprays/pours the chemical and the youth wipes it down/cleans with it. Seven interviewed staff each responded youth are not allowed to clean with toxic, flammable, or poisonous substances.

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

The center has a written policy and procedures which addresses proper use, storage, and disposal of flammable, toxic, caustic, and poisonous items. The plan addresses the procedure to follow in the event of a chemical leak or spill. An interview with the center's maintenance mechanic confirmed materials are disposed of by evaporation, compaction, or with a contracted disposal service. The kitchen has a container outside to dispose of grease which this is disposed through a contracted vendor. Medical biohazardous waste is disposed of with a contracted vendor. The interview with the maintenance mechanic further confirmed there were no chemical spills or leaks at the center within the annual compliance review period.

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 has a written policy and procedures regarding the use of confinement under twenty-four hours. Seven under twenty-four hour confinement reports were reviewed. Each were documented on confinement Visual Observation Report (VOR) logs. All reports documented the room was searched prior to the youth being placed in the room, the rooms were clear of obstruction, the confinement report was completed within one hour, and the juvenile justice detention officer supervisor (JJDOS) reviewed each report within two hours and every three hours thereafter. The superintendent or designee reviewed all confinements within twenty-four

hours and the confinements were communicated with school personnel. Seven interviewed staff each responded when a youth is placed in confinement, staff must search the confinement room, conduct/document ten-minute room checks, and complete a confinement report.

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

The center has a written policy and procedures addressing confinement over twenty–four hours. Seven confinement reports for confinements over twenty-four hours were reviewed. The confinements over twenty-four hours were approved by the center's superintendent or designee. The juvenile justice detention officer supervisor (JJDOS) completed reviews evaluating the confinement every three hours. Five of the seven confinements included a review by a mental health professional every twenty-four hours while two did not. All seven confinements were approved by the regional director, as required. None of the confinements extended beyond three days; therefore, no confinement hearings were required.

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

The center has a written policy and procedures to manage various emergencies and disaster events. Two Continuity of Operations Plan (COOP) drills were conducted within the prior year. Hurricane drills were conducted in May and in September of 2019. One of the drills was conducted in May prior to the beginning of hurricane season, as required. Written scenarios, drill forms, critique forms, e-mails, and logbook entries used to document the drills were reviewed to ensure compliance. The center has a comprehensive COOP which includes annexes which define facility specific emergency information. Seven staff were interviewed on the type of drills they participated in during the past six months. All seven staff responded they have participated in a weather drill, major disturbance drill, bomb threat drill, escape drill, and fire drill. Five staff additionally responded they have participated in a hostage situation drill and three staff responded they have participated in a flood, chemical spill, or terrorism drill as well.

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

The center has a written policy and procedures to address escape drills and escape prevention. The policy requires the center to conduct escape drills quarterly. Reviewed documentation of escape drills with corresponding logbook entries verified drills are conducted quarterly as required. Recommendations and critiques of the drills were included in each report. A review of the logbooks revealed all escape drills were documented in the logbook, as required. Seven staff were interviewed on the type of drills they participated in the past six months. All seven staff responded they have participated in an escape drill. Training records of seven staff were reviewed and each staff received escape prevention training during the previous year.

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

The center has a Fire Prevention and Evacuation Plan which was reviewed and approved by the local fire marshal and addresses fire prevention and safety of the center. A review of documentation supported the center conducted fire drills each month on each shift for the past six months. The fire drills were also documented in the master control and module logbooks. The center had a fire inspection completed in the previous twelve months and documentation of corrective actions were completed as recommended. Fire extinguishers located inside the center as well as vehicles were inspected during the previous twelve months. Seven interviewed staff each responded they have participated in monthly fire drills in the past six months. Training records of seven staff were reviewed and each received fire prevention training during the previous year. Seven youth were interviewed and four stated they have been instructed on what to do in the case of a fire while three responded they have not been instructed on what to do in case of a fire. Reviewed documentation confirmed each of the three youth received an orientation to the center, which includes what to do in case of a fire. This information was also advised to the superintendent.