STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

Annual Compliance Report

Brevard Regional Juvenile Detention Center

Department of Juvenile Justice
(State-Operated)
5225 Dewitt Avenue
Cocoa, Florida 32927

Review Date(s): October 27-30, 2020

Promoting Continuous Improvement and Accountability
in Juvenile Justice Programs and Services

Rating Definitions

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

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

Review Team

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

Kamille Payne, Office of Accountability and Program Support, Lead Reviewer (Standards 1 and 4)
Teresa Andersen, Office of Accountability and Program Support, Deputy Supervisor (Interviews, Standards 4 and 5)
Lenon Anderson, Orange Regional Juvenile Detention Center, Juvenile Justice Detention Officer Supervisor (Standard 5)
Cindy Jones, Office of Education, Deputy Education Director (Standard 2)
Tamara Mahl-Adkins, Office of Accountability and Program Support, Regional Monitor (Standard 2)
Gustavo Mazorra, Office of Accountability and Program Support, Regional Monitor (Standard 3)
Jesin Miah, Office of Accountability and Program Support, Regional Monitor (Standards 1 and 5)

Program Name: Brevard Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: Brevard County / Circuit 18
Review Date(s): October 27-30, 2020

MQI Program Code: 244
Contract Number: N/A
Number of Beds: 40
Lead Reviewer Code: 161

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

Overall Rating Summary

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

Limited Ratings	Failed Ratings
1.05 Protective Action Response (PAR)	5.16 Confinement Over Twenty-Four Hours
5.18 Escape Drills	

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)	Limited
1.06	Pre-Service/Certification Requirements *	Satisfactory
1.07	In-Service Training	Satisfactory
1.08	Grievances	Satisfactory
1.09	Entering Alerts(JJIS) and Sharing of Alert Information *	Satisfactory

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

Standard 2: Youth Management
Detention Rating Profile

Indicator Ratings

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

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

Indicator Ratings

Standard 3 - Mental Health and Substance Abuse Services		
3.01	Designated Mental Health Clinician Authority (DMHCA)	Satisfactory
3.02	Licensed MH/SA Clinical Staff *	Satisfactory
3.03	Non-Licensed MH/SA Clinical Staff	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/Exposure Control/Education	Satisfactory
4.18	Prenatal Care/Education	Satisfactory

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Standard 5: Safety and Security
Detention Rating Profile

Indicator Ratings

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

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Program Overview

The Brevard Regional Juvenile Detention Center is a state-owned detention center, operated by the Department, located in Cocoa, Florida. The center serves youth in Brevard County in Circuit 18. The center is co-located with the Juvenile Assessment Center, operated under a contract with the Juvenile Services Program, Inc. Male and female youth who are detained pending adjudication, disposition, or placement in a residential commitment program are housed in the forty 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 Brevard County School Board. The center's management team includes the superintendent, two assistant superintendents, one administrative assistant, seven juvenile justice detention officer supervisors (JJDOS), and thirty-eight juvenile justice detention officers (JJDO). Mental health and healthcare services are provided through the contracted provider, Camelot Community Care, Inc. Mental health services are provided by one full-time designated mental health clinician authority (DMHCA) who is a licensed mental health counselor (LMHC), one part-time LMHC who provides services as needed, and a licensed psychiatrist who is on-site two hours a week. Clinical services provided by the center include mental health and substance abuse evaluations, mental health treatment planning, individual, group, and family therapy, mental health crisis intervention services, on-site psychiatric services, and availability for substance abuse services for youth with co-occurring disorders. Medical services are provided by one designated health authority (DHA), one advanced practice registered nurse (APRN), one registered nurse (RN) who serves as the nurse manager, two licensed practical nurses (LPN), and one medical records technician. The medical clinic maintains nursing coverage Monday through Friday, from 7:00 a.m. to 7:00p.m., and on weekends, eight hours a day from between 7:00 a.m. and 7:00p.m. Food services are provided by Department staff and include menus, meal planning, meal schedules, special diets, nutritional analysis, daily allowance, food preparation, health certifications, food product standards, sanitation, and cleaning. Staff are responsible for the custody and control of youth in their care, providing youth supervision twenty-four hours a day, seven days a week.

The center has three living modules which are divided by males and females; however, when population is low, the female youth sleep on one side of the male's module to allow for proper staffing and supervision. There are fifty-eight security cameras at the center, of which all were operational at the time of the annual compliance review. Observations during a tour of the center found all interior and exterior areas to be neat, clean, and free of graffiti. At the time of the annual compliance review, the center had fifteen vacancies, which included five JJDO I positions, eight JJDO II positions, including the field training coordinator, one JJDOS, and one assistant superintendent. In addition, the center's superintendent is on leave pending retirement in December 2020 and the one assistant superintendent was recently hired and is in training; therefore, the regional office is providing support and assistance during the transition and was on-site during the annual compliance review.

Strengths and Innovative Approaches

- The center offers virtual yoga through Kula for Karma.

Standard 1: Management Accountability

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

The center hired seventeen new staff since the last annual compliance review. A review of staff records determined each staff had a background screening completed with an eligible rating from the Department's Background Screening Unit (BSU) prior to the date of hire. Fifteen of the seventeen staff were eligible for a pre-employment assessment tool. The remaining two staff do not work with the youth. Thirteen of the fifteen applicable staff passed the Ergometrics pre-employment assessment tool. Two staff did not pass the pre-employment assessment tool; however, an override was provided for both staff from Detention Headquarters. The center has a contract with Camelot to provide medical and mental health services which began on March 15, 2020; however, all staff with Camelot were previously providing services at the center and were previously background screened with the provider Agency for Healthcare Administration's Clearinghouse system. The Clearinghouse system reflected all contracted staff were added to the Camelot roster, as required. The center has had no new volunteers on-site during the annual compliance review period. The center submitted an Annual Affidavit of Compliance with Level Two Screening Standards for detention staff on January 3, 2020 and the school board submitted an affidavit on January 6, 2020.

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

A review of the center's staff and volunteer roster determined two staff were applicable for a five-year rescreening during the annual compliance review period. One of the two applicable staff had a background rescreening completed within the required timeframe. The remaining staff is on military leave and has been since 2016 and was not able to sign the required documentation for a background rescreening; therefore, the staff was ineligible to receive the background rescreening. The center had six volunteers applicable for a background rescreening; however, documentation confirmed none of the six volunteers were on-site for more than ten hours a month during the annual compliance review period and did not need to receive a rescreening.

1.03 Staff Code of Conduct	Satisfactory Compliance

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

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

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

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

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

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

The center has a facility operating procedure (FOP) in place outlining the code of conduct for staff and the provision of an abuse-free environment. An interview with the regional director confirmed the center has zero tolerance for verbal, physical, or emotional abuse of youth. Staff are required to sign an acknowledgement of receipt of the employee handbook and code of conduct upon hire which asserts any violations will result in corrective action. Six reviewed staff records each contained a signed acknowledgement indicating the staff received the center's code of conduct, found in the employee handbook, on the date of hire. Three of the six staff were applicable for disciplinary action as a result of a violation of the code of conduct. Each disciplinary action was due to an incident reported to the Central Communications Center (CCC). Each of the three staff received a re-training as the management response to the violation of code of conduct. In addition, one of the three staff had a second instance of code of conduct violation and the staff was given an official oral reprimand. Three of the six staff records contained commendations for Detention Services Employee of the Month during the annual compliance review period.

Five interviewed staff reported the working conditions at the center were good. None of the staff reported hearing coworkers threat, intimidate, or humiliate youth. Three staff reported never hearing coworkers use profanity when speaking with youth and two said they have heard profanity occasionally. Each of the staff reported if a youth requests to contact the Florida Abuse Hotline or CCC they would allow the youth to call, they could call if they needed to, and the supervisor would be contacted. Three staff also reported they would call the superintendent. One of the five interviewed youth reported they have never been prevented from calling the Florida Abuse Hotline. The remaining four youth reported they have never wanted to call the Florida Abuse Hotline. All five interviewed youth reported they felt safe at the center, staff speak respectfully to youth, have never heard a staff threaten the youth, and they have never had contact with staff outside of the center. Three youth reported they have never heard the staff use profanity when speaking to youth and two reported they have heard staff use profanity occasionally.

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 had forty-three incidents reported to the Central Communications Center (CCC) since the last annual compliance review, five of which were reviewed. Each of the five reviewed incidents were reported to the CCC within the required two-hour timeframe. Four of the five reports were documented in the master control logbook. A review of internal incident reports and youth records found no additional incidents which should have been reported to the CCC. The center had an increase in CCC reports since the last annual compliance review period; however, the increase was as a result of the COVID-19 pandemic, as the center was required to report any tests conducted on youth or staff. The regional director was interviewed and confirmed the reporting process for the CCC and Florida Abuse Hotline. In addition, the regional director reported if an allegation is made against staff, the staff would be placed on no youth contact pending an investigation.

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

The center had forty-nine Protective Action Response (PAR) incidents during the annual compliance review, five of which were reviewed. Each of the five reviewed PAR reports were reviewed by the supervisor, PAR instructor, and superintendent, as required. Three of the five reports did not document a post-PAR interview was conducted with the youth within thirty minutes of the incident. The center reported the previous process was for the nurse to conduct all post-PAR interviews; however, the process has been updated in the last three weeks and now requires the supervisor to conduct interviews with the youth in order to meet the thirty-minute deadline. Two of the five reports did not include all narratives from each involved staff. Each of the two incomplete reports were missing narratives from two staff involved. The remaining three reports included all narratives from each involved staff completed by the end of the staff's workday. None of the five PAR incidents required the use of mechanical restraints, a post-PAR medical review, or notification to the Central Communications Center (CCC) or Florida Abuse Hotline.

A review of internal incident reports and youth records indicated there were no additional PAR incidents which did not have a report. The center's PAR rate during the annual compliance review period was 13.04, which is below the statewide Detention PAR rate of 16.36. The center had an increase in PAR incidents since the last annual compliance review which the center attributed to housing youth from other circuits and having an increase in youth in the center with neighborhood conflicts. An interview with the regional director confirmed physical and mechanical restraints are tracked in the Facility Management System (FMS); however, the center has not utilized mechanical restraints during the annual compliance review period. The regional director reported the supervisors and superintendent are required to review all PAR incidents and submit fidelity checks and any injury reports to regional staff. Five interviewed staff reported staff try to talk with youth prior to engaging in PAR techniques.

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

Five staff records were reviewed for pre-service training requirements. Each record documented staff completed all required training, including Protective Action Response (PAR), first aid, cardiopulmonary resuscitation (CPR), automated external defibrillator, mental health and substance abuse services, suicide prevention, safety, security, and supervision, Prison Rape Elimination Act (PREA), human trafficking, and detention operations prior to contact with youth. Four of the five staff records documented staff completed all training, including the Phase Two academy training, and were certified within 180-days of hire. The remaining staff was certified twenty-two days late; however, a training waiver was obtained from the Department's Office of Staff Development and Training due to limited class sizes during the COVID-19 pandemic.

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

Five staff records were reviewed for in-service training requirements completed during calendar year 2019. Each of the five staff completed required training in Protective Action Response (PAR), suicide prevention, professionalism and ethics, active shooter, and human trafficking. Four of the five staff completed training in first aid, automated external defibrillator (AED), and cardiopulmonary resuscitation (CPR); the fifth staff was a first aid/CPR/AED trainer whose certification expires in 2022 and was not required to participate in the refresher training. Two of the five staff records were applicable for supervisory training. Each of the supervisors completed more than the required amount of supervisory training hours. One staff completed sixty-eight hours of training in management, leadership, personal accountability, employee relations, fiscal, and communication skills. The remaining staff completed thirteen hours of training in personal accountability, fiscal, and employee relations. All five staff, including the two supervisory staff, completed training in medication administration and the use of an epinephrine auto-injector. The center has a training plan which outlines required trainings throughout the year and is updated, as needed. An interview with the regional director confirmed required training for staff.

1.08 Grievances	Satisfactory Compliance

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

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

The center has facility operating procedures (FOP) which outlines the grievance process for youth including informal, formal, and appeal phases. The center did not had any grievances submitted during the annual compliance review period. None of the five interviewed youth completed a grievance; however, each youth knew they could request to submit a grievance at any time. Each of the five interviewed staff reported youth can request to fill out a grievance at any time and the forms would be given to the supervisor for response. An interview with the regional director confirmed youth can request a grievance at any time. Grievances are submitted in the Facility Management System (FMS) and reviewed by a supervisor for response. Youth have the opportunity to appeal their grievance findings, if needed.

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

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

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

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

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

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

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

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

The center has facility operating procedures (FOP) for entering alerts into the Department's Juvenile Justice Information System (JJIS) and sharing alert information with staff to ensure the

safety and well-being of youth with critical and special alerts and to ensure alerts are documented, reviewed, and responded appropriately. A review of five youth records confirmed alerts were entered into JJIS if youth were admitted with special risks and needs including metal health, substance abuse, physical health, and security risk factors. The five youth records revealed the center's medical and mental health staff reviewed the alerts for each youth and ensured each alert was correctly tracked and managed. Documentation in each record indicated updates and responses were completed by medical and mental health staff for each youth alert. A review of the center's shift briefing reports and observations of a shift briefing validated youth alert information was shared and made available to appropriate staff. Alerts were printed, and a copy was given to each staff during the observed shift briefing.

All five interviewed staff indicated they are informed of youth alerts during daily shift debriefings and by utilizing the alert forms. Two staff indicated they are informed of youth alerts through JJIS. The regional director indicated alerts are entered by the center's juvenile justice detention officers and medical staff based on assessments, observations, and information provided by the youth and parent/guardian; the alerts are reviewed during each shift briefing and the dining hall staff receive a copy for dietary needs and allergies.

Standard 2: Assessment and Performance Plan

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

In all five youth records reviewed, the Department's Juvenile Justice Information System (JJIS) Admission Wizard documented the arrest affidavits or custody orders, Detention Risk Assessment Instruments (DRAI), and Suicide Risk Screening Instruments (SRSI) were reviewed, as well as frisk, strip, and/or electronic searches were conducted on the youth. In all five records, mental health, substance abuse, and medical screenings were completed during the admission process and all youth received a meal. Three of the five records documented the youth received a telephone call or documented refusal of the telephone call. The remaining two records did not have documentation indicating the youth was offered a telephone call. During the annual compliance review, a youth admission was observed. The youth was admitted to the center after lunch time was over; however, the youth received a bagged lunch with a milk. The intake officer attempted to contact the youth's Department of Children and Families (DCF) caseworker and left a voicemail. The intake officer reviewed the intake paperwork, including the DRAI, SRSI, and arrest affidavit/custody order, and completed the Secure Detention Admission Wizard form, as required.

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 facility operating procedures (FOP) regarding the orientation of youth at admission. In all five youth records reviewed, documentation indicated each youth received an

orientation within twenty-four hours of admission. Each record contained an orientation form which was signed by the youth to document the content had been discussed. All five records documented the orientation was provided verbally and in writing, and included rules and regulations, youth rights, visitation, telephone calls, grievance procedures, the possibility of receiving new law violations for destruction of property, behavior expectations and consequences, as well as access to medical, mental health and substance abuse services, the Florida Abuse Hotline, and Central Communications Center (CCC) telephone numbers. During the annual compliance review, a youth admission was observed in which the intake officer discussed all required orientation topics with the youth, as required. The youth indicated a video was shown during orientation but they did not want to pay attention. The youth signed the orientation form. Each of the five interviewed youth indicated an officer explained the rules and regulations, daily schedule, education services, visitation, abuse reporting, and behavior management system (BMS) upon 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 facility operating procedures (FOP) which outline the requirements of the classification of youth upon admission. All five reviewed youth records documented the youth were classified during admission, which included a review of information concerning the youth's history and status, the arrest affidavit/custody order, Detention Risk Assessment Instrument (DRAI), and Suicide Risk Screening Instrument (SRSI). Consideration of potential safety and security concerns in room assignments for the youth included, but were not limited to, gender, height, weight, age, level of aggressiveness, mental illness, intellectual disabilities, physical disabilities, history of violent behavior, gang affiliation, and criminal behavior. Each youth's history of sexual offenses, including sexual battery charges which were reduced to a lesser offense, medical, escape, security, and suicide risk identified and suspected were reviewed. In all five youth records, a review of the Vulnerability to Victimization and Sexually Aggressive

Behavior (VSAB) results was documented by the staff making the youth's room assignment, as indicated by the dated signature on page three of the VSAB form. All five youth were assigned to a room based on the classification process and alerts were entered, updated, and closed, as applicable. The center only has single room occupancy; therefore, reclassifications are not required.

The center identifies youth aggression and those vulnerable to victimization through a review or completion of the Secure Detention Admission Wizard, alerts, and the VSAB. The center staff remain informed of how to identify and address local youth gangs through a review of the detailed alert list from the Department's Juvenile Justice Information System (JJIS) , which is updated by the Juvenile Assessment Center (JAC) screening staff. The information is shared with probation staff. A review of the JJIS alert list found one youth in the center with a gang alert, which was reflected on the youth's classification documentation. An interview with the regional director indicated the admission classification process factors, such as mental health status, physical health status, cognitive performance, age, and prior victimization are considered when assigning youth to a room, as well as review of alerts, the SRSI, the VSAB, and other applicable forms.

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 facility operating procedures (FOP) indicating the center shall identify the juvenile probation officer (JPO) designated as the circuit gang representative to communicate information regarding suspected youth gang activity. Detention staff shall document any indications of gang activity such as youth flashing hand signs, gang tattoos, gang-related drawings, or related activity, and notify the JPO circuit gang representative. None of the five reviewed youth records were applicable for gang alerts or notification.

The center had one youth in the center during the annual compliance review with a gang alert; however, the youth was previously identified as a gang member and notification was not required. The center has a gang book which was maintained by the field training coordinator/gang liaison. The gang liaison resigned effective September 25, 2020 and has not been replaced; therefore, the gang liaison was unable to be interviewed. The center staff indicated the juvenile justice detention officer supervisors (JJDOS) will inform master control (MC) of any gang information, which is entered into the Department's Juvenile Justice Information System (JJIS) as an alert, probation staff are notified, and gang alerts and activities are discussed during the weekly detention reviews.

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.	

In all five youth records reviewed, the Personal Property Receipt form was signed by the youth, as well as the detention staff, and maintained in each record. All records contained a letter of acknowledgement regarding unclaimed property, which was signed by the youth. Each of the records documented the youth's personal property, including clothing, was placed in an assigned locker, as documented on the Personal Property Receipt form and maintained in the youth record. One of the five youth had valuables which were verified and secured in a clear tamper-proof property bag. The bag included the date, youth's name, the Department identification (DJJID) number, and a listing of items placed in the bag. The tamper-proof bag was placed in the drop safe and the drop safe bound logbook documented the date, the name of the youth, DJJID, and printed name of the officer.

During the annual compliance review, one admission was observed. The youth signed the Personal Property Receipt form, as well as the letter of acknowledgement regarding unclaimed property. The youth had no valuable property. The personal property was placed in the locker along with a copy of the Personal Property Receipt. Another copy of the receipt was placed on the outside of the locker in a small pouch to identify the contents. All five interviewed youth indicated their personal property was checked by center staff upon arrival to the center and they signed a form stating the personal property was correctly accounted for. An interview with the regional director indicated all valuables are placed in a tamper-proof bag which is placed in the safe and documented in the Department's Juvenile Justice Information System (JJIS) to ensure the youth's property is secure. All other items are stored in a room at intake/release in their assigned lockers. The items in the lockers are accessible to the supervisors and intake/release officers and only administration staff have access to the safe.

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

Three personal property lockers were inspected. Each locker was found to be locked, in a locked room in the intake/admission/release area of the center. All three lockers had a Personal Property Receipt in a pocket on the outside of the locker, with a copy of the receipt on the inside of the locker documenting the correct items contained within. Each youth signed the Personal Property Receipt form. Three valuable clear tamper-proof property bags were observed in the drop safe. All property bags had a list of items on the outside of the bag correctly reflecting items inside the bag. The bound safe logbook documented the contents inside the property bags. The items in the lockers are accessible to the supervisors and intake/release officers and only administration staff have access to the safe. In addition, the safe is under constant video surveillance.

A review of Central Communications Center (CCC) reports during the annual compliance review period indicated there were no incidents regarding youth property. During the annual compliance review, one admission was observed. The youth signed the Personal Property Receipt form, as well as the letter of acknowledgement regarding unclaimed property. The youth had no valuable property. The personal property was placed in the locker with one copy of the

Personal Property Receipt and another copy of the receipt was placed on the outside of the locker to identify the contents. An interview with the regional director indicated the process for disposal of property not claimed is to donate unclaimed property to a non-profit organization and obtain a receipt. A money order is obtained for all money and sent to the detention regional office.

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.*	

A review of three closed records confirmed the on-duty supervisor reviewed all paperwork related to each youth's release, including court orders, as well as verifying the youth and parent/guardian's identification (ID) prior to release. The parent/guardian's ID was photocopied and placed in each youth's record. None of the three youth were applicable for Endangered Persons alerts. A review of Central Communications Center (CCC) reports during the annual compliance review period indicated there were no unauthorized releases. During the annual compliance review, one release was observed. The youth was in the care of the Department of Children and Families (DCF) and the detention staff photocopied the caseworker's ID. The youth received their property, verified all items were received, and signed the Personal Property Receipt. The caseworker also signed the receipt.

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

A review of three closed records confirmed the youth and parents/guardians signed the Personal Property Receipt form upon release. Three records applicable for property held for more than thirty days after a youth's release were reviewed. In each record, the center sent a letter to the parent/guardian within seven days of the youth's release indicating the property will be disposed of after thirty days from notice, unless retrieved. If the property remains after thirty days, the money is sent to detention services and the remaining property is given to charity. A letter to detention services was observed for all three records indicating the amount of money sent, as well as a receipt to a charity indicating all items donated.

During the annual compliance review, one release was observed. The youth was in the care of the Department of Children and Families (DCF) and the detention staff photocopied the caseworker's identification card. The youth received the property, verified all items were received, and signed the Personal Property Receipt. The caseworker signed the receipt. Observations determined the property location was incorrectly documented on the Personal Property Receipt; the youth's locker contained another youth's belongings, which was correctly reflected on the receipt contained on the outside of the locker and within. The switched lockers were one above the other and all property was accounted for.

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 facility operating procedures (FOP) indicating medication for youth released from the center shall be given to the person to whom the youth is released to and is documented on the release paperwork. The medication release form shall be completed and given to medical staff. Both the youth and parent/guardian or person taking custody of the youth shall be advised of issues related to the youth's health or welfare. The parties shall sign all applicable release forms. One of three closed youth records reviewed was applicable for release of medications; therefore, two additional applicable records were reviewed. In all three applicable closed records reviewed, a copy of the identification (ID) of the appropriate person the youth was released to was maintained, as well as the completed Detention Release Wizard form. The form documented the youth and the person to whom the youth was released to were reminded of any health or welfare issues, including medical, mental health, and/or substance needs and any pending appointments. Each of the three closed applicable records contained the receipt of medications which was signed by the person receiving the youth.

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

A review of weekly detention review paperwork during the annual compliance review period was conducted. Each of the weekly detention reviews included notes on what was discussed, as well as staff who attended. None of the weekly detention reviews included tasks assigned for follow-up. Weekly detention reviews were attended either in-person or telephonically by the audit chair, captain, medical staff, education staff, mental health staff, juvenile probation officer supervisors (JPOS), Brevard Family Partnerships staff, chief probation officer (CPO), assistant chief probation officer (ACPO), commitment manager, intake screening staff, Brevard Cares staff, Bay Area Youth Services (BAYS) supervised release tracker (SRT) staff, detention review specialist, and Department of Children and Families (DCF) liaison.

A weekly detention review was observed during the annual compliance review. The center does not have an acting superintendent or assistant superintendent; therefore, the CPO acted as audit chair. The review began with a roll call by the CPO to document in-person and telephonic participation. All youth on home detention, home detention with electronic monitoring, and secure detention were discussed. Staff with involvement in the youth's care provided information or insight, as needed, which was documented on the detention review paperwork. An interview with the regional director confirmed the superintendent, CPO, JPOS, medical,

mental health, education, and DCF staff attend the weekly detention reviews for youth in secure detention, as well as home detention. The reviews are conducted telephonically in the center's conference room every Thursday. Information such as release dates, court dates, contact data for parent/guardian, Authority for Evaluation and Treatment (AET), commitment status, and other pertinent facts are discussed during the reviews.

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

During a center tour, the daily activity schedule was found posted throughout the modules. A copy of the schedule was reviewed, and the schedule included wake up/personal hygiene, meal times, visitation, education, recreation and physical activities, indoor activities, bed times, groups, and open program time activities. Daily observations during the annual compliance review indicated the center adheres to the daily activity schedule. Each of the five interviewed youth and five interviewed staff indicated the center has a daily activity schedule which is followed.

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

Thirteen different dates in the center's module and master control logbooks were reviewed for adherence to the daily schedule. Eleven of the thirteen dates reflected hygiene was conducted during the scheduled time slot for breakfast and breakfast was during the scheduled time slot for hygiene. All other activities were conducted as specified on the activity schedule. The logbooks documented movement of youth throughout the center; however, some of the entries are difficult to discern which activity the youth were involved in due to alternative arrangements during the COVID-19 pandemic, such as meals occurring on the modules. Daily observations during the annual compliance review indicated the center adheres to the daily activity schedule. All five interviewed youth and five interviewed staff indicated the daily scheduled is followed.

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

The center has facility operating procedures (FOP) to provide for educational access. The center integrates education into the daily schedule to ensure the youth receive the minimum instruction of twenty-five hours a week distributed over a twelve month period. The year-long calendar, approved by the School Board of Brevard County, and the daily bell schedule were reviewed and incorporated the required 250 days of instruction with ten days used for teacher planning. Due to the COVID-19 pandemic, the school schedule has been converted to a block schedule; however, the schedule allows for the same number of instructional minutes each week. The youth earn credit for completed courses as appropriate. Five interviewed youth and

an interview with the lead educator verified the youth are attending school according to the schedule, and the youth indicated they attend school Monday through Friday with little interruption during the school day. Each of the youth reported they are being well prepared for the continuation of their education. The teachers resumed on-site education August 19, 2020 following alternative measures which were put in place due to the COVID-19 pandemic. A review of the logbook and video footage for three days confirmed the youth attended school in accordance with the daily school schedule.

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

The center has facility operating procedures (FOP) regarding career education. An interview with the lead educator revealed skills and activities are offered to meet the requirements of a Type 1 Career Education program. These activities incorporate critical thinking skills, communication, resume writing, and additional character-building activities built into the core curriculum classes. My Florida Shines and other Career exploration curriculum materials are utilized.

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

The center has facility operating procedures (FOP) to incorporate trauma-informed care throughout the programming and care of youth in the center. The center's practice for implementing trauma-informed care into daily activities includes the softening of the overall aesthetics by using bright, vibrant, cheerful colors, as well as numerous murals on the walls. The center has a soft room, which is used for youth receiving special incentives. The soft room has pictures of beach scenes, a pastel color on the wall, and comfortable seating. The center utilizes Kula for Karma yoga, which is offered virtually, as well as providing youth opportunities to express themselves by drawing on chalk boards in the individual rooms. The behavior management system and specialized behavior plans, utilized for youth with specialized behavior needs, are designed to allow youth to achieve incentives such as playing games, snacks, and other special privileges. A review of five in-service staff training records indicated all staff were trained on trauma-informed care practices. An interview with the regional director indicated environmental changes, training for the staff, changes in the behavior management system, and programming have been utilized to implement trauma-informed practices.

Standard 3: Mental Health and Substance Abuse Services

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

The center has a contract for mental health and substance abuse treatment services with Camelot Community Care, Inc. The center has a contract with a licensed mental health counselor (LMHC) who serves as the designated mental health clinician authority (DMHCA) and has an active and clear license in the State of Florida under Chapter 491, which expires March 31, 2021. The DMHCA is scheduled to be at the center forty hours each week which was verified through a review of the sign-in logs. The center has identified a back-up DMHCA who is an LMHC with an active and clear license under Chapter 491, which expires on March 31, 2021. A review of the provider's contract and an interview with the DMHCA found the DMHCA is responsible for the coordination and implementation of mental health and substance abuse services at the center.

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 has facility operating procedures (FOP) regarding the qualification and supervision of licensed mental health and substance abuse clinical staff. The center has a contract with Camelot Community Care, Inc. for the provision of licensed clinical staff and the center was appropriately staffed, as required. The center has one part-time licensed clinical social worker (LCSW) who holds an active and clear license in the State of Florida which expires March 31, 2021. The center is staffed with a psychiatrist who is scheduled to be on-site two hours a week. The psychiatrist holds a clear and active license in the state of Florida which expires on January 31, 2022.

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

The center has facility operating procedures (FOP) governing the use and supervision of non-licensed mental health and substance abuse clinical staff. The center does not utilize non-licensed mental health and substance abuse clinical staff and did not utilize any non-licensed clinical staff during the annual compliance review period. The center holds a license under Florida Statute 397 which expires April 1, 2021.

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

The center has facility operating procedures (FOP) governing the screening process for mental health and substance abuse services for youth arriving at the center. The center uses the Massachusetts Youth Screening Instrument-Second Version (MAYSI-2) and Suicide Risk Screening Instrument (SRSI) as the screening instruments. The assessments are completed by trained medical staff and/or mental health staff. Five youth records were reviewed, and each contained a MAYSI-2 and SRSI which were completed at the time of the youth's admission to the center. The completed forms were in the youth record, as well as documented in the Department's Juvenile Justice Information System (JJIS).

Three of the five youth records had positive responses on the SRSI, and the youth were placed on suicide precautions, in addition to having a mental health referral completed, which documented the youth's need for an Assessment of Suicide Risk (ASR). In addition, the appropriate alerts were entered into JJIS. All three applicable youth records contained a completed ASR which was completed prior to the youth's removal from suicide precautions. Documentation indicated the superintendent was notified regarding the additional assessment required on each of the three youth. The results of the MAYSI-2 assessments indicated the need for a comprehensive assessment for the same three youth who required additional suicide risk assessment. The screener referred the three youth to mental health clinical staff for the required comprehensive assessment.

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

The center has facility operating procedures (FOP) governing mental health and substance abuse evaluations for youth, which includes a process for the review of all completed evaluations and communication with the youth's juvenile probation officer (JPO) regarding the evaluations. None of the five youth records reviewed were applicable for a mental health and substance abuse evaluations at the time of the annual compliance review; therefore, two additional applicable youth records were reviewed. The center did not have any additional youth applicable for a completed comprehensive assessment during the annual compliance review period. Both applicable youth were identified upon admission to be in need of a comprehensive assessment and were referred to mental health clinical staff. The two applicable youth records contained new substance abuse and mental health (SAMH) assessments completed by the designated mental health clinical authority (DMHCA) within thirty days of the referral using the Department form, which included all required elements. The evaluations for each youth reflected treatment recommendations were made based on the youth's diagnoses; however, neither of the two youth were at the center long enough to receive the recommended services. None of

the youth records reviewed were applicable for having SAMH assessments completed by community providers.

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

The center has facility operating procedures (FOP) outlining the process for treatment and discharge planning. The five youth records reviewed were not applicable for treatment and discharge planning, as the youth had not been in the center long enough for treatment and discharge planning. The center provided three applicable youth records for review. The additional three youth records contained initial treatment plans which were completed within seven days of the initiation of treatment. The initial treatment plans were developed on the Department's form, which contained all the required information, such as the reason for referral for treatment, diagnosis/symptoms, initial treatment methods, initial treatment goals, and psychiatric services. The forms contained the signatures of mental health/substance abuse clinical staff and the youth.

Each of the three applicable youth records contained an individual treatment plan developed by the thirty-first day of the youth's admission and signed by licensed clinical staff within ten days of completion. All three treatment plans were documented on the Department's form and included treatment focused symptoms, treatment goals, strengths/abilities, psychiatric services including psychotropic medication and frequency of usage, pharmacological interventions, and progress notes. The three treatment plans were signed and dated by the youth, clinical staff, and treatment team members. Attempts were made to contact two of the youth's parents/guardians for signatures, with notes indicating one parent/guardian was contacted and messages were left on two occasions for another youth's parent/guardian. The third youth was over the age of eighteen; therefore, parental signature was not required. Reviews were completed every thirty days for one youth, as required. The remaining two youth were not in the program long enough to require thirty-day reviews. The center did not conduct any mini-treatment team meetings during the annual compliance review; therefore, observations were not conducted.

Three closed youth records were reviewed for mental health/substance abuse treatment discharge summaries. All three records contained discharge summaries which were completed on the Department's form. Each of the reviewed records contained documentation verifying the youth, parent/guardian, and juvenile probation officer were provided a copy of the discharge plan.

3.07 Mental Health and Substance Abuse Treatment [Detention Staff/Contract Provider]	Satisfactory Compliance

Mental health and substance abuse treatment planning in Department facilities focuses on providing mental health and/or substance abuse interventions which will reduce or alleviate a youth's symptoms of mental disorder and/or substance abuse impairment and enable youth to function adequately in the juvenile justice setting.

Each youth determined to need mental health treatment, including treatment with psychotropic medication, or substance abuse treatment while in at the center, must be assigned to a mini-treatment team.

The center has facility operating procedures (FOP) regarding mental health and substance abuse treatment provided to youth. One of the five reviewed youth records did not require mental health or substance abuse treatment, one record was discharged during the annual compliance review, and the remaining three records were for youth who had not been at the center long enough to establish treatment teams; therefore, three additional applicable youth records were reviewed. Each of the three applicable youth records documented the youth were assigned to a mini-treatment team, which included all required members. Each of the youth received individual and group counseling, as required by the plans.

The three youth records reviewed all contained Authorization for Evaluation and Treatment (AET) forms, as well as consents for substance abuse treatment. The treatment teams included all required staff, as indicated by signatures on the treatment team forms. Appropriate consents for treatment were obtained in all three records and treatment notes were properly documented on the Counseling/Therapy Progress Note document. Mental health staff had adequate access to youth in order to provide treatment services. A review of group sign-in sheets and logbooks verified group therapy was limited to groups of less than ten youth for mental health groups and less than fifteen youth for substance abuse groups.

An interview with the designated mental health clinician authority (DMHCA) revealed the DMHCA completes comprehensive evaluations, treatment plans, individual sessions, and group sessions for the youth. Other staff are assigned to provide clinical services, as needed. Mental health and substance abuse treatment includes individual counseling, as well as crisis intervention. The youth, alongside of the DMHCA, is involved in the formulation of their treatment plan. The youth is given an opportunity to add, change, or delete items in the treatment plan. Prior to finalizing the plan, the DMHCA attempts to obtain signatures from the youth and the youth's parent/guardian, if applicable. Youth are routinely released from the center with a referral to an outside provider or community mental health agency. Two of the five interviewed youth rated the mental health services provided at the center as “good,” and the remaining three youth indicated they were not receiving services.

3.08 Psychiatric Services [Contract Provider] (Critical)	Satisfactory Compliance

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

The center has facility operating procedures (FOP) regarding psychiatric services and contracts with Camelot Community Care, Inc. for the provision of a psychiatrist. The psychiatrist holds an active and clear license in the State of Florida under Chapter 464, which expires January 31,

2022. The contract requires the psychiatrist to visit the center for a minimum of two hours a week. A review of sign-in logs indicated the psychiatrist was on-site for the required two hours weekly.

Three of the five reviewed youth records were applicable for psychiatric services. A review of documentation confirmed the psychiatrist completed initial psychiatric interviews and evaluations for all three youth within fourteen days of admission, as required. All the initial psychiatric interviews documented the reasons for referrals, historical information, mental status examinations, diagnostic and statistical manual of mental disorders, treatment recommendations, prescribed medications, explanations for the need for medication, and the frequencies of medication monitoring.

All three youth records were applicable for an in-depth psychiatric evaluation, which were conducted within thirty days of each youth's admission. The psychiatric evaluations all included the reasons and factors leading to the referrals, historical information, mental status examinations, identification of individuals, family, and environmental factors, diagnostic formulations, treatment recommendations, prescribed medications, and frequencies of medication monitoring/management, explanations of the need for psychotropic medications related to the youth's diagnosis, target symptoms, potential side effects, risks, youth's adherence to medication regimes, and benefits of taking the medications.

Each of the three evaluations included documentation on page three of the Clinical Psychotropic Progress Note (CPPN) indicating the youth's parent/guardian provided consent for the medication, which was witnessed. All three evaluations were signed by the psychiatrist. All three applicable youth records contained a properly executed Authority for Evaluation and Treatment (AET). None of the applicable youth were over the age of eighteen or in the custody of the Department of Children and Families (DCF). None of the youth were in the center long enough to receive monthly medication monitoring. The designated mental health clinician authority (DMHCA) reported meeting with the psychiatrist weekly, as well as communicating by telephone and e-mail, as needed. The DMHCA advised there has not been a need for a back-up psychiatrist; however, one would be provided by the provider, if necessary. The center's FOP and the provider's contract outlines the provision of tele-psychiatry services; however, tele-psychiatry was not utilized during the annual compliance review period.

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

The center has a suicide prevention plan which was last reviewed and signed by the superintendent and designated mental health clinician authority (DMHCA) on July 21, 2020. The plan includes procedures to identify and assess youth at risk of suicide, staff training, suicide precautions, levels of supervision, referral process, communication, notification, documentation, immediate staff response, review process, and emergency contact telephone numbers.

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

The center has facility operating procedures (FOP) and a suicide prevention plan detailing suicide prevention services. The center has two suicide response kits available for immediate use, if needed, maintained in master control and the medical office. Three of the five youth records reviewed were applicable for suicide prevention services. In each record, the youth was determined to be at risk during the admission screening. A review of the Department's Juvenile Justice Information System (JJIS) indicated the appropriate alerts were entered and updated, as necessary. Each of the youth identified to be at risk at admission were placed on precautionary observation (PO). Appropriate staff observations were included on the suicide PO logs. A referral to the mental health staff, notification of the superintendent, and an Assessment of Suicide Risk (ASR) were completed for each youth. The ASR was completed by a licensed clinician within twenty-four-hours on the Department's form, which included all required elements. None of the youth required a follow-up ASR. The suicide observation logs were completed in their entirety. A review of the logbooks verified staff documented the beginning and ending times each youth was placed on precautions. The center did not have any youth applicable for secure observation during the annual compliance review period.

The superintendent has an established review process for every serious suicide attempt or serious self-inflicted injury (requiring hospitalization or medical attention) and a mortality review for a completed suicide. The review includes the circumstances leading up to the event, center procedures relevant to the incident, training received by involved staff, pertinent medical and mental health services involving the youth, possible precipitating factors, and any recommendations for changes in policy or training.

Two of the five interviewed youth had been placed on precautionary observation while at the center. Both youth reported they were always observed by staff while they were on PO. All five interviewed staff reported they would notify mental health, search the youth, document supervision, and place the youth under constant sight and sound supervision if a youth displayed suicidal actions or ideations. One staff advised an appropriate alert would be entered in JJIS.

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

The center has facility operating procedures (FOP) governing the supervision of youth while placed on suicide precautionary observation (PO). Three reviewed PO logs revealed the logs were maintained for the entire duration the youth was placed on suicide PO. All logs were reviewed and signed by each shift supervisor and mental health clinical staff each day. None of the youth displayed warning signs while on observation. Observations of the youth's behaviors while on PO did not exceed thirty-minute intervals. Interviews with three youth placed on suicide PO verified the staff were always with them while they were on suicide PO 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 has facility operating procedures (FOP) ensuring all staff receive the required six hours of suicide prevention and training annually. Five reviewed staff training records reflected each staff received six hours of training on suicide prevention to include four hours of instructor-led training and two hours of web-based training on suicide prevention. The center maintains a binder to document all suicide drills. A review of the suicide drill documentation found drills were conducted at least quarterly and staff participated, as required. Staff who are not present during a quarterly drill can review each drill scenario and procedures to understand the process and are able to receive the necessary training to respond to an incident of a suicide attempt or incident of serious self-inflicted injury. Each of the reviewed drills were documented in the master control logbook. All five interviewed staff reported there are a suicide response kits located in master control and medical.

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

The center has a Crisis Intervention Plan which was reviewed and signed by the superintendent and the designated mental health clinician authority (DMHCA) on July 21, 2020. This plan addresses the notification and alert system, means of referral-including youth self-referral, communication, supervision, documentation, and review as required.

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

The center has an Emergency Care Plan addressing immediate staff response, notifications, communication, supervision, authorization to transport for emergency mental health or substance abuse services, transport for emergency mental health evaluation and treatment, transport for emergency substance abuse assessment and treatment, documentation, training, and mock drills. The plan was reviewed and signed by the superintendent and the designated mental health clinician authority (DMHCA) on July 21, 2020. Copies of the plan are located in the superintendent's office, medical clinic, and mental health office. Staff can access the plan electronically by utilizing the center's dedicated K-drive on any Department computer in the center. A review of Central Communications Center (CCC) reports and the master control logbook verified there were no instances requiring emergency procedures due to a suicide attempt or serious self-inflicted injury during the annual compliance review period.

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

The center has facility operating procedures (FOP) for the completion of a crisis assessment if a youth is in psychological distress. The Crisis Assessment will include the reason for the assessment, a mental status examination and interview, determination of danger to self and others, initial clinical impression, supervision recommendations, treatment recommendations, recommendations for follow-up, and notification of parent/guardian of follow-up treatment, if applicable. In addition, a mental health alert is to be entered into the Department's Juvenile Justice Information System (JJIS), when youth receives a crisis assessment. The plan was reviewed and signed by the designated mental health clinician authority (DMHCA) and superintendent on July 21, 2020. None of the five reviewed youth mental health and substance abuse records were applicable for the completion of a Crisis Assessment. The center has not had any Crisis Assessments during the annual compliance review period.

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

The center has facility operating procedures (FOP) regarding Baker and Marchman Act services. None of the five reviewed youth records were applicable for a Baker or Marchman Act while at the center. The center provided the only additional applicable record for a Baker Act during the annual compliance review period. The mental health and administrative staff made the decision to send the youth out for emergency mental health services. The youth's parent/guardian was notified, as required. The youth was placed on suicide precautionary observation and was maintained on constant supervision upon return from the local crisis unit. A review of the youth record verified a mental health referral was completed indicating the need for a Mental Status Examination (MSE) which was completed upon the youth's return to the center. The youth was not lowered in supervision until a follow-up Assessment for Suicide Risk (ASR) was completed with clinical staff and the superintendent was consulted. The center followed all requirements in the FOP for Baker Act services. An appropriate alert was entered in the Department's Juvenile Justice Information System (JJIS) and updated when the youth's status changed.

Standard 4: Health Services

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

The center has a contract with Camelot Community Care, Inc. to provide medical services which includes the provision of a physician to serve as the designated health authority (DHA). The DHA has a clear and active license in the State of Florida, which expires January 31, 2021, and is board-certified in internal medicine. The center has a back-up DHA who is board-certified in pediatric internal medicine and has a clear and active license in the State of Florida, which expires January 31, 2021; however, the back-up DHA was not utilized during the annual compliance review period. The DHA has collaborative practice protocols in place with an advanced practice registered nurse (APRN) to provide clinical services at the center. The APRN is certified in pediatric nursing and has a clear and active license in the State of Florida which expires July 31, 2022. A review of sign-in logs for the last six months found the DHA was on-site weekly for at least one hour, as required. An interview with the DHA confirmed their role reviewing and approving all policies, conducting clinical duties, as needed, communicating with center staff regarding the medical needs of youth, and being on call twenty-four hours a day, seven days a week for consultation. The DHA reported the APRN is responsible for clinical services at the center; however, the DHA is available to provide any services when on-site and provide oversight for all medical services.

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

The center has facility operating procedures (FOP) and nursing protocols in place for all health-related procedures and services. The designated health authority (DHA) approved all FOPs and protocols between August 3 and August 20, 2020 and the superintendent reviewed and signed all FOPs on August 4, 2020. A cover page was found for both the FOPs and protocols which was signed by each medical staff on August 4, 2020. The psychiatric FOPs were updated on July 1, 2020; however, the FOPs were not signed by the psychiatrist. The center provided the previous FOP which was signed by the psychiatrist as well as the FOP found under mental health which covered psychiatric services and was approved and signed by the psychiatrist for fiscal year 2020-2021. The psychiatrist signed the medical psychiatric FOPs while the annual compliance review team was on-site. There were no new healthcare staff hired during the annual compliance review period.

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.	

Five youth individual healthcare records (IHCR) were reviewed. Each IHCR contained a valid Authority for Evaluation and Treatment (AET) form. Two IHCRs contained the original AET forms and the remaining three were stamped as “copy.” All of the AET forms were obtained

prior to providing medical services to youth. Three additional youth IHCRs were provided for youth in the custody of the Department of Children and Families (DCF) and each included a Limited Consent for Evaluation and Treatment form signed by the youth's DCF caseworker, as required.

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.	

Five youth individual healthcare records (IHCR) were reviewed, of which three were applicable for parental consent and notification of medical services. Each of the three youth were applicable for notifications regarding psychotropic medications and two included verbal notification documented on the youth's progress notes and consent and written notification utilizing the Clinical Psychotropic Progress Note (CPPN) page three, as required. One youth's record included the CPPN and documented the parent/guardian's verbal consent when the psychiatrist discontinued the youth's psychotropic medication; however, consent was not obtained upon the youth's admission when the psychiatrist held the youth's medication until the youth could be seen, which occurred twelve days later. All three records indicated the verbal consents were witnessed, as required. None of the reviewed youth were applicable for parental notification of off-site care.

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

Five youth individual healthcare records (IHCR) were reviewed for the healthcare admission screenings. Each of the IHCRs included a Medical and Mental Health Admission Screening form completed on the day of admission by a juvenile justice detention officer (JJDO). Four of the five IHCRs contained documentation to indicate a licensed healthcare staff reviewed the screening form with the youth within twenty-four hours, as required. The center reported the remaining youth's admission screening was reviewed with the youth; however, it was not documented. One of the five youth was applicable for notification to the designated health authority upon admission and the notification was found in the youth's IHCR. Two of the five youth were applicable for a qualitative urine pregnancy screening test. Both applicable IHCRs documented the youth's consent and completion of the tests.

None of the youth were applicable for a change in physical custody while in the center; therefore, three additional youth IHCRs were reviewed for an admission rescreening. Each of the three applicable IHCRs contained documentation indicating the rescreening was completed the day the youth returned to the center by a JJDO and was reviewed by a licensed healthcare staff within twenty-four hours. An interview with the regional director confirmed JJDO staff are responsible for completing the screening form and the healthcare staff is responsible for reviewing the form with the youth.

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

Five youth individual healthcare records (IHCR) were reviewed for orientation and education regarding healthcare services provided at the center. Each of the five IHCRs included documentation reflecting each youth was oriented to healthcare services and was provided education on all required topics, which were documented on the Health Education form. Three of the five IHCRs reflected the youth received the orientation within twenty-four hours of admission, as required. One of the two remaining IHCRs documented the youth received the orientation one day late, and one received the education three days late. The center maintains a list of healthcare contacts for the youth which was verified to be accurate.

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.	

One of the five reviewed youth individual healthcare records (IHCR) was applicable for notification to the designated health authority (DHA) upon admission. Two additional youth records were reviewed. Each of the three applicable IHCRs reflected the youth were admitted with a chronic condition and the DHA was notified, as required. One of the three youth was admitted to the center on psychotropic medications and was applicable for notification to the psychiatrist, which was completed, as required. None of the youth were identified as requiring emergency care upon admission. Each of the three applicable youth were included on the center's chronic condition log and indicated the DHA and/or psychiatrist was notified of the youth's admission.

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

Five youth individual healthcare records (IHCR) were reviewed and each included a health-related history (HRH) completed within seven days of admission by a licensed healthcare staff on the Department's form. Four of the completed HRHs were new and one was revised based on the youth's previous admission. Each HRH was reviewed, as required, by the designated health authority (DHA) or advanced practice registered nurse (APRN) prior to completion of the comprehensive physical assessment (CPA).

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

The center has facility operating procedures (FOP) regarding the requirements of the comprehensive physical assessment (CPA) and Tuberculosis (TB) screening. Five youth individual healthcare records (IHCR) were reviewed and each included a new or updated CPA completed within seven days of admission by the designated health authority (DHA) or advanced practice registered nurse (APRN). Four of the CPAs were new, and one was updated

in which the APRN conducted a focused evaluation with the youth to update the current CPA in the youth's IHCR. The youth's updated CPA included documentation indicating the CPA was reviewed, signed, and dated by the APRN. The four new CPAs included all required elements and completed, as required. Two youth refused parts of the exam which were indicated on the CPA and accompanied with a refusal form signed by the youth. The Department's Problem List for each youth was updated, as required.

Each of the five youth received a Tier I Tuberculosis (TB) screening upon admission. Three of the five youth IHCRs included documentation reflecting the youth had a current tuberculin skin test (TST). The remaining two IHCRs documented the youth refused the test and signed refusal forms were included in the IHCRs. The DHA did not order x-rays for the two youth who refused testing and documentation contained in the IHCRs revealed an X-Ray was not clinically indicated. None of the reviewed youth required further follow-up or care for TB.

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

Each of the five reviewed youth individual healthcare records (IHCR) included documentation indicating the youth were screened for sexually transmitted infections upon admission. Four of the five IHCRs indicated a referral to the designated health authority (DHA) or advanced practice registered nurse (APRN) was necessary for further evaluation and each was completed, as required. None of the youth consented for a gynecological exam or were out of Department custody for thirty or more days which would require a rescreening. Each of the four applicable youth received testing and the laboratory results were maintained in the laboratory section of the IHCR. Three of the four youth had results documented on the Infectious and Communicable Diseases (ICD) form. One youth's test results were not documented on the ICD form; however, the results were added while the annual compliance review team was on-site.

Three of the five reviewed IHCRs indicated the youth provided written consent to be tested for the human immunodeficiency virus (HIV). There was documentation in each youth's Health Education Record indicating the youth was provided pre and post-test counseling. The center previously had a certified HIV counselor conduct all testing and education; however, due to the COVID-19 pandemic, the outside provider was not coming to the center. During the annual compliance review period, all HIV testing and education was provided by the DHA or APRN. Results were documented in each youth's IHCR, on the ICD form. Each IHCR was stamped as "highly confidential." The center reported the IHCRs are only able to be accessed by medical staff or other staff trained in the Health Insurance Portability and Accountability Act (HIPAA) with a need to access the records. Each youth's ICD form had documentation reflecting the DHA or APRN reviewed the results. Each of the five interviewed youth confirmed they are able to request an HIV test at any time.

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 medical facility operating procedures (FOP) which were approved by the designated health authority (DHA) on August 20, 2020 and nursing protocols which were approved by the DHA on August 3, 2020. The treatment protocols are for both registered nursing and licensed practical nursing levels. Sick call is conducted in medical between 8:00 a.m. and 10:00 a.m. daily and conducted by the registered nurse (RN), DHA when on-site, or the advanced practice registered nurse (APRN). Through an interview with the RN, it was determined there are procedures in place for staff, when there is not a licensed nurse on-site. A review of the procedures validated the shift supervisor will review all sick call requests no longer than four hours after a request is submitted and must check the wellbeing of the youth every four hours until the youth is seen by the nursing staff, if the shift supervisor is unable to provide over-the-counter medication to remedy the sick call. None of the five youth individual healthcare records (IHCR) were applicable for a sick call during the annual compliance review period.

Three additional applicable IHCRs were reviewed. Each IHCR included a Sick Call Request form which was completed, as required, and maintained in the youth's progress notes. Each of the three sick calls was documented on the Sick Call Referral Log. Two of the three sick calls were conducted by an RN and one was conducted by a licensed practical nurse (LPN) who conferred immediately with the APRN. One sick call was the third time the youth had the same complaint and a referral was made to the DHA, as required. None of the youth were applicable for severe or unfamiliar pain necessitating a call to the DHA. A review of fourteen confinement reports determined all medical reviews were conducted, as required, while the youth was in confinement. There were no sick calls submitted during the annual compliance review; therefore, observations of a sick call were not completed.

One of the five interviewed youth indicated when a sick call is submitted, they are seen immediately, one youth indicated they are seen within a day, one indicated within three days, and two youth indicated they have not requested a sick call. Two youth indicated the nurse conducts sick call; two youth indicated they have not requested a sick call. One youth indicated submitting a sick call two weeks prior and had not been seen. The youth further stated requesting to have a prescription refilled, from a prescription obtained prior to entering the center, which had not been completed. The youth was asked if a visit to the nurse was still needed, the youth stated a visit was not needed. Upon further review of sick calls, it was determined the youth had not submitted a sick call request. The medication the youth was referring to was documented in the medical record; however, documentation supported the prescription was not current and medical staff did not complete a new order for the medication the youth referenced. The five youth were asked how they would rate the medical services, one youth stated "poor," two stated "good," one stated "very good," and one stated he had not received any medical services. Five interviewed staff indicated the staff enter the sick call into the system for the youth and the nurse conducts the sick calls.

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

The center has facility operating procedures (FOP) and healthcare protocols which outline the requirements and services provided for episodic and emergency care of youth. Two of the five reviewed youth individual healthcare records (IHCR) were applicable for episodic care during the annual compliance review period. One additional applicable youth record was reviewed. Each of the three episodic care incidents were completed by a licensed healthcare staff and documented, as required. One of the three incidents was documented in the center's Episodic Care Log. The center reported the designated health authority (DHA) and the advanced practice registered nurse (APRN) were not adding the youth they saw in the log; however, all other documentation was completed, as required, and the issue was addressed with the DHA and APRN.

The center has two automated external defibrillators (AED). One is located in medical and one is located in master control. Each of the two AEDs have batteries which expire August 20, 2021 and the pads expire March 28, 2021. Both AEDs were observed, and both displayed the green light, indicating the AEDs were in working order. The AED instruction guide is located in the compartment with each of the two AEDs. The agency who services and provides the AEDs to the center checks to ensure the AED batteries and pads are operable. The batteries and pads, for both AEDs, were last changed on September 25, 2018. Each AED was serviced by the company providing the AEDs to the center, on December 4, 2019. Each AED is checked daily by nursing staff and documented on the center's AED checklist, which was reviewed and found to be in compliance.

The center maintains nineteen first-aid kits, of which seven are designated for the center's vehicles. The center has a list of first-aid items, which was approved by the DHA on August 17, 2020. Three first aid-kits were reviewed for expired and approved contents; each kit contained an approved list and all approved items, with no expired items. A review of the first-aid kit check log validated each kit was monitored monthly by medical staff and replenished, as needed. The center's emergency medical drills were reviewed for the last six months.

A review of documentation found medical drills were completed on each shift and each quarter, at a minimum, for the last six months. Cardiopulmonary resuscitation (CPR) or the AED was utilized at least quarterly on each shift, exceeding the annual requirement. Each of the drills were documented in the center's logbook. Medical staff maintain a list of emergency numbers, including Poison Information Center, which was observed in medical and inaccessible to youth. A review of each licensed healthcare staff's CPR/AED documentation validated each staff holds a current certification. Five interviewed staff indicated they are permitted to call 9-1-1 in the event of an emergency.

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.	

None of the five reviewed youth individual healthcare records (IHCR) were applicable for off-site care; therefore, three additional applicable youth IHCRs were reviewed. Each of the three

applicable IHCRs included the youth's discharge instructions, which were reviewed by the designated health authority (DHA) or advanced practice registered nurse (APRN), and documentation indicating the DHA was notified upon identification of the emergency which required off-site care. Each of the three instances were documented on the Episodic Care Log. Two of the three IHCRs included the Summary of Off-Site Care form completed by the off-site practitioner. One of the records included a blank copy of the form and the center reported the emergency room did not complete the form. Each of the three youth required follow-up care and documentation was found in the progress notes to support each youth's follow-up care was tracked, documented, and communicated, as required.

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.	

Two of the five reviewed youth individual healthcare records (IHCR) were applicable for chronic care; therefore, one additional applicable youth IHCR was reviewed. Each of the three applicable youth IHCRs indicated the youth had a chronic condition, the Department's Problem List was updated, and all treatment orders were clearly distinguishable. Two of the three youth were found on the program's chronic care log, which is tracked daily at the youth's admission, and had correctly identified medical grades. The third youth was identified with a chronic condition during the comprehensive physical assessment (CPA). The youth's medical grade was not updated to include the condition and the youth was not included on the chronic condition tracker for the center; however, the center corrected the youth's medical grade and chronic care tracker while the annual compliance review team was on-site and the youth received all required services for the chronic condition. There was no indication of lapses of care for any of the three youth. The center did not have any youth at the center long enough to necessitate a periodic evaluation during the annual compliance review period.

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

Three of the five reviewed youth individual healthcare records (IHCR) were applicable for taking medications while at the center. Each youth's medication administration was tracked on the Department's Medication Administration Record (MAR) specific to each youth, all medications were verified to have a valid order, and given pursuant to a current practitioner order or prescription. Two of the youth entered the center on the medication and the designated health authority (DHA) and psychiatrist were contacted to continue applicable medications until the youth could be seen. There was documentation for one of the two youth indicating the medications were verified using the Medication Receipt Transfer Disposition form. The remaining youth's medications were continued by the psychiatrist, as previously prescribed; however, as the youth was transferred from out of state and the center ordered new medications for the youth. None of the youth were applicable for receiving medications in restricted housing; however, a review of fourteen confinements found each documented the youth received all required medical care and medications. Each youth's MAR included all required elements including stop and start dates, the initials of the healthcare staff administering the medication, and documentation of weekly side effect monitoring.

Two youth IHCRs and MARs indicated the youth was prescribed psychotropic medications. One of the two youth was applicable for and received the initial diagnostic psychiatric interview within fourteen days of admission. The remaining youth had not yet been at the center for fourteen days. Neither of the two youth had been at the center long enough to require monthly medication management. There was no indication of lapses in care or medication errors. None of the three youth were applicable for refusal of medication or administration of over-the-counter or parenteral medications. None of the three applicable MARs documented administration of medication by a non-healthcare staff; however, the center provided documentation indicating staff were trained in assisting in the self-administration of medication in the event healthcare staff are not on-site, which included all supervisors and each of the five staff reviewed for in-service training. A review of documentation found there were no standing orders, emergency treatment orders, or as needed orders for psychotropic medications.

An interview with the nurse validated medication delivery is the sole responsibility of the nurse or staff administering the medication; and while administering the medication, the staff are not responsible for the supervision of the youth. Observations of medication pass for two youth during the annual compliance review validated this practice. The nurse administered each youth's medication while the center staff maintained security of the youth. The center staff escorted the youth to medical for medication pass. During the medication pass, the Six Rights of Medication Administration were verified for each of the youth. Each youth approached the nurse individually when it was their turn for medication, allowing for privacy of the youth. The nurse and each youth signed the Medication Treatment Record/Medication Administration Record (MAR), while reviewing the youth's allergies and alert status. The nurse ensured each youth swallowed the mediation. Neither youth's medications were pre-poured. The center has a contract with a consulting pharmacist, whose license expires December 31, 2022. The pharmacist is on-site monthly for destruction of expired and discontinued medications. A review of the center's Medication Disposal Log verified the process. Through an interview with the nurse, it was determined over-the-counter medications administered are documented on the youth's MAR. Four of the five interviewed youth indicated the nurse provides medications and one youth stated they do not take medications. Four of the five interviewed staff indicated they do not give medications to youth and one stated they are trained and can give medication to youth.

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

Observations and a tour of the center's medical department validated all medical equipment classified as sharps are securely stored, as required. The medical department has a locked door leading to the hallway. There is a locked door in medical where the sharps are maintained in locked cabinets. A review of the perpetual inventory and weekly inventory of sharps validated medical staff conducts both as required. A review of the perpetual inventory of medication for all prescriptions and over-the-counter (OTC) medications validated all medications were maintained, as required. The center has a contract with a consulting pharmacist, whose license expires December 31, 2022. The pharmacist is on-site monthly for destruction of expired and discontinued medications. A review of the center's Medication Disposal Log verified the process.

During the annual compliance review, there were no youth taking controlled substances; however, the registered nurse (RN) indicated all controlled substances, when on-site, are maintained behind two locks in the medication cart and behind two locked doors, as required. The RN indicated medical staff conduct shift-to-shift inventory counts for all controlled substances, when controlled substances are on-site. The RN provided documentation of a shift-to-shift count for a controlled substance for a youth who was recently in the center. The nurse indicated each morning, when a youth is at the center on a controlled medication, a third shift-to-first shift count of controlled medications are conducted and documented on the youth's Medication Administration Record (MAR), prior to beginning medication pass. Supervisory level, non-healthcare staff who are trained in the delivery and oversight of medication self-administration only perform these duties when nursing staff are not on-site. Medical staff maintain weekly inventory counts for all OTC medications. The nurse indicated when there is a medication inventory discrepancy, the youth MARs and center logbook are reviewed to determine if there is a discrepancy in either. If the discrepancy is not able to be determined and the medication is not located, the Central Communications Center will be contacted to report the medication error.

Three randomly selected sharps were reviewed and compared to the sharps inventory list; pill cutters, staple removers, and butterfly needles. Each of the three sharps matched the inventory; there were no discrepancies. Three different OTC medications were selected and compared to the inventories. Each of the three OTC medications matched the inventory for both opened OTC medications and the extra stock OTC medications; there were no discrepancies. There were no youth at the center during the annual compliance review taking controlled medications; therefore, inventory of controlled medications were not reviewed.

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

The center has facility operating procedures (FOP) and an exposure control plan which outline the guidelines for exposure and infection control. The exposure control plan is written in accordance with the Occupational Safety and Health Administration (OSHA) standards and includes all required components in risk assessment and methods of compliance. The infection control procedures include the prevention, containment, treatment, and reporting requirements for each of the required categories of diseases. The procedures include protocols for chemical exposure and needle stick exposure. Staff have access to personal protective equipment and use Universal Precautions. The Hepatitis B vaccination is available and offered to all staff.

The center had four cases of COVID-19 among staff, including three in one month, during the annual compliance review period, and all reporting was conducted, as required, to the Central Communications Center (CCC). The center did not have any additional instances of infectious or communicable diseases which required the center to contact the CCC, Centers for Disease Control and Prevention (CDC), or the local county health department.

The center has a process for maintaining records of facility/occupational exposure; however, there were no incidents of exposure. Five youth individual healthcare records (IHCR) were reviewed and each included documentation in the youth's Health Education Record the youth received education in infection control, hand-washing, Universal Precautions, prevention/transmission of communicable diseases, and vaccinations within seven days of admission. Five pre-service and five in-service staff training records were reviewed and each staff received infection control and exposure control training upon hire and annually, as required.

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 medical facility operating procedures (FOP) for prenatal care for and education of pregnant youth entering the center. The center was able to provide two medical records for two youth who were pregnant while in the center. The center did not have any additional youth for review since the last annual compliance review. One youth did not enter the center with an Authority for Evaluation and Treatment (AET) form and was only on-site for three days. The center was unable to obtain the youth's AET form prior to the youth's release; therefore, medical services, including any orders related to pregnancy care, were not provided.

For the one youth applicable for prenatal services, prenatal care began immediately upon determination of the youth's pregnancy and was provided at recommended intervals. The youth was on-site less than thirty days and did not require a focused medical evaluation. The youth had daily monitoring for danger signs of pregnancy complications. The youth received nutritious food in quantities appropriate for a pregnant youth, as ordered by the practitioner. The youth was routinely monitored for nutritional and weight status.

Neither of the two pregnant youth complained of issues related to pregnancy while at the center and did not receive a documented plan for post-birth psychological and physical care, as it was not applicable. Each of the youth received health education for all required topics relating to pregnancy and all education was documented on each youth's Health Education Record. The registered nurse provided in-service education on girl's healthcare, Girl's Health to include Pregnancy, to all non-healthcare staff on July 9, 2020. Five staff in-service training records were reviewed and each received training on topics related to pregnant youth. All five interviewed youth indicated they have not needed or received any prenatal, obstetrical, or gynecological services.

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 facility operating procedures (FOP) for active supervision of youth. The annual compliance review team observed positive interactions between youth and staff throughout the annual compliance review during activities such as youth movement, meals, education, free time, and outside recreation. The youth were within sight of staff at all times. Head counts were conducted and logged in the master control and module logbooks. Staff called master control for authorization to move throughout the day. Four of the five interviewed staff said they felt there were enough staff to provide for the safety and security of youth. One of the staff interviewed felt the center was often short-staffed.

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

The center has facility operating procedures (FOP) regarding the center's behavior management system (BMS). The center's BMS is posted on the youth's modules. The BMS includes rewards for positive behavior and consequences for inappropriate behavior. The center's BMS aligns with the FOPs. The center's BMS is implemented statewide and approved by the Detention Assistant Secretary.

Daily activities were observed by the annual compliance review team and determined proper implementation of the center's BMS. The center's logbook was reviewed, which included

documentation of youth level three rewards such as game room/television time, pizza night, wing night, and canteen. The youth point card binder, which maintains all point cards for each youth in the center, was reviewed and documented each youth's point status and level drops. A review of the logbook youth point cards, and youth interviews validated the center ensures rewards and consequences are consistent with the center's BMS and FOP.

The superintendent indicated the center's BMS is a point system with three levels, which involves positive reinforcement. Five youth were interviewed and rated the center's BMS; two youth rated it as "fair," two rated it as "good," and one as "very good." All five interviewed youth explained the center's BMS. Each indicated there are three levels and they have to behave appropriately in order to move up to the next level. All the youth indicated they are offered canteen as a reward. In addition, three of the youth indicated youth are rewarded with pizza night, wing night, meals from a fast food restaurant, and free time in the game room. Each youth indicated staff use the rewards the same and are always fair. Five staff were interviewed and all explained the process of the center's BMS. All the staff indicated the BMS is posted on the youth modules. The five interviewed staff indicated the youth rewards include canteen, pizza night, wing night, BBQ, game room/television free time, and extra phone call time for level three youth. All five staff indicated items cannot be taken from youth as a punishment, only points or levels, if justified. The staff further indicated they have never observed a co-worker do otherwise. All the staff indicated they feel the BMS is effective. The staff indicated staff speak with youth to discuss the consequences imposed, youth are given an opportunity to explain their behavior, and staff speak with youth about alternative acceptable behaviors. The five staff indicated feedback is provided from supervisor's regarding the implementation of the BMS includes discussion each day and during debriefings, as needed; and one staff further indicated this is done annually on their performance evaluation.

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

The center has facility operating procedures (FOP) regarding unauthorized use of punishment. The center's FOP states any form of corporal punishment is prohibited and if any allegation of such punishment is alleged, it will be reported to the Florida Abuse Hotline and the Central Communications Center. The center's FOP states youth group punishment and the use of drugs to control the behavior of youth is prohibited. All five interviewed youth indicated youth are never encouraged or allowed to punish other youth. The youth indicated they have never witnessed youth handcuffed or shackled to prevent them from hurting themselves or others. Three youth indicated they have never been sent to their room for punishment. Two youth indicated they have been sent to their room for punishment and this is when they were fighting and placed in

confinement. Both youth indicated while in their room for confinement, the door was shut and locked and staff maintained checks on them, as required. Both indicated they felt the punishment was fair for their behavior. When the two youth were asked if anything was taken away when they were punished, both indicated only points and levels were deducted, but nothing else was taken from them. Five staff were interviewed and indicated only points and levels can be taken away as a consequence and they have never observed a co-worker do otherwise. The staff stated they have never observed any staff encourage youth to beat up another youth.

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

The center has facility operating procedures (FOP) regarding ten-minute checks. The facility has fifty-eight cameras throughout the facility and all cameras were operational at the time of the annual compliance review. The center stores the video recordings for thirty days. The center utilizes a wand system to electronically conduct all ten-minute checks. Video observations were conducted for checks covering each shift and module to verify ten-minute checks were completed, as documented and to fidelity. All checks were completed, with staff conducting each check by clearly looking in each room. During the annual compliance review, it was discovered the checks had not been downloaded by supervisory staff in two weeks; however, the center only had one staff member on-site with access to the reports and does not currently have an acting superintendent or assistant superintendent. The reports were downloaded while the annual compliance review team was on-site.

Each of the five interviewed staff reported checks are conducted every ten-minutes when youth are in their rooms. The regional director was interviewed and explained room checks are conducted for all youth with the wand system while secured in their room for shower, shift change, or bedtime. While in confinement, checks are documented on a visual observation log.

5.05 Census, Counts, and Tracking	Satisfactory Compliance

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

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

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

The center has facility operating procedures (FOP) for census, counts, and tracking. A review of master control and module logbooks determined counts were conducted at the beginning and end of each shift. Staff were observed counting youth prior to movement during the annual compliance review. When the population changed, staff called in the adjusted count to master control and master control called random headcounts throughout the shift. Staff only counted youth who were physically present in the count. Each of the five interviewed staff reported counts are done at the beginning and end of each shift and after codes are called. Two staff reported counts are conducted before and after school, and before and after meals.

5.06 Logbook Maintenance	Satisfactory Compliance

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

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

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

The center has facility operating procedures (FOP) regarding logbook maintenance. There are separate logbooks located in master control and each module, as well as a logbook for visitors and another for contracted staff. Logbooks were reviewed which covered the annual compliance review period. Logbooks were bound with numbered pages, with date on top of the page, and all entries documented times of the events in a.m. and p.m. The logbook entries documented the staff names with brief descriptions of the events and staff initials of the staff making the entry. All entries impacting the safety and security of the facility, including medical and/or mental health alerts were highlighted. All errors made by staff had a single line through it. The master

control logbook included entries which covered emergency situations, population counts at beginning and end of shifts, admissions, releases, all youth and group movements, drills, confinements, precautionary observations, and presence of law enforcement.

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

The center has facility operating procedures (FOP) regarding logbook reviews. The master control and module logbooks were reviewed which covered the annual compliance review period. The superintendent or designee reviewed all logbooks on a weekly basis. The supervisor reviewed the master control logbook and the modules logbook daily. The regional director was interviewed and reported supervisors are required to document reviews and security checks in the facility logbooks at least twice during the shift. Administrators are required to document reviews and security checks once a week on each shift, at a minimum. Blue or black ink must be used and there should be no white out, write over, or scribbling in the logbooks.

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

The center has facility operating procedures (FOP) regarding key control. The keys were observed in a locked box located in master control and in the supervisor's office. The emergency keys are in a separate locked box located in master control. A review of the key inventory and the keys matched the actual key rings in use. The inventory included the ring number, number of keys on each ring, capability of each key, and to whom the key ring was issued. There is a system in place to address missing, lost, and replacement of damaged keys. The annual compliance review team observed staff giving the supervisor their personal keys

and receiving facility keys in return. The supervisor locked personal keys in a locked box located in the supervisor's office. Visitor's keys are kept in master control in a locked box. The facility keys are color-coded, as required, on a tamper-resistant ring, with the ring number, number of keys on each ring, and capability of each key. Each staff signs keys in and out, as required.

A review of three staff found each staff had the correct key ring with the appropriate keys on the ring and did not have any personal keys. A review of Central Communications Center (CCC) reports found one incident in which a key was reported missing; however, the key was found on the same day in another locked box within the center. Five pre-service training records were reviewed and reflected each staff completed key control training and acknowledged the key control FOP to be responsible for the security of keys and carry them at all times in the center, not take the keys outside of the center, report any lost keys to the supervisor, and not allow youth to handle keys at any time.

The master control operator was interviewed to determine the process for restricting usage of keys such as medical and mental health. The operator reported all staff have assigned keys and no one receives keys assigned to another department. The center has procedures in place when keys are lost, damaged, or missing. Lost, damaged, or missing keys are reported immediately to a supervisor or superintendent. Staff complete a key replacement log which is signed by the superintendent. Maintenance then replaces the key and takes inventory of keys. Each of the five interviewed staff reported youth do not have access to keys, personal keys are securely stored, and master control is notified about missing keys. The regional director reported only administrators have permanently issued keys which are secured at the center.

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

The center has facility operating procedures (FOP) regarding vehicles and maintenance which outlines the official use of center vehicles, vehicle preventive maintenance, the roles and responsibilities of maintenance staff, transporting staff before and after transport, and security and supervision of youth during transport. The center has seven vehicles, of which six are utilized to transport youth. The remaining vehicle is used for maintenance purposes and is not used to transport youth. All seven vehicles were present at the center during the annual compliance review. All six vehicles used to transport youth 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 approved by the designated health authority (DHA), which is reviewed monthly. Reviewed documentation revealed all seven vehicles had an annual inspection conducted by a certified mechanic. One of the seven vehicles was found unlocked while the vehicle was not in use. The regional detention chief was present when this was discovered. The remaining six vehicles were found locked and secured while not in use.

A review of weekly visual checks for the annual compliance review period confirmed the center's maintenance staff conducted weekly visual checks of all vehicles and the checklist included water coolant, lights, oil, emergency equipment, brakes, horn, interior/exterior, and cleanliness. A review of monthly visual checks for the annual compliance review period revealed the center's maintenance staff conducted inspections of tires, battery, windshield, wipers, windows, mirrors, and damages for all vehicles. An informal interview was completed with the

center's maintenance staff. The maintenance staff indicated he is responsible for the weekly and monthly inspections of all vehicles and ensures weekly and monthly inspections are completed for all vehicles. Each vehicle used for youth transportation has a corresponding binder and logbook and a review of the logbooks confirmed the transporting staff documented the vehicle check, destination, number of youth and staff, and the date and time the transport began and ended for each transport. For one youth transport, the vehicle check was documented on the vehicle logbook; however, the vehicle inspection log checklist was not completed after the transport and this was addressed to the regional detention chief during the annual compliance review.

A transport was observed during the annual compliance review. Prior to the transport, one of the two transporting staff inspected the vehicle and ensured there was no contraband in the vehicle, the vehicle had sufficient gasoline, the seatbelts were securely anchored, the screen/cage was secured, and confirmed the vehicle folder contained the vehicle logs, gas card, and registration. A copy of the current transportation procedures were maintained in the vehicle and the transportation staff documented the vehicle inspection in the vehicle logbook. Each youth was searched prior to entering the vehicle. A cell phone was assigned to the vehicle and youth and staff wore seatbelts prior to the transport. After the transport, the vehicles were searched for contraband and any remaining youth and each youth was searched upon return to the center. After the transport, the annual compliance review team could not observe if the youth and staff were wearing seatbelts; however, the transporting staff confirmed the youth and staff were wearing seatbelts. All five interviewed youth indicated staff are driving safely when transporting youth. All the youth indicated they never saw anyone place contraband in a transport vehicle.

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

The center has a facility operating procedure (FOP) regarding tool inventory and management. The tool room and kitchen were inspected, and all tools were stored in a secure, locked area in the facility. All tools had identification codes to identify them as Department Property. The tool shed was observed to be neat and orderly with a clearly organized shadow board system to allow staff to identify tools. A review of the perpetual inventory determined the inventory was completed, as required, and signed by the superintendent. No tools were found missing or unaccounted for. The kitchen utilizes a shadow board system for the maintenance of sharps. A perpetual inventory was found with nothing missing or unaccounted for. Monthly inspections of the tool area and kitchen were completed and submitted, as required.

An interview with the maintenance staff found there have been no lost or broken tools during the annual compliance review period; however, if a maintenance or kitchen tool was lost or missing they would let the superintendent know, report to the Central Communications Center (CCC), if necessary, and fill out a and tool replacement form. The maintenance staff reported anytime vendors are on-site, the vendors are supervised by the maintenance staff at all times. Maintenance staff have a system ensuring all tools are returned, and the work area is cleaned and inspected for contraband prior to allowing youth access. The regional director reported only maintenance staff and administration have access to facility tools.

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

The center has facility operating procedures (FOP) regarding youth access and use of tools and cleaning items. The youth are not allowed to use any tools or cleaning items other than a mop and a broom. Youth were not observed using any tools, including mops and brooms during the annual compliance review. Each of the five interviewed youth reported they do not use tools, two youth reported they have used a mop and a broom. All five interviewed staff reported youth only use a broom or a mop for cleaning.

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

The center has facility operating procedures (FOP) regarding access to flammable, toxic, caustic, and poisonous items. The FOP states youth are not allowed access to flammable, toxic, caustic, and poisonous items. The annual compliance review team reviewed the center's Safety Plan and observed all items were stored in a secure area which is not accessible to the youth. Maintenance staff maintain an inventory of all flammable, toxic, caustic, and poisonous items which was compared to the actual items on-site and all items were accounted for. A Safety Data Sheet (SDS) for each item was found in a binder and posted near items, and available to staff.

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

The center has facility operating procedures (FOP) regarding access to flammable, toxic, caustic, and poisonous items which states youth are not allowed access to these items. All chemicals were found stored in a secure area with an accurate inventory accounting for all items. Four of the five interviewed staff said no youth have access to toxic items. The remaining staff reported youth are allowed to wipe chemicals to clean after the staff has sprayed the item. All five interviewed youth reported they do not have access to any chemicals, including cleaning supplies.

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

The center has facility operating procedures (FOP) regarding the disposal of flammable, toxic, caustic, and poisonous items. The center reported there has not been any incidents of chemical spills or disposed of any flammable, toxic, caustic, or poisonous items during the annual compliance review, which was verified through an interview with the maintenance staff; however, there is a process in place to dispose of any items at the Brevard County Landfill. The center does not use grease.

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

The center has facility operating procedures (FOP) regarding confinement under twenty-four hours. Education materials are provided to the youth when they are in confinement during school hours. Five interviewed staff indicated youth who are temporary placed in confinement are provided education materials. No confinement observations were made during the annual compliance review.

The center had 139 confinements during the annual compliance review period. As a result, fourteen youth confinement reports were reviewed. A review of documentation confirmed each youth was placed in confinement alone and the confinement was approved by a supervisor. Prior to each of the fourteen confinements, each room was searched and the search documented in the Department's Facility Management System (FMS). Each of the reviewed confinement reports documented the windows and cameras were observed and free of obstructions or scratches. A Visual Observation Report (VOR) was completed for each of the

fourteen confinements. Each VOR documented youth checks were completed every five minutes for the first hour and the remaining checks were completed every ten minutes, with the exception of one check, which was ten minutes late.

All reviewed confinements documented an initial review by the supervisor, with the youth, within two hours of the incident and the reason for the confinement was documented on the confinement report; all reviewed confinement reports were completed by the end of the supervisor's shift. All three-hour supervisory reviews, while each youth was on confinement, was completed as required, with the exception of four supervisory reviews; one confinement was completed fourteen minutes late, two were fifteen minutes late, and one was sixteen minutes late. Twelve of the fourteen reports were reviewed by the superintendent or designee within twenty-four hours of the youth's release from confinement, to determine if each confinement was appropriate. One confinement report was reviewed seventeen hours and twenty minutes late and one report was not reviewed. The center's superintendent had retired and had not been replaced at the time of these two confinements. The captain, who was in charge at the center was new, was still in training during this time. Regional staff have oversight over the center while the center is short staffed in administration.

Five interviewed staff explained the center's process for placing youth in confinement. Each indicated they are required to complete a confinement report, conduct and document ten-minute checks, and search the confinement room. Two staff further stated within the first hour, all checks are completed every five minutes; and one staff also stated they need to inform the supervisor of the youth's placement in confinement. The regional director indicated regional management staff receives the alerts when a confinement report is generated in FMS; weekly reviews are conducted by Regional Office Operations Team and headquarters. The Department's Tableau system generates a daily report which also reflects this information.

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

The center had three youth confinement reports for youth who were in confinement over twenty-four hours since the last annual compliance review, each of which was reviewed. Each report contained all required documentation and checks up until the youth were in confinement over twenty-four hours. A Confinement Review was not requested for any of the three youth. The regional director and the chief for Detention Services were on-site at the center on the day the three youth were in confinement and met with all three youth while in confinement. The chief instructed administration to release all three youth, based on the conversations with the youth, which was five hours prior to the youth's release and prior to the youth being in confinement over twenty-four hours. The youth were not released from confinement until twenty-four hours and forty minutes, making the confinement forty minutes over the twenty-four-hour period. The captain and the staff who were responsible for the oversight of the three confinements were reprimanded. The captain received a verbal reprimand which was placed in the staff's record; and the staff member took a voluntary demotion. The center provided the reprimand

documentation to the annual compliance review team. The regional director indicated regional detention management review the use of confinements weekly.

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

The center has Continuity of Operations Plan (COOP) which outlines the requirement for evacuation drills. The annual compliance review team reviewed a COOP drill completed on May 20, 2020. The drill included all required documentation. The center has yet to complete a second COOP drill for this annual year; however, there is still time remaining to complete the drill and the center staff reported it was scheduled to occur during the annual compliance review. The drill was documented in the master control logbook. Four of the five interviewed staff reported they participated in medical, and suicide drills in the last six months, four staff reported they participated in fire and escape drills, and staff also reported they participated in major disturbance, bomb threats, hostage, and flood drills during the annual compliance review period. The regional director reported the center ensures staff are properly trained, review all incidents, use the incidents as training tools, conduct safety meetings, and request assistance from Regional Office, as needed.

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

The center has an Escape Prevention Plan which included all required elements. The center did not conduct quarterly escape drills during the last two quarters on the C shift. The center conducted quarterly drills on the A and B shifts during the annual compliance review period. The two reviewed drills conducted on the B shift were not documented in the master control logbook. Four of the five interviewed staff reported they have participated in an escape drill during the annual compliance review period. Five in-service staff training records were reviewed and documentation confirmed each staff completed training in escape prevention.

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

The center has a fire prevention plan which was approved by the Brevard County Fire Marshal. Each of the center's fire extinguishers was inspected during the annual compliance review period. Monthly fire drills were reviewed for the annual compliance review period and found all required drills were conducted on the A and B shift. Four of the six required drills were completed for the C shift. Fourteen of the sixteen reviewed drills were found in the master control logbook. Each of the five interviewed youth reported they knew what to do in case of a fire. Four of the five interviewed staff reported they have participated in a fire drill during the annual compliance review period.