STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

# BUREAU OF MONITORING AND QUALITY IMPROVEMENT

## Annual Compliance Report

## Brevard Regional Juvenile Detention Center

**(State-Operated)**
**5225 Dewitt Avenue**
**Cocoa, Florida 32927**

***Review Date(s): October 29, 2019 - November 1, 2019***

Promoting Continuous Improvement and Accountability
in Juvenile Justice Programs and Services

## Rating Definitions

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

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

## Review Team

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

Paul Czigan, Office of Program Accountability, Lead Reviewer (Standard 1)
Teresa Andersen, Office of Program Accountability, Deputy Supervisor (Standard 2)
Tamara Mahl-Adkins, Office of Program Accountability, Regional Monitor (Standard 5 and Interviews)
Kamille Payne, Office of Program Accountability, Regional Monitor (Standard 4 and 5)
Bonita Williams, Office of Program Accountability, Regional Monitor (Standard 4 and 5)
Angenette Williams, Central Region, Detention Services, Government Operations Consultant, (Standard 5)

Program Name: Brevard Regional Juvenile Detention Center
Provider Name: Department of Juvenile Justice
Location: Brevard County / Circuit 18
Review Date(s): October 29, 2019 - November 1, 2019

MQI Program Code: 244
Contract Number: N/A
Number of Beds: 40
Lead Reviewer Code: 77

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

## Overall Rating Summary

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

| Limited Ratings | Failed Ratings |
|---|---|
| 2.12 Adherence to Daily Schedule | 5.14 Confinement Over Twenty-Four Hours |
| 5.01 Active Supervision of Youth * | |
| 5.02 Ten-Minute Checks * | |
| 5.07 Vehicles and Maintenance | |
| 5.13 Confinement Under Twenty-Four Hours | |

# Standard 1: Management Accountability
# Detention Rating Profile

## Indicator Ratings

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

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

# Standard 2: Youth Management
# Detention Rating Profile

## Indicator Ratings

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

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

## Indicator Ratings

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

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# Standard 4: Health Services
# Detention Rating Profile

## Indicator Ratings

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

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# Standard 5: Safety and Security
# Detention Rating Profile

## Indicator Ratings

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

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## Program Overview

The Brevard Regional Juvenile Detention Center is a state-owned detention facility, 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 contract #10105 by 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 (JJDOs). Mental health and healthcare services are provided through the contracted provider Maxim Healthcare Services Inc.

Mental health services are provided by one designated mental health clinician authority (DMHCA) who is a licensed mental health counselor (LMHC) forty hours a week, one non-licensed mental health clinician eight hours a week, and one psychiatrist 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, one hour a week, an advanced practice registered nurse (APRN) sixteen hours a week, one clinical manager served by a registered nurse (RN) forty hours a week, licensed practical nurse (LPN) services fifty-six hours a week, and a records clerk forty hours a week for both medical and mental health record keeping.

The medical clinic maintains nursing coverage twelve hours a day Monday to Friday and eight hours a day on weekends from 7:00 a.m. to 7:00 p.m., and on weekends from 7:00 a.m. to 7:00 p.m. Sick call is provided from 8:00 a.m. to 10:00 a.m. daily.

Food services are provided by Department staff and include menus, meal planning, meal schedules, special diets, nutritional analysis, daily allowance, food preparation, health certifications, food product standards, sanitation, and cleaning. Staff are responsible for the custody and control of youth in their care, providing youth supervision twenty-four hours a day, seven days a week. The center has three living modules which are divided by male and female. There are fifty-five security cameras at the center, of which fifty-five were operational.

During the time of the annual compliance review, the team observed the center to be pest free, clean, recently painted, and tastefully decorated. The fence in the large recreation yard had recently been repaired. Classrooms were very neatly organized. There were attractive wall murals in several areas. At the time of the annual compliance review, the center had nine vacancies, which included seven JJDOs and two food service workers.

# Standard 1: Management Accountability

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

The center has facility operating procedures addressing background screening. A review of staff personnel records revealed twenty-three staff received an eligible background screening prior to hire. One contract staff received an eligible background screening prior to hire. There were no new volunteers applicable for background screening. Each of the new staff completed the pre-employment assessment tool prior to hire and received a passing score.

The center submitted the Annual Affidavit of Compliance with Level 2 Screening Standards to the Department's Background Screening Unit on January 10, 2019. The school board submitted the Annual Affidavit of Compliance with Level 2 Screening Standards for school board personnel on January 7, 2019.

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

The center has facility operating procedures addressing five-year background rescreening. A review of the staff roster revealed two staff were eligible for five-year background rescreening. One applicable staff received their five-year rescreening within the required time frame. The second applicable staff rescreening was not submitted within the time frame. Staff recognized the error and submitted the rescreening eighteen days late. Administrative staff maintains a roster grid which lists all staff with applicable dates of initial screening and rescreening to ensure the error does not happen again.

| 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.*<br><br>*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.*<br><br>*Officers shall not verbally abuse, demean or otherwise humiliate any youth, and shall not use profanity in the performance of their job.*<br><br>*Officers shall not engage in or allow horseplay, either verbal or physical with and/or between any youth.*<br><br>*Officers shall not engage in personal relationships nor discuss personal information related to themselves or other officers with any youth.*<br><br>*Management takes immediate action to investigate or address all allegations or violations of the code of conduct.* | |

The center has facility operating procedures addressing staff code of conduct. A review of five new hire staff records revealed each staff signed the code of conduct upon hire. The code of conduct included all the required elements. A review of five staff records revealed none of the staff contained any disciplinary action regarding violations of the code of conduct. Interviews with administrators revealed none of the staff received any disciplinary action regarding violations of the code of conduct in the past twelve months.

The center documented training in code of conduct in the months of January, March, May, and September 2019 resulting in thirty staff completing the training event. A review of staff commendations revealed six staff received commendations in the past twelve months for awards such as juvenile justice detention officer of the year, regional employee of the month, and recognition by the provider/agency in their monthly newsletter. Fourteen staff also received individual certificates of appreciation from the region for exceptional performance during a particular assignment above and beyond the normal duties.

Five youth were interviewed regarding the use of the Florida Abuse Hotline. All five youth indicated they never had an occasion to report abuse. Four of five interviewed youth indicated staff are respectful when talking to youth. One of the five interviewed youth indicated certain staff brings stress to work and take it out on the youth. Another youth indicated sometimes staff are respectful and do not listen to the youth. Five youth were interviewed on how often they heard staff use profanity when speaking with youth. Three youth indicated they never heard staff use profanity, one youth indicated once, and one youth indicated occasionally. Youth were interviewed on how often they heard staff threaten youth. Four of five youth indicated they never heard staff threaten youth. One youth indicated hearing staff threaten youth. Follow-up questions clarified the youth was referring to when staff warned youth of consequences on continued misbehavior. All five interviewed youth indicated they felt safe at the center.

An interview with administration regarding abuse allegations and the code of conduct revealed the center ensures staff communicates and interacts with youth in a manner which provides a role model of socially accepted behaviors. The center requires staff behavior shall be respectful

of others and reflect desired behaviors for youth. If a staff member is believed to be involved with any kind of physical abuse, threats, or profanity towards a youth; staff call the Abuse Registry immediately upon learning of the incident. Staff will notify the Department's Central Communications Center (CCC), central region administration, and conduct an internal investigation. The employee is removed from any contact with youth until the conclusion of the investigation. Based on any substantiated findings the employee is disciplined up to and including dismissal.

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

The center has facility operating procedures regarding incident reporting. A review of logbooks, youth, and staff records did not reveal any reportable incidents which had not been reported. The center had thirty-one incidents during the annual compliance review period. Five incidents were reviewed. Each of the five incidents were reported within the required time frame. Three were related to medical needs, one was a behavior incident with complaint about staff, and one was a disruption within the center and youth behavior. None of the incidents revealed a violation of the code of conduct or found allegation of abuse.

An interview with administration revealed when a reportable incident occurs, the center shall notify the Department's Central Communications Center (CCC) within two hours of the incident or within two hours of becoming aware of the incident. Incidents shall be called in with the basic information such as who, what, when, where and how. If a youth is involved in the incident, the youth's Department identification number must be provided.

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

The center has facility operating procedures regarding Protective Action Response (PAR) reports. Five PAR reports were selected for review. None of the reports involved the use of mechanical restraints, required a PAR medical review, resulted in serious injury requiring contact with the Central Communications Center (CCC), or resulted in a call to the Florida Abuse Hotline. Each of the five reports were completed prior to the end of the staff's shift, reviewed by a supervisor trained in PAR or a certified PAR trainer, and received a post-PAR interview. Three of the five reports did not include a statement by all staff involved in the PAR incident. Four of the five PAR reports were reviewed by the superintendent/designee within the required time frame. The superintendent/designee review for one of the five reports was five days late.

The center's PAR rate during the annual compliance review period was 0.57, which is below the statewide Detention PAR rate of 11.75. The center has consistently had a below average PAR rate.

An interview with administration revealed each administrator upon arriving at the facility includes as a daily routine to check email and the Facility Maintenance System (FMS) for any information from supervisors regarding PAR incidents in the last shift. When a PAR incident is entered into the FMS system, an email is automatically generated to notify administrators for a PAR review. Each of the administrators and supervisors review video of any activity related to PAR incidents. The administrative team also review all logbooks for applicable incidents to review. Four of five interviewed youth indicated staff try to talk to youth prior to using physical intervention techniques. One youth indicated staff do not.

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

The center has facility operating procedures regarding pre-service training. Five staff records were reviewed for pre-service training. Four of the five staff were certified within the required time frame. One staff received an extension from the Department and was certified within the extended time frame. Records revealed each of the five staff received the essential skills training prior to being in the presence of youth. There was documentation each of the five received the required training for phase one and two for juvenile justice detention officer (JJDO). All trainings was documented in the Department's Learning and Management System (SkillPro).

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

The center has facility operating procedures regarding in-service training. Five staff records were reviewed for in-service training. The review of the five staff records revealed three of the staff received all of the required training within the calendar year with the exception of two staff who did not document training in active shooter within the calendar year. Two of the staff were applicable for taking eight or more hours of supervisory training. One staff record documented nine hours of supervisory training. One staff record documented three hours of supervisory training.

An interview with administration revealed management staff is required to complete all the Department's Learning and Management System (SkillPro) and instructor-led training as mandated by the State of Florida and the Department. The administrator provided the annual training calendar for review. A review of the annual training calendar revealed training was scheduled according to the calendar and updated as needed.

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

The center has facility operating procedures regarding entering alerts and sharing of alert information. A review of alerts for five youth selections revealed each youth had alerts entered into the Juvenile Justice Information System (JJIS) upon admission or upon the action triggering the alert. The team observed shift change in which staff were informed of alerts for all youth utilizing the JJIS alerts printed and included in the shift change documentation.

Five staff were interviewed regarding the alert system. All five staff indicated they are informed of alerts during shift change meetings, four staff indicated through JJIS, and one staff indicated mental health provides alerts when applicable. Staff were also interviewed on how administration informs staff of issues within the center. Four staff indicated administration utilizes the logbook while two staff indicated in staff meetings. One staff indicated administration speaks to supervisors who then informs staff. An interview with an administrator revealed alerts are printed, given to each staff, and discussed in shift briefing for all three shifts.

# 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:*<br><br>1. *Review of required paperwork from law enforcement and screening staff.*<br>2. *All youth shall be electronically searched, frisk searched, and stripped searched by an officer of the same sex as the youth.*<br>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.*<br>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.*<br>5. *All youth shall be screened to identify medical, mental health, and substance abuse needs.* | |

Five youth records were reviewed to verify the center's practice of youth admissions. Each contained the Department's Juvenile Justice Information System's Admission Wizard and validated the review of the arrest affidavit, Detention Risk Assessment Instrument and Suicide Risk Screening Instrument. Each record further documented each youth was searched, received their phone call, a meal if admission was completed two or more hours prior to the next scheduled meal, and the medical, mental health, and substance abuse screening was completed for each youth. There were no admissions during the annual compliance review week; therefore, an admission was unable to be observed.

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

Five youth records were reviewed to verify the center's orientation process and documentation supported each youth received their orientation within twenty-four hours of admission. Each youth signed a form acknowledging orientation was completed and explained to them verbally, as well as the youth were provided with an orientation packet containing the required elements as it is outlined in the center's policy. Five youth were interviewed and three indicated they received an orientation regarding center information and the center's expectations. Two of the

youth indicated they did not receive this information; however, each of the five youth signed the center's Booking Checklist which documents each youth received orientation documentation. There were no admissions during the annual compliance review week; therefore, an admission was unable to be observed.

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

Five youth records were reviewed and validated the center's classification process included the required documentation. The center utilizes a classification form and documents their findings and information considered when assigning each youth to their room. Any special needs were documented and verified for each youth. All of the classification documents were reviewed and considered prior to making the room assignment for each youth.

All alerts were noted in the Department's Juvenile Justice Information System's (JJIS) Admission Wizard for each youth reviewed and each documented the appropriate youth alerts. The center completed the Vulnerability to Victimization and Sexually Aggressive Behavior for each of the five youth, in addition to additional screening forms to determine each youth's vulnerability to victimization which matched the center's facility operating procedures. The center maintains a gang binder which includes the picture of youth who are associated with gangs or display any signs of gang activity, staff who attended gang training, correspondence between the center and circuit JPOs, and gang identifying information. A review of JJIS verified gang members, suspected gang members, and associates of gang members are documented as required.

| 2.04 Notification of Juvenile Probation Officer Circuit Gang Representative | Satisfactory Compliance |
|---|---|
| *Each center shall identify the juvenile probation officer (JPO) designated as the circuit gang representative to communicate suspected gang activity.*<br><br>*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.*<br><br>*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 maintains a gang binder which documents email correspondence between the superintendent and the assigned circuit juvenile probation officer (JPO) regarding any suspicions of gang activity. Three youth were identified by their JPO as documented or associated gang members but had not been verified by law enforcement; therefore, the alerts were not entered. A review of email correspondence verified the communication between the JPO and the superintendent for these three youth, which follows the center's procedures. An interview with the assistant superintendent indicated the superintendent serves as the center's gang representative. The superintendent further indicated gang information is discussed during the detention review meetings where detention staff, JPO staff, and transition staff are present.

| 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.* | |

When a youth is admitted into the center, a property receipt form is completed and the property information is also entered onto a Property Receipt Report for each youth. Five youth records were reviewed and each contained a Property Receipt Report and each contained the youth's signature. Each report documented the required information. Each record contained a letter of acknowledgement regarding any unclaimed property signed by both the youth and the center's staff. The center utilizes a clear tamper proof plastic bag which contains the youth's name, date, the Department Juvenile Justice Identification (DJJID) number and a list of items in the bag. Three of the five youth were admitted with valuable items and each of the three youth's items were documented and stored in a locked room in a safe in which only the superintendent and assistant superintendents have access. None of the five youth refused to sign the Property Receipt Report.

Observation validated the center maintains a logbook for all valuable items which documents the date, youth's name, DJJID, printed name of the detention officer, and signature of the detention officer. Each of the five youth had property such as clothing and shoes stored in the secured property lockers. Each locker maintained a Property Receipt Report with both the youth and center staff's signatures.

Five youth were interviewed and each indicated when they arrived at the center, staff checked in their personal property and each signed a form indicating the personal property listed was correct. The superintendent verified the process for youth's personal property as they are

admitted into the center. There were no admissions during the annual compliance review week; therefore, an admission was unable to be observed.

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

The property storage area where youth's valuable and personal property is located, was observed and found to be locked, secured, and inaccessible to youth. Each occupied locker had a completed inventory form on the front. The superintendent and the two assistant superintendents are the only center staff with access to the youth's property. The room is under video surveillance.

The center maintains a logbook for all valuable items which documents the date, youth's name, the Department' Juvenile Justice Identification (DJJID) number, printed name of the detention officer, and signature of the detention officer. The center utilizes a clear tamper proof plastic bag which contains the youth's name, date, DJJID, and a list of items in the bag. A review of Central Communications Center reports validated there were no complaints regarding youth property being reported missing or damaged.

The superintendent indicated each youth's property is inventoried upon entering the screening unit. All money and personal items of value are documented and placed in a tamper proof property bag. The description of the items in the bag is completed on the outside form of the bag, the youth's property receipt form, and in the property logbook. The property is then placed in a drop safe which is under twenty-four hour surveillance.

The superintendent further indicated, any property which is not picked up within thirty days after a youth is released is considered abandoned. A registered Notice of Impending Disposal of Property is forward to the youth's last known address. After thirty days the property is donated to North Brevard charities and a money order for all cash is obtained and sent to the Department's Central Region Office. The center provided a copy of this process which was completed in October 2019 and validated this practice. There were no admissions during the annual compliance review week; therefore, an admission was unable to be observed.

| 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.*<br><br>*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.*<br><br>*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.*<br><br>*Questions concerning release are presented and addressed by the superintendent, or designee, prior to release.*<br><br>*The releasing officer shall verify the identification of the youth.* | |

Three youth closed records were reviewed to verify the center's release process and validated all paperwork was reviewed by the center's on-duty supervisor prior to each youth's release to include paperwork from the court. Each youth's identity was verified prior to their release. Each record contained a copy of the individual's identification to whom the youth was released. A reminder of future court dates was provided to each youth. Each required form was signed by all parties. Each youth signed for their personal property upon release.

A review of the Department's Juvenile Justice Information System's (JJIS) validated the release date in JJIS matched the release date in each of three youth's record. A review of Central Communications Center reports for the last six months validated there were no incidents regarding unauthorized releases. There were no releases during the annual compliance review week; therefore, the release process was unable to be observed.

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

Three youth records were reviewed to verify the center's process when releasing a youth and returning their personal property. Each youth's property receipt record was signed by the youth and parent/guardian upon release. The center provided a copy of the process for property held for more than thirty days which was completed in October 2019 and validated the center's practice. The center's documentation was in the form of a packet which contained a memorandum signed by the superintendent and assistant superintendent, which was submitted to the central region detention director. A memorandum to the Department's operations and management consultant manager, included a list of property (cash and valuables) removed from the safe, a copy of the money order for cash, donation receipt to the local charities center, and the Notice of Impending Disposal of Property to the youth who had property left over thirty days. There were no releases during the annual compliance review week; therefore, the release process was unable to be observed.

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

The center has a process for youth who are released with medication and providing aftercare instructions. A review of three closed youth records who were released with medication, validated the center follows their policy and procedures. Each record documented a copy of identification for the person to whom the youth was released. Each of the three records contained a completed copy of a signed Medication Receipt, Transfer and Disposition Form and Health Discharge Summary Transfer Note. None of the three youth had follow-up appointments; however, any health or welfare issues were noted if applicable.

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

An evaluation of detention review paperwork for the last six months validated weekly detention reviews are being completed with consistent documentation of participation by all parties who are responsible for each youth. Each youth is discussed, the status and follow-up are noted in the paperwork packet, and each team member signed in on the sign-in sheets. A detention review meeting was observed during the annual compliance review and validated the center's practice. The superintendent, assistant superintendent, medical staff, mental health staff, education staff, juvenile probation officer (JPO) from each local unit, assistant chief probation officer, intake screening officer, detention review specialist, and several local provider staff were present during the review meeting. The detention review team reviewed each youth individually. The superintendent indicated detention review meetings are held weekly at the center and is attended by center staff, JPO staff, and private providers as validated in the review of the last six months of detention 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 the annual compliance review, daily activities such as education, dining, and youth movement were observed. According to the daily activity schedule, hygiene, meals, visitation, education, recreation, indoor activities, shift change, bed times, and groups are provided which indicates the youth are scheduled to participate in constructive activities. The daily activity schedule was posted throughout the center including on each youth dorm. Five youth were interviewed and indicated the center has a daily activity schedule. Five interviewed staff indicated restorative justice is offered daily to the youth which coincides with the daily activity schedule.

| 2.12 Adherence to Daily Schedule | Limited Compliance |
|---|---|
| *Center staff shall adhere to the daily activity schedules. Documentation of all activities shall be made in all applicable logs.*<br><br>*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.*<br><br>*Any cancellation of visitation shall be approved by the superintendent.* | |

During the annual compliance review, daily activities such as education, dining, and youth movement were observed by the review team and a review of the center's logbooks for the last six months. Through observation and review of the logbooks it was determined the activity schedule was being followed with the exception of large muscle activity. A review of logbooks for two consecutive weeks during the annual compliance review period, documented large muscle activity was not completed on each of the three dorms for eleven of the fourteen days reviewed. Three days documented one dorm participated, five days documented two dorms participated, and three days documented all three dorms participated.

Two weeks prior to the annual compliance review week, the center replaced the razor wire on the recreational area which had been falling down for four to six months. Prior to the replacement of the razor wire, the assistant superintendent indicated for safety and security, youth were not permitted outside; however, the logbooks did not indicate the youth were participating in large muscle activity in another location during this time.

The center recently updated their shift report process as a result of the process changing statewide. A review of the shift reports validated there was no reference of any significant changes in the activity schedule or indication as to why large muscle activity was not being conducted. Five staff and five youth were interviewed and all staff and three youth indicated, the activity schedule is followed. Two youth indicated the activity schedule is not followed. Additionally, one youth indicated only one time were they able to participate in recreational/large muscle activities since being at the center for the last three weeks. One youth indicated, shift change might affect when youth get out of their room and another youth indicated staff change the schedule to accommodate their way.

| 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 is staffed through the local school board with three lead teachers and one assistant teacher. One teacher on staff has been employed at the center for eighteen years. An interview with the teacher was conducted while on site for the annual compliance review. The center holds class 300 minutes a day with the requirement of twenty-five hours of instruction weekly. The teacher indicated school has not been cancelled within the last year with the exception of the evacuation during the hurricane in September 2019. The teachers have in-service days which are not counted in the required minutes to hold education classes. The youth are provided the opportunity to earn course credit while in the center. The teacher further indicated the center has a grant which allows the youth to take the pre-test for the general education

diploma (GED). The teacher awards one student each week with a student of the week certificate, to recognize their behavior in the classroom.

A review of three dates for each of the three modules validated class started on time and ended on time. Through observation throughout the annual compliance review, it was determined the education schedule was adhered to.

Five youth were interviewed and each indicated education is offered at the center Monday through Friday with minimal, if any interruptions. The five youth indicated they are offered classes in the topics of career choices, life skills, math, science, history, reading and social studies. Five staff, as well as the superintendent were interviewed and indicated there are minimal interruptions in education.

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

An interview with the lead teacher validated the center provides career education opportunities for youth while at the center. Type 1 life skills groups, career activities, and class instruction are provided to youth. The teachers provide youth the opportunity to partake in online career education and provided certificates for examples of youth who completed Occupational Health and Safety Act (OHSA) Bloodborne Pathogens course, SafeStaff, and Customer Service. Each youth is able to participate in Florida Shines, which guides youth in a career path based off their corresponding answers.

Youth are provided guidance and education on job applications, interviewing skills, and job searches. The center coordinates with Arts4All of Florida who provides art, drama and music education to the youth three times a year for six weeks. When a youth is being released and has shown interest in future education and career opportunities, the teachers provide the youth with a pre-printed Career and Transition Plan folder, where the youth can document their education and work history. The teachers include copies of the youth's certificates earned while in the center, social security number, employment websites, and guidance on transitioning.

| 2.15 Behavior Management System | Satisfactory Compliance |
|---|---|
| *The center provides a system of rewards, privileges, and consequences to encourage youth to fulfill the center's expectations.*<br><br>*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.*<br><br>*The behavioral norms and expectations for youth shall be posted in all living areas and shall clearly specify appropriate and inappropriate behaviors.* | |

The center has a process in place and adheres to their facility operating procedures (FOPs) on the behavioral management system (BMS). The center was scheduled to take training on the Department's new detention BMS in September 2019; however, due to evacuations related to the hurricane, the center was unable to participate in the training. The training was rescheduled to November 13, 2019. The new BMS took effect on October 1, 2019 but due to the center's

staff not being trained, the center has not implemented the new BMS. As a result, the fiscal year 2019-2020 FOPs do not match the details of the old BMS system; however, the center is adhering to their current BMS. The center maintains a level three incentive calendar which documents weekly incentives. The center has initiated a book report program which encourages youth to read and complete a book report for extra incentives.

The center utilizes a Behavioral Management System – Reminder/Warning/Level Drop Form to document levels of consequences for youth. A review of six forms validated the center follows this process. A review of the logbook for the past six months validated the center provides level three incentives. Five staff were interviewed; one rated the BMS as very poor, one as fair, and three as good. All five staff indicated the youth are given the opportunity to explain their behavior, discuss their consequences, and as a result all five staff feel the BMS is effective. The five staff indicated they are provided feedback on a weekly, monthly, and as needed basis. Five youth were questioned if they felt the consequences were fair, two indicated it was not fair, one indicated it was fair, and two indicated they have not received consequences. The superintendent indicated the center utilizes a level system and was able to explain the process.

| **2.16 Unauthorized Use of Punishment (Critical)** | **Satisfactory Compliance** |
|---|---|
| *The center's behavior management system (BMS) restricts certain types of penalties on youth who demonstrate negative behaviors.*<br><br>*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.*<br><br>*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.*<br><br>*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 an established behavioral management system (BMS) and as part of the facility operating procedures it indicates corporal and/or physical punishment will not be utilized. Group punishment is not permitted.

Five staff were interviewed and indicated only levels and extra snacks can be withheld from youth as a consequence of negative behavior. Five staff also indicated they have never observed other staff encourage youth to punish other youth. Three of the five interviewed youth indicated levels and snacks are taken away. In addition, one youth indicated mats were taken and shower time was skipped for a whole day. Two youth indicated they have not received consequences. The five youth were questioned if they were able to punish other youth. Four indicated no and one youth indicated youth are permitted to punish other youth; however, the youth could not provide an example of such punishment.

| 2.17 Grievances | Satisfactory Compliance |
|---|---|
| *The grievance procedures establish each youth's right to grieve and ensure all youth are treated fairly, respectfully, without discrimination, and their rights are protected. The process includes:*<br><br>1. *Informal phase, wherein the JJDO attempts to resolve the complaint or condition with the youth using effective communication skills;*<br>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*<br>3. *Appeal phase, wherein the youth may appeal the outcome of the formal phase to the superintendent or designee.* | |

The center has a policy and procedures regarding grievances which indicates their formal phase attempts to resolve the complaint or condition with the youth using effective communication skills. The assistant superintendent indicated this is the phase the center utilizes often when the youth has a grievance. The center utilizes a formal phase where the youth submits a written grievance which results in a response from a detention supervisor by the end of the shift if possible, otherwise within twenty-four hours. The assistant superintendent indicated the center has not had any formal grievances since the last annual compliance review.

During the tour of the center, grievance forms were observed to be posted on each dorm. According to the center's facility operating procedures (FOPs) the supervising officer(s) shall enter each grievance into the Facility Management System (FMS) on behalf of the youth. The superintendent was able to explain the center's grievance system and further indicated all grievances are stored at the center for five years. Five youth were interviewed and indicated they have not filed a grievance while at the center. Five staff were interviewed and each were able to explain the center's grievance system.

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

Through an interview with the assistant superintendent, it was indicated the center does not have a specific written practice on the implementation of trauma-informed care; however, the center engages in trauma-informed care practices. According to the superintendent, trauma-informed practices consist of staff conducting groups with youth, training of staff on trauma-informed care and triggers for youth and staff, and communication between shifts at briefings

passing along any information about a youth who has specific triggers. The center does not utilize a soft room. The superintendent also indicated a volunteer comes in on a weekly basis to conduct a trauma informed care group for the youth. The center is painted in soft colors with murals displaying encouraging messages and pictures. A review of ten staff training records, five in-service and five pre-service documented staff received training in trauma-informed care.

# Standard 3: Mental Health and Substance Abuse Services

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

The center maintains a contract with Maxim Healthcare, Inc. who provides services to all applicable youth in the center. Maxim provides a licensed mental health counselor (LMHC) who serves as the designated mental health clinician authority (DMHCA). The DMHCA holds a clear and active license with the Department of Health, Bureau of Medical Quality Assurance expiring on March 31, 2021. The DMHCA is on-site Monday through Friday and Saturday, totaling forty hours per week. The DMHCA reported being responsible for overseeing the consistent implementation of mental health and substance abuse services to youth in the center. Another licensed clinical social worker provides mental health and substance abuse services on Sundays.

| 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 a policy and procedures in regard to licensed mental health and substance abuse clinical staff. The center has two part-time licensed clinical staff and one pro re nata (PRN) licensed clinical staff. Each of the licensed clinical staff has clear and active licenses with the Department of Health, Bureau of Medical Quality Assurance expiring on March 31, 2021. The center is also staffed with a psychiatrist scheduled to be on-site two hours a week. The psychiatrist holds a clear and active license with the Department of Health, Bureau of Medical Assurance expiring on January 31, 2020.

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

The center has a policy and procedures regarding the non-licensed mental health and substance abuse clinical staff. The center does not currently employ non-licensed mental health and substance abuse clinical staff and did not utilize any non-licensed staff during the annual compliance review period. The center has a process in place to provide services if the provider begins to utilized non-licensed clinical staff in the future.

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

The center has a policy and procedures regarding mental health and substance abuse admission screening for youth entering the center. The center currently administers the Massachusetts Youth Screening Instrument-Second Version (MAYSI-2) and Suicide Risk Screening Instrument (SRSI). The center's medical staff and/or mental health staff completed the admission forms in entirety and each of the screens were administered by a trained staff. A review of five youth records contained a MAYSI-2 and SRSI completed at the time of their admission to the center. Each of the forms were located in the youth record and in the juvenile justice information system (JJIS) and were completely in its entirety. Four of the five youth records indicated the need for further assessment. In each case, the staff completed a referral as a result of the MAYSI-2 and SRSI. One indicated suicide risk elevation and received a referral for an Assessment of Suicide Risk (ASR). The superintendent and mental health clinical staff were notified of the results. The superintendent reported the mental health, substance abuse, and suicide risk screenings are completed by the juvenile justice detention officer's, supervisor's, nursing, and mental health staff.

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

The center has a facility operating procedures regarding the completion of mental health and substance abuse evaluations for applicable youth. None of the youth reviewed were applicable for completion of a comprehensive mental health and substance abuse evaluation; therefore, the only two applicable youth records were provided by the center. None of the additional evaluations were completed by a community provider. Each of the evaluations were completed by the detention provider Maxim. Both of the applicable youth were identified after admission and referred to the detention provider. The comprehensive mental health and substance abuse evaluations were completed within thirty days of the referral.

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

The center has a policy and procedures regarding mental health and substance abuse treatment provided to youth in the center. None of the reviewed youth records were applicable for mental health and substance abuse treatment; therefore; an additional three youth records were provided for review. Each of the three reviewed youth records included an Authorization for Evaluation and Treatment (AET) and when needed, a consent for substance abuse treatment were found in the youth records. All three youth requiring treatment were assigned to a mini-treatment team. The treatment teams included all required staff as indicated by signatures on the forms. Each of the three youth received individual counseling as required by their plans, which was documented on the Department's Mental Health/Substance Abuse form containing all required elements. None of the youth were applicable for group counseling. Two of the five interviewed youth reported not receiving mental health/substance abuse services, two stated the services are good, and one reported very good.

An interview with the designated mental health clinician authority (DMHCA) revealed treatment of mental health and substance abuse issues is multi-disciplinary in nature and can include individual counseling, crisis intervention, and psycho-pharmacological intervention. After the data is collected, the DMHCA and the youth discuss the individualized mental health/substance abuse treatment plan. The youth is given an opportunity to add, change, or delete items in the treatment plan. If there are no changes to be made in the treatment plan, the DMHCA attempts to obtain signatures from the youth and the youth's parent/guardian. It is possible for youth to be released from the detention center with a referral to an outside provider or community mental health agency.

Five youth were interviewed regarding the quality of the mental health care at the center. Two youth rated the mental health care good, one rated it very good, and two youth indicated they were not receiving services.

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

The center has a policy and procedures regarding treatment and discharge planning. None of the reviewed youth were applicable for treatment and discharge planning; therefore; an additional three youth records were provided for review. In each of the three youth records, the initial treatment plans were completed within seven days of the initiation of treatment. The initial treatment plans were developed on a Department's form which contained all the required information. The plans included the reason for referral for treatment, diagnosis/symptoms, initial treatment methods, initial treatment goals, psychiatric services, and signatures of mental health/substance abuse clinical staff and youth. The individual treatment plans were developed by the each of the youth's thirty-first day and signed by the licensed clinical staff. Each of the treatment plans included symptoms which are treatment focused, treatment goals, strengths/abilities, psychiatric services, pharmacological interventions, and progress notes. All three treatment plans were signed and dated by the youth, clinical staff, treatment team

members and parent, if possible. Reviews were completed every thirty days when applicable in each of the three individual treatment plans. During the annual compliance review, the center did not have any mini-treatment team meeting to observe.

Three closed youth records were reviewed for mental health/substance abuse treatment discharge summaries. All three discharge summaries were completed on the Department's form which contained all required elements. In each of the three youth records, there was documentation to support the youth, parent/guardian, and juvenile probation officer were provided a copy of the discharge plan.

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

The center has a policy and procedures regarding psychiatric services for youth in the center including the services of a psychiatrist. The psychiatrist holds a clear and active license with the Department of Health, Bureau of Medical Quality Assurance expiring on January 31, 2020. The contract requires the psychiatrist to visit the center for a minimum of two hours a week. The center does not utilize the services of a psychiatric advanced registered nurse practitioner. A review of sign-in logs indicated the psychiatrist is on-site the required two hours weekly.

One of the five youth records reviewed was applicable for psychiatric services; therefore, an additional two records were provided for review. The psychiatrist completed an initial psychiatric interview and evaluation for all three youth. The evaluation was completed on the Clinical Psychotropic Progress Note (CPPN) including page 3 within fourteen days of admission to the center. The initial psychiatric interview included the reason for the referral, history, mental status examination, diagnosis, treatment recommendations, prescribed medication, explanation of the need for psychotropic medication, and frequency of medication management.

All three youth records included an in-depth psychiatric evaluation completed within thirty days of their admission utilizing a CPPN including all three pages. One of the three youth is under Department of Children and Families and the center had a court order to provide psychotropic medication. The remaining two youth had a signed Authorization for Evaluation and Treatment (AET). None of the youth received new medications while in the center. The designated mental health clinician authority (DMHCA) reported meeting with the psychiatrist weekly.

| 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 approved and reviewed by the designated mental health clinician authority (DMHCA) and superintendent on July 31, 2019. The plan includes all required elements such as identification and assessment of youth at-risk of suicide, referral, communication, immediate staff response, notification, levels of supervision, suicide precautions, staff training, documentation, and review process.

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

The center has a policy and procedures regarding suicide prevention services. 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. Youth placed on suicide precautions are maintained on one-to-one or constant supervision. The superintendent has a review process for every serious suicide attempt or serious self-inflicted injury and a mortality review for a completed suicide.

Four of the five reviewed youth records were applicable for suicide prevention services. A review of the Juvenile Justice Information System (JJIS) indicated the appropriate alerts were entered and removed, as required. Each of the four applicable youth identified to be at risk at admission was placed on precautionary observation. Reviewed documentation reflected staff observations were included on the suicide precaution observation logs and an Assessment of Suicide Risk (ASR) was completed for each youth during the required time frame. Each of the ASRs were completed by a non-licensed clinical staff under the supervision of the designated mental health clinician authority (DMHCA). None of the youth required a follow up ASR. Reviewed logbooks reflected staff documented the beginning and ending times each youth was placed on precautions.

Three additional youth were reviewed for secure observation. Each of the three youth placed in secure observation were authorized by the superintendent and designated mental health clinician authority (DMHCA), secure room designated in writing, Health Status Checklist completed, suicide precautions observation log completed in its entirety, follow up ASR completed, and parent/guardian and juvenile probation officer notified of potential suicide risk. The mental health clinical staff provided supportive counseling and level reduced after the superintendent/licensed mental health professional conference. Each of the youth were removed from secure observation within twenty-four hours of placement; however, there was no clear documentation in the center's logbook in regard to the youth being placed in or taken out of secure observation for two of the three youth records.

One of the five interviewed youth indicated having been placed on precautionary observation. The remaining youth reported not being placed on precautionary observation. The one youth which was placed on precautionary observation, reported staff watched them at all times. Five staff were interviewed and reported when a youth expresses suicidal thoughts they are to notify mental health, search the youth and room, document supervision of youth, and the youth is placed on constant sight and sound supervision. Each of the five interviewed staff reported there is a suicide response kit in master control, medical, and the training room. Interviews with

the superintendent indicated the center utilizes secure observation only when a youth on precautionary observation is displaying inappropriate behavior or refusing to comply with facility rules.

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

The center has a policy and procedures regarding supervision of youth placed on suicide precautions. The center uses the Department's Suicide Precaution Observation Log Forms for youth placed on precautionary observation. A review of seven precautionary observation logs revealed the logs were maintained for the duration of each youth placed on precautionary observation. Each of the logs were reviewed and signed by the supervisor and mental health clinical staff. None of the youth displayed warning signs while on observation. Youth supervision while on precautionary observation where supervised not exceeding thirty-minute intervals; however, all of the times were not in real time. Interviews with three youth placed on precautionary observation revealed the staff were with them at all times.

| 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.* | |

Ten staff training records, five pre-service and five in-service were reviewed for completion of required suicide prevention training. Each of the staff completed the required six hours of annual training on suicide prevention and implementation of suicide precautions. A review of the emergency drill evaluation forms found each mock suicide drill included the date, time, shift, and the participating staff. Mock suicide drills were held on each shift, quarterly. Seven reviewed in-service staff training records revealed each participated in at least one semi-annual mock suicide drill. Each current staff member participated in drills semi-annually.

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

The center has a written mental health crisis intervention plan which was approved and signed by the designated mental health clinician authority (DMHCA) and superintendent on July 31, 2019. The plan addresses the notification and alert system, means of referral to include youth self-referral, communication, supervision levels, documentation, and review.

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

The center has a written emergency care plan which was approved and signed by the designated mental health clinician authority (DMHCA) and superintendent on July 31, 2019. The plan addresses immediate staff response, notifications, communication, supervision of youth, authorization to transport for emergency services, transportation for emergency mental health and/or substance abuse evaluation and treatment, documentation, training, and review.

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

The center has a policy and procedures regarding mental health crisis intervention plan and procedures. The plan details crisis intervention procedures including a notification and alert system, means of referral including youth self-referral, communication, supervision, documentation, and review. The center's plan was reviewed, approved, and signed by the designated mental health clinician authority (DMHCA) and superintendent on July 31, 2019. The center did not have any crisis assessments in the past six months.

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

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

# Standard 4: Health Services

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

The Department has a contract with Maxim Health Services, Inc. to provide all medical services at the center, which includes the provision of a licensed physician to serve at the center's designated health authority (DHA). The contract also provides an on-call physician employed with the provider to provide coverage in the event of the DHA's absence. Both the DHA and the back-up physician holds a clear and active license with the Department of Health, Bureau of Medical Quality Assurance expiring on January 31, 2021. The DHA has an agreement with an advanced practice registered nurse (APRN) which includes a Collaborative Practice Protocol on record with the center. The APRN holds a clear and active credentials with the Department of Health, Bureau of Medical Quality Assurance expiring on July 31, 2020 and is board certified in pediatric nursing. A review of the weekly sign-in sheets from the annual compliance review period, found the DHA was on-site each week for at least one hour, as required. The sign-in sheets found the APRN was on-site at least eight hours a week to provide additional clinical services to the youth. The center's facility operating procedures (FOPs) outline the DHA's duties as providing required clinical services, reviewing and prescribing youth medication, assisting in the development of policies and procedures, and communicating with the center regarding youth's medical needs. An interview with the DHA confirmed their role and specified they are available twenty-four hours a day, seven days a week for consultation and coordination of emergency and off-site care. The center does not utilize Telemedicine.

| 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 a policy and procedures which outlines healthcare services provided to youth. The facility operating procedures (FOPs) were last reviewed by the designated health authority (DHA) on July 29, 2019 and by the superintendent on July 30, 2019. The psychiatrist reviewed the FOPs on August 7, 2019. In addition, the center utilizes healthcare protocols which were last reviewed by the DHA on August 4, 2019. A cover page was found for the FOPs and protocols which was signed by all center medical staff, including regional staff who are periodically at the center indicating each staff completed an annual review. The center had one new healthcare staff hired during the annual compliance review period and documentation found the staff received a comprehensive clinical orientation to Department's healthcare. The orientation was provided by the corporate regional clinical director, who is an advanced practice registered nurse (APRN).

| 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 (IHCRs) were reviewed for documentation of a completed Authority for Evaluation and Treatment (AET). Two of the five IHCRs included a valid original AET, two IHCRs included a valid AET copy, and one IHCR included a Limited Consent AET for a youth who was found to be in the custody of the Department of Children and Families (DCF). Two additional youth records were provided for youth in the custody of DCF and both youth's IHCR included a Limited Consent AET, as required. In all seven IHCRs reviewed, the AET or Limited Consent AET was obtained prior to providing medical services.

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

Five youth individual healthcare records (IHCRs) were reviewed for parental notification of any medical services provided or medications which were not covered by the Authority for Evaluation and Treatment (AET). Two youth required notification for over-the-counter medications not covered by the AET and two youth required notification for changes in medication. Notification was documented and sent utilizing the Department's form and sent on the day of the medical services. Each of the two youth applicable for medication changes had documentation the nursing staff received consent from the parent/guardian by telephone prior to the written notification being sent. In both youth IHCRs, the telephone consent was documented in the Nursing Chronological Progress notes and included a witness. One youth was applicable for parent/guardian notification for continuance of a psychotropic medication and documentation was found verbal consent was obtained and witnessed and written notification sent. None of the five reviewed youth were applicable for parental notification for immunizations, prescription of a new psychotropic medication, change in chronic condition, or 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 (IHCRs) were reviewed and each included a Healthcare Admission Screening completed on the date of admission by a juvenile justice detention officer (JJDO). Each of the admission screenings was reviewed by a licensed practical nurse (LPN) or registered nurse (RN) within twenty-four hours and the center's advance practice registered nurse (APRN) prior to completion of a Comprehensive Physical Assessment (CPA). One of the youth was a female and applicable for a pregnancy test which was completed after the youth provided verbal consent, as required. None of the youth were applicable for a change in custody while at the center. There was one additional applicable record for review which documented the youth changed custody while at the center and a rescreening was completed by a JJDO upon the youth's return and reviewed by the RN on the day the youth returned. An

interview with the superintendent verified the detention staff complete the admission screenings and nursing staff review them.

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

The center has a policy and procedures which outline required healthcare education provided to youth, including at orientation. Five youth individual healthcare records (IHCRs) were reviewed and each documented youth were provided an orientation to healthcare services within twenty-four hours of admission. The healthcare orientation packet was provided for review and included all required topics. Each topic reviewed was documented on the Department's form and maintained in the youth's IHCR. A review of healthcare contacts included in the healthcare orientation found all contacts were 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.* | |

The center has facility operating procedures which requires the notification to the designated health authority (DHA) in the event an admitted youth has a chronic condition, was admitted with medication, or is in need of emergency care. Five youth individual healthcare records (IHCRs) were reviewed and two were applicable for DHA notification within twenty-four hours for chronic conditions or medication. An additional youth IHCR was provided for review regarding DHA notification. Each of the three applicable youth IHCRs documented the DHA was notified of the youth's admission within twenty-four hours.

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

The center has facility operating procedures regarding Health-Related History (HRH). Five youth individual healthcare records (IHCRs) were reviewed for completion of an HRH and each was completed on the Department's form within the required time frame by a licensed practical nurse (LPN) or registered nurse (RN). Three of the HRHs were new and two were updated from previous youth admissions with all required signatures and dates. Each HRH was found to be completed prior to the Comprehensive Physical Assessments (CPA).

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

The center has a facility operating procedures (FOPs) which requires each youth to receive a Comprehensive Physical Assessment (CPA) within seven days of admission to the center and a valid tuberculosis screening to be on record for each youth. Five youth individual healthcare records (IHCRs) were reviewed and each included a new or updated CPA within seven days of

admission. Three of the CPAs were new, completed in full, and any deferred portion of the exam was explained. Two youth had current CPAs in their IHCR at admission and updates were completed during a focused evaluation. Four of the CPAs were completed by the advanced practice registered nurse (APRN) and one was completed by the designated health authority (DHA). One youth refused a part of the exam and a refusal form was found signed by the youth documenting their refusal.

Four of the five youth were applicable for updates to the Department's Problem List and each was updated as required. Each of the five youth IHCRs included a verified tuberculin skin test (TST) and a tier I tuberculosis (TB) screening. None of the youth required further testing or follow-up for TB symptoms.

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

The center has a facility operating procedures (FOPs) regarding sexually transmitted infections/human immunodeficiency virus (HIV). Four of the five reviewed youth individual healthcare records (IHCRs) were applicable for screening for sexually transmitted infections (STIs). Each was completed as required. One of the four applicable youth was referred for testing based on the screening. Testing was completed and documented in the IHCR. Each of the screenings were found on the Department's Infectious and Communicable Diseases form.

Two of the five youth were offered, consented, and referred for HIV testing. One additional IHCR was provided for review and found the youth was offered, referred, and consented to HIV testing. Each of the three applicable youth IHCRs included consent for HIV testing from the center the day of screening and the community provider on the day of the test. All testing, pre-test education, and post-test education was completed by a certified HIV counselor and documented in the youth's IHCR. The youth's results were filed in the IHCR in a sealed envelope marked as "confidential". Five youth were interviewed and each reported they could request an HIV test.

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

The center has a policy and procedures which outlines the provision of sick call for youth, including procedures for review of sick call requests in the event there are no healthcare staff are on-site. The center utilizes separate healthcare and non-healthcare staff treatment protocols for treatment of youth during sick call. The center provides sick call from 8:00 a.m. to 10:00 a.m. daily by the nursing staff and as needed when the designated health authority (DHA) or advanced practice registered nurse (APRN) are on-site. Five youth individual healthcare records (IHCRs) were reviewed and three were applicable for sick call requests. Two of the sick calls were conducted by a licensed practical nurse (LPN) and reviewed by the registered nurse (RN) or designated health authority (DHA) who is a medical doctor (MD) within twenty-four hours. Each sick call was documented on the Sick Call Request Form and the Sick Call Referral Log,

as required. None of the three applicable youth presented with the same complaint three or more times or experienced pain with which the clinician was unfamiliar.

A review of seven restricted housing reports found all youth had access to medical care as needed and were evaluated by medical staff at least once during their confinement. A sick call was not able to be observed during the annual compliance review; however, the process for sick call encounters was reviewed and found the sick call process ensures youth privacy. Five youth were interviewed and four reported sick call is conducted by the nurse within one day of submitting a sick call and one youth never had a sick call. Three of the youth reported medical care at the center is very good, one youth reported it was very poor, and one youth never used medical services at the center. Five staff were interviewed and each reported staff places the sick call in the system and the nurse conducts sick call. One staff reported the DHA will sometimes conduct sick call.

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

The center has a policy and procedures in place regarding the provision of episodic and emergency medical care. The facility operating procedures (FOPs) requires the center to provide emergency and episodic medical care services to youth twenty-four hours a day. The center maintains a list of emergency numbers in the medical clinic, including the Poison Control number which are inaccessible to youth.

Five youth individual healthcare records (IHCRs) were reviewed and three were applicable for instances of episodic care. Each of the three episodic care events was conducted by a licensed healthcare staff, included all required information, and documented in the youth's IHCR. Each episodic care event was found on the Episodic Care Log.

A review of the Episodic Care Log found there were no instances of non-healthcare staff conducting episodic care during the annual compliance review period. The center's FOPs and non-healthcare staff treatment protocols which were approved by the center's designated health authority (DHA), outlines the process in the event non-healthcare staff would need to conduct episodic care.

A review of five pre-service staff training records found four completed first aid, cardiopulmonary resuscitation (CPR), and automated external defibrillator (AED) training. Documentation was found the remaining staff completed the training; however, there was no indication the staff passed the certification. A review of five in-service staff training records found each completed the annual training in first aid, CPR, and AED. In addition, training documentation was provided to support supervisors were trained in the use of epinephrine auto-injector. Each licensed healthcare staff had documentation of certification in first aid, CPR, and AED, at a minimum.

The center maintains two AEDs and fifteen first aid kits on-site. The center utilizes an outside provider to monitor the AEDs which are located in master control and the medical clinic. The batteries and pads were replaced by the outside provider in August 2018 and expires in March of 2021. The green light was observed and functional on the front of both AEDs. The instructions for the AEDs were maintained with the AED.

The fifteen first aid kits are maintained in master control, medical clinic, two classrooms, dining hall, three living units, and seven vehicles. Each first aid kit was reviewed and found fourteen were monitored monthly by the medical staff during the annual compliance review period. The first aid kit in the maintenance van, which is not used to transport youth had not been checked during the annual compliance review period. A review of each vehicles first aid kit and the kits in master control, classroom one, and the dining hall found each kit was secured with a zip tie and included all designated health authority (DHA) approved items. The kits in master control and the dining hall included expired gauze pads and the kit in master control included an expired hand sanitizer. Expired items were replaced while the review team was on-site. The center's FOPs requires medical drills to be conducted at least quarterly on each shift and include first aid and CPR at least once a quarter and at least once a year for each shift. All drills were found to be conducted as required.

| **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.* | |

Five youth individual healthcare records (IHCRs) were reviewed and none were applicable for off-site care. Three additional records were provided for review of off-site care. Each of the three applicable records included the Summary of Off-Site Care form, discharge instructions, and each were reviewed by the designated health authority (DHA). Documentation was found in each IHCR, the DHA was notified at the time the youth was sent off-site. Two youth required follow-up care and both received care as required. All three incidents were found on the center's Episodic/Emergency Care log.

| **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.* | |

Five youth individual healthcare records (IHCRs) were reviewed and three were found to have chronic conditions. None of the three youth were applicable for periodic evaluations. One interviewed staff indicated there were no youth who had been at the center long enough to require a periodic evaluation during the annual compliance review period. The center tracks chronic conditions by logging each youth's chronic conditions at admission in a binder for the designated health authority (DHA) to review each week. The center also tracks youth with chronic conditions by reviewing the alert list. Further, the DHA sees any youth who has been at the center for ninety days to ensure all youth including those with chronic conditions are receiving periodic evaluations.

One of the three youth identified with chronic conditions was found in the DHA binder identifying them with chronic conditions. One of the two youth not included in the binder was diagnosed with a chronic condition during the Comprehensive Physical Assessment (CPA) and the other youth was found to have a pre-existing diagnosis which was not reported until the CPA. Two of the three youth with chronic conditions were found to have an active alert on the center's alert list. The third youth was diagnosed with obesity which is no longer included on alert lists. The center did not have documentation this youth was tracked for periodic evaluations; however, the youth received care for the chronic condition. All three youth with chronic conditions had

documentation of their chronic conditions in their IHCRs and the Department's Problem List. All three youth were found to receive care for the conditions, as required.

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

The center has a facility operating procedures (FOPs) addressing medication management. The center stores all medication in the locked medication cart which is secured in the medical clinic. Oral, topical, and liquid medications are stored separately. Controlled medications are stored in a locked box inside the medication cart. All over-the-counter (OTC) medications are securely stored in locked cabinets in the medical clinic.

Five youth individual healthcare records (IHCRs) were reviewed and four received medications while admitted to the center and all prescribed and OTC medications were administered pursuant to active prescriptions and orders. One of the four applicable youth entered the center with medication and reviewed documentation supported the designated health authority (DHA) and psychiatrist were notified at admission. The psychiatrist continued the medications and the medications were verified. Each of the four youth's Medication Administration Records (MAR) was documented on the pre-printed Department's form and included all required information. Initials were found for both the medical staff providing the medication and the youth for each medication administered. Refusals were clearly documented on the MAR and accompanied by a Refusal form. Weekly side effect monitoring was documented for each youth on the MAR by healthcare staff. No lapses were found in medication administration. None of the four applicable youth were administered medication by non-healthcare staff. One additional IHCR was provided of non-healthcare staff providing medication on five different occasions during the annual compliance review period and all documentation was completed as required. Documentation was found each non-healthcare staff who provided youth with medications was trained in assisting youth with administration of medication. The center maintains a list of all non-healthcare staff trained to assist youth with the administration of medication.

Two additional youth IHCRs were provided for youth admitted with psychotropic medications and both included documentation the prescription was continued following notification of the DHA and psychiatrist and the prescription was verified. One of the three youth applicable for psychotropic medications was at the center long enough to require an initial diagnostic interview, which was completed as required. None of the three youth were applicable for thirty-day medication monitoring. The center did not have any youth prescribed psychotropic medication after admission during the annual compliance review period. There were no standing orders or treatment protocols for psychotropic medications. A review of seven instances of restricted housing found each youth received medication, as scheduled. There were no youth required parenteral medication during the annual compliance review period.

A medication pass was observed during the annual compliance review. The registered nurse (RN) who is the clinic manager conducted the medication pass. The RN's sole responsibility was to administer medications to youth. The RN administered all medications from the medication cart which was organized during the medication pass. The direct care staff escorted youth to the medical clinic for medication pass and supervised youth. The RN ensured the Six Rights of Medication Administration for the youth by verifying information prior to administering the medication. After the medication was administered, the youth was provided a cup of water

and then the RN checked the youth mouth to ensure medication was consumed. The RN then initialed the MAR and had the youth initial the MAR as well. There was no pre-poured medication. Two youth required wound care and the RN brought the youth back into the medical clinic exam area individually to provide care. The direct care staff was positioned to provide supervision while ensuring the youth's privacy.

Five youth were interviewed and two reported the nurse provides medication. The other three youth reported they do not take medications. Five staff were interviewed and three youth reported they do not give youth medications. Two staff reported they have been trained to assist youth in the administration of medications.

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

The center has a facility operating procedures (FOPs) addressing medication/sharps inventory and storage process including the disposal of medication. All medication which needs to be disposed of is stored in a labeled and sealed bag and disposed of by the consulting pharmacist who is on-site monthly. The center stores all medication in the locked medication cart which is secured in the medical clinic. Oral, topical, and liquid medications are stored separately. Controlled medications are stored in a locked box inside the medication cart. All sharps and over-the-counter (OTC) medications are securely stored in locked cabinets in the medical clinic.

Inventories were reviewed for the sharps and OTC medications for the annual compliance review period found the center had a weekly and perpetual count of all items. Three sharps and three OTC medications were counted with the clinic manager and each matched the inventory. Three youth prescriptions were counted including one controlled medication. The controlled medication matched the controlled medication inventory which included a perpetual inventory and shift-to-shift counts, as required. The two non-controlled medications were counted and verified which were based on the youth Medication Administration Record (MAR) and when the medication was prescribed; however, there is no requirement for the center to count youth medications. The clinic manager reported, any inventory discrepancies would be reported to the superintendent, regional clinical manager, and Central Communications Center and would be identified through shift-to-shift counts. The clinical manager reported, a discrepancy would be identified for non-controlled medication based on all medical staff knowledge of when medication is ordered which is only ordered for fifteen days at a time; however, there is no formal process in place.

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

The center has a policy and procedures to outline the infection control process which includes an Infection Control Plan and Exposure Control Plan. The plan is written in compliance with the Occupational Safety and Health Administration standards. The facility operating procedures (FOPs) and related plans include all required information in risk assessment, methods of compliance, and procedures for different types of diseases. The plan was reviewed by the superintendent on July 30, 2019.

Universal precautions are followed by staff and protective equipment is available to staff in each first aid kit in the center. Staff are offered the Hepatitis B vaccine upon hire, as documented in staff records. The center did not have any instances of reportable infectious diseases during the annual compliance review; however, the center's FOPs outlines the reporting and documentation criteria in the event of an outbreak.

Five staff pre-service and five staff in-service training records were reviewed and each completed training in exposure control and infection control. Five youth individual healthcare records were reviewed and each received education in exposure and infection control as part of the healthcare orientation upon admission, which was documented on each youth's Health Education log.

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

The center has a policy and procedures and healthcare protocols which outlines the care and education of pregnant youth in the center. A review of five youth individual healthcare records (IHCRs) found none of the youth were applicable for prenatal care and education. There were no instances of a pregnant youth admitted to the center during the annual compliance review period. The center provided for review the education binder and treatment protocols utilized to provide prenatal education in the event a pregnant youth was admitted.

Five staff in-service training records were reviewed and each received female health education which was found to include information on the care of pregnant youth, as required. Five youth were interviewed and none of the youth required gynecological or prenatal services.

# Standard 5: Safety and Security

| 5.01 Active Supervision of Youth (Critical) | Limited 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.*<br><br>*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).*<br><br>*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.*<br><br>*When a youth leaves the group or program area of the center for any reason, all staff assigned to supervise the youth are informed.*<br><br>*Master Control authorizes all movement of youth prior to the actual movement, and no movement occurs until cleared by Master Control.*<br><br>*Staff moves youth from one area of the center to another in accordance with Florida Administrative Code.* | |

The center has a policy and procedures regarding active supervision of youth. The team reviewed supervision of youth activity each of the four days of the review including during school/education, meals, breaks, and line movement. Staff interacted with the youth giving positive options for everyday living challenges. Youth were engaged in the positive conversation led by the staff. Youth were in sight and accompanied by staff during awake hours. Head counts were conducted throughout the day and were logged in the logbooks. Staff positioning was appropriate during all activities including line movement.

Five staff were interviewed regarding if there were enough staff to provide for the safety and security of youth and staff. Three of the five staff indicated they feel they have enough staff to perform their job. Two of the five staff indicated they have a shortage of officers on the weekends.

The team reviewed video footage of one day in which staff were observed leaving the living unit with the youth unsupervised in their rooms for a period of seventeen minutes..

An additional video observation was reviewed on the next day at 12:00 a.m. which revealed most youth were locked in their rooms in the living units while one youth was on precautionary observation (PO) in the common area outside of the living unit. During the video, staff were observed leaving their respective units with the doors propped open to supervise the youth on PO or sight and sound supervision and complete other tasks in the common area; however, they were leaving their units unattended and returning periodically to complete ten-minute checks, instead of monitoring the youth on PO at the doorway to their units to ensure youth in the living units and the youth on PO were properly supervised.

| 5.02 Ten-Minute Checks (Critical) | Limited Compliance |
|---|---|

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

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

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

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

The center has facility operating procedures (FOPs) regarding ten-minute checks. A review was conducted of the center's ten-minute checks including documents of the checks and comparing video recording of the checks for random dates over the past six months. The written ten-minute checks for October 13, 2019 on the first shift revealed a ten-minute check was conducted for all youth in their sleeping rooms at 7:52 a.m. and 7:59a.m. The recorded video viewed during the annual compliance review revealed no staff were present on the living unit at 7:52 a.m. Further on this shift, the ten-minute observation log for two rooms indicated a completed check at 7:59a.m.; however, there were no staff initials to indicate who completed the check.

Maintenance staff indicated the center has fifty-five cameras in the facility in which all are operational. The hardware has capacity for thirty to forty-five days of video storage.

Five staff were interviewed regarding the frequency of youth checks when non-suicidal youth are locked in their room. All five staff indicated room checks are completed every ten minutes and documented on the visual observation log and in the logbook.

| 5.03 Census, Counts, and Tracking | Satisfactory Compliance |
|---|---|

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

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

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

The center has facility operating procedures regarding census, counts, and tracking. A review was conducted of the center's policy for counts, census, and tracking of youths. A review of logbooks indicated shift beginning and shift ending counts were conducted daily. Logbooks also indicated head counts being conducted following emergencies, randomly, and when population change occurs. All admissions and releases were documented in the master control logbook.

Five staff were interviewed regarding when emergency counts are conducted. Four staff indicated emergency count is conducted when a youth is believed to be missing, five indicated after a major disturbance, and two when visibility is hindered. Other responses included after every code and another indicated after blue, white, red, or cut-down suicide code.

| **5.04 Logbook Maintenance** | **Satisfactory Compliance** |
|---|---|
| *The center maintains a chronological record of events, incidents, and activities in logbooks maintained at master control and in each living area in accordance with Florida Administrative Code. Each logbook is a bound book with numbered pages. If electronic logbook software is used by the facility, it is password-protected and configured to prevent entries from being deleted or altered after they are saved.*<br><br>*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.*<br><br>*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 regarding logbook maintenance. Master control and unit logbooks were reviewed for the review period and were bound with numbered pages. All logbooks were in good physical condition. Logbook entries were consistently documented in black ink including the date/time of entry, name, and signature of person making the entry. Errors were consistently marked with a line through and included initials of the person making the correction. Highlighted entries included medical, special needs, mental health alerts, or other issues impacting facility safety and security. Entries included conditions such as emergency situations, incidents including the use of Protective Action Response (PAR), drills, population counts, youth counts following emergency situations, group movement, admissions, and releases, presence of law enforcement, and names of youth placed in confinement or on precautionary/secure observation along with the time initiated and time ended. Logbooks are maintained in the living area and separate logbooks for visitors and contract staff are maintained in master control.

| 5.05 Logbook Reviews | Satisfactory Compliance |
|---|---|
| *The superintendent or designee reviews all logbooks on a weekly basis.*<br><br>*The supervisor(s) reviews the facility logbook maintained at master control when he/she accepts responsibility for the facility.*<br><br>*The juvenile justice detention officer (JJDO) supervisor(s) reviews logbooks maintained in each living area daily.*<br><br>*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 regarding logbook reviews. Three logbooks were reviewed at random for each of the three living modules and three master control logbooks. All logbooks included the superintendent or designee weekly review. Master control logbook included juvenile justice detention officer supervisor (JJDOS) review upon assuming shift and unit logbook reviews on each shift. Unit logbooks included daily reviews of the juvenile justice detention officer (JJDO) assigned to the individual unit. Logbooks also documented a walk-through of the superintendent, assistant superintendent, or staff in charge of the center during each shift.

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

The center has facility operating procedures regarding key control. A review was conducted of the facility key control policy and inventory. All facility keys are checked out through the supervisor on duty. Staff are to provide the supervisor with their personal keys to receive assigned keys for the day. Both staff and the supervisor signs the key log sign-out sheet. Staff personal keys are secured in the supervisor's office and visitors keys are secured in master control. Facility keys for medical, youth records, and youth property locker are secured in master control. These keys are only provided to the appropriate staff. Facility keys are stored on a tamper proof key ring which includes the ring number. The key inventory logbook was reviewed all keys labeled and logged matched the inventory logbook.

An informal interview with three staff indicated the key policy of turning in their personal keys to the supervisor and signing out their assigned facility keys in the key log. Interviewed staff also confirmed the procedure to report missing or broken keys. Staff indicated youth are not allowed to handle facility keys.

Emergency keys are secured in master control in a secure coded lock box. Interviewed staff confirmed only the superintendent, two assistant superintendents, and maintenance staff has the code to the emergency keys lock box. In case of an emergency, staff will have to contact one of the four persons to gain access to the emergency keys. There were no reports of lost, damaged, missing keys, or staff leaving the center with the center keys on their persons in the past six months. Staff were knowledgeable of the protocol to take if such incident occurs. Three staff facility key-rings were reviewed and compared against the key log inventory sheet. All key-rings matched the inventory log.

Five staff were interviewed regarding what does the center considers as restricted keys. Four staff indicated restricted keys are medical records, three indicated mental health records, and two indicated youth property area, case management, and kitchen keys, Follow-up responses included shackles and van keys, emergency exit doors, supervisor's office, administration, and maintenance shed.

Five staff were interviewed regarding the center's process for daily tracking of keys. All five indicated personal keys are securely stored, a daily tracking of keys using the key log, and a key is replaced for damaged keys. Four staff indicated center keys are assigned to staff, youth do not have access to keys, and the facility and youth are searched for missing keys. Three staff indicated the center maintains an inventory of keys. Two staff indicated visitors' keys are given to master control upon entry.

Follow-up comments revealed staff provides to the supervisor their personal keys and in return obtains the key assigned on the hook to which the personal key is placed. If missing keys are noticed, the supervisor is notified and all movement stops, the facility is locked down, all areas are searched, a call is made to the Central Communications Center (CCC), and possibly locks are changed.

| **5.07 Vehicles and Maintenance** | **Limited 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.*<br><br>*Youth and staff are not permitted to use tobacco products.*<br><br>*Center vehicles are locked when not in use.* | |

The center has facility operating procedures (FOPs) regarding vehicles and maintenance. The team reviewed all documentation related to vehicles and maintenance. The center had seven vehicles in which six are utilized for youth transports. One of the six vehicles was in the shop for maintenance. The remaining five vehicles were observed with the appropriate number of working seat belts, a box in each which contained a fire extinguisher, a window punch, a seat belt cutter, and a first aid kit which is approved by the designated health authority (DHA) and reviewed monthly. During random checks of the center's vehicles, each were found locked while not in use.

A youth transport was observed. The youth were taken to a separate room, searched by the staff, and taken to the transport vehicle. Youth were buckled into the seat with assistance from the staff. The two staff transporting the youth also placed seat belts on prior to the vehicle departing. Observation of the vehicle being searched prior to the transport was unable to be conducted and the center was unable to locate documentation of the search. The staff advised the process was completed.

The previous six months of weekly visual vehicle checks were reviewed for all vehicles. The maintenance checklist included water coolant, lights, oil, emergency equipment, brakes, horn, interior/exterior, and cleanliness. The checks were conducted for all vehicles every week, unless they were taken off-site for repairs/maintenance reasons.

The previous six months of monthly visual checks were reviewed for all transport vehicles. The checklist included tires, battery, windshield and wipers, windows, mirrors, and any damage on the vehicle. The inspections were documented on the mandatory form and maintained by the maintenance staff.

A review of eight youth transports in four different vehicles were reviewed regarding inspections being conducted prior to each use of the vehicle. In all eight transports, the center was unable to provide documentation regarding ensuring the vehicle had sufficient gasoline to reach destination, verifying seatbelts were securely anchored, testing of security screen/cage, ensuring the vehicles are locked prior to use, ensuring a cellphone is assigned to the vehicle charged and turned on prior to departure, confirming the vehicle folder contained the vehicle log, and vehicle registration. In six of the transports, the youth search was not documented. In two of the transports, there was no documentation to confirm the vehicle folder contained the mechanical restraint keys, and in three transports the inspection/search of the vehicle regarding contraband was not documented.

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

The center has facility operating procedures (FOPs) regarding tool inventory and management. A review was conducted of the center's kitchen tool policy. Kitchen tools and maintenance shed was inspected for the level of safety and security. All tools were labeled with an identification code. All tools were listed on the inventory and no tools were missing off the inventory log. The kitchen sharps inventory sheet provided for review revealed the inventory matched the kitchen tools stored. Maintenance staff confirmed the policy to follow upon missing tools or sharps. Staff indicated they will report missing tools or sharps to maintenance and the superintendent. They will also log in the Department's Juvenile Justice Information System (JJIS) for a work order. Maintenance staff indicated if a tool is missing, all movement in the facility is stopped and facility is placed on lock down. Youth are secured in the classroom or other designated area until missing items or a work order is completed.

Five staff were interviewed regarding the process for damaged or missing tools. Three staff did not know the process. Two staff indicated they would notify the supervisor and maintenance and document the action in the logbook.

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

The center has facility operating procedures (FOPs) regarding youth access and use of tools and cleaning items. A review of the center's policy was conducted for tools and use of cleaning items. The FOPs indicates youth are not allowed to use or access any tools, including kitchen or medical equipment.

Five youth were interviewed regarding the use of tools. Four of the five youth stated they are only allowed to use mops and dust brooms. One youth indicated they do not use tools.

Five staff were interviewed regarding youth use of tools. All five indicated youth are only allowed to use dust brooms and mops. One staff further indicated youth are allowed to use a cloth for wiping facilities. Informal interviews indicated some youth are allowed to clean on weekends under staff supervision. Both youth and staff indicated youth are not allowed to use tools. During tours of the facility, the team observed staff mopping the living units.

| 5.10 Inventory of all Flammable, Toxic, Caustic, and Poisonous Items | Satisfactory Compliance |
|---|---|
| *The Superintendent is responsible for the implementation of a safety plan addressing proper use, storage, and disposal of chemicals, including flammable, toxic, caustic, and poisonous items.*<br><br>*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.*<br><br>*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.*<br><br>*No hazardous chemicals should be mixed, as this could result in an explosion or emission of toxic gas.* | |

The center has a policy and procedures regarding flammable, toxic, caustic and poisonous items. A review of the facility safety plan revealed all flammable, toxic, caustic, and poisonous items are stored in a secured area not accessible to youth. A review of the facility inventory log included all listed flammable, toxic, caustic, and poisonous item located in the facility. Safety data sheet (SDS) are located on all modules, kitchen, master control, nurse station, maintenance office, and supervisor office or where the items may be stored. Inventories accurately reflected the items found in storage.

| 5.11 Access to all Flammable, Toxic, Caustic, and Poisonous Items | Satisfactory Compliance |
|---|---|
| *Flammable, toxic, caustic, and poisonous fluids and other dangerous substances may only be drawn or acquired by authorized personnel.*<br><br>*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 regarding access to flammable, toxic, caustic, and poisonous items. A review of operating procedures revealed youth are prohibited access to flammable, toxic, caustic, and poisonous items.

Five youth were interviewed regarding cleaning with any type of cleaning agent such as bleach, laundry soap, window, or toilet cleaners. All five youth denied having access to these cleaning agents. Further responses revealed staff spray on the cleaning fluids and youth wipe it down.

Five staff were interviewed and each indicated youth are not allowed to use cleaning agents. Follow-up interviews revealed staff will spray the cleaning solution and the youth wipe it off.

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

The center has a policy and procedures regarding disposal of flammable, toxic, caustic, and poisonous items. There were no reports of chemical spills at the center or disposal of applicable materials in the past six months. Maintenance staff interviews confirmed all poisonous, toxic, caustic, and flammable items are disposed of at the Brevard County Land Field. Interviews further confirmed the center did not dispose of any items in the past six months.

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

The center has a policy and procedures regarding the confinement of youth in the event the youth's behavior threatens the physical safety of self or others. During a tour of the center, the confinement rooms were observed and were found to be free of obstructions and contained no non-fixed items. Youth in confinement were afforded living conditions available to those in the general population; however, no youth in confinement was allowed contact with the general population.

Seven youth confinements which lasted under twenty-four hours were reviewed. Each included documentation the room was searched prior to placement. Each of the seven confinements was reviewed by a supervisor within two hours for fairness and appropriateness, the superintendent documented the need for continued confinement based on the youth's behavior, and the

superintendent reviewed the confinement within forty-eight hours. In each of the seven confinements, all three-hour supervisory checks were completed within the required time frame except one which was forty-eight minutes late.

Four of the youth were applicable for missing school during their confinements and three were provided education materials after notifying the school the youth would be absent due to the confinement. In one confinement report, there was no documentation education was notified or the youth received educational materials. Three of the seven confinements documented the staff's report was completed beyond the one-hour time frame and one was not completed. One of the two involved staff completed the report thirty minutes late for one youth's confinement. In the second youth confinement, two staff completed their reports by ten minutes and one hour and twenty-seven minutes late. The third youth confinement reflected all three involved staff completed reports past the required time frame by one hour, one hour and seventeen minutes, and forty-two minutes. Three of the seven confinement reports were completed within the required one-hour timeframe.

Five staff were interviewed and three reported in the event of a confinement, they must complete the report and conduct ten-minute checks on the youth. Two staff reported they would search the confinement room. In addition, two of the staff specified youth are provided meals, education, clothing, and hygiene while in confinement.

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

The center has a policy and procedures regarding confinements over twenty-four hours. Seven confinement reports were reviewed for compliance. None of the confinement reports exceeded three days. Each of the confinement reports were located in the Department's Juvenile Justice Information System (JJIS). The reports included documentation the rooms were searched prior to placement and was approved by the superintendent or designee.

Two of the seven confinement reports reviewed were approved for confinement beyond twenty-four hours by the regional director. The remaining reports did not have permission to extend

beyond twenty-four hours. The center reported five applicable youth were not supposed to be in confinement, the five youth were authorized for release by the assistant superintendent prior to the twenty-four-hour mark but staff failed to remove the youth from confinement. Six of the seven reports included three-hour reviews by the supervisor. The remaining report, the supervisor did not conduct an interview for six hours on the(overnight shift.

Each of the three-hour reviews included reason for continued confinement. The medical staff conducted their medical review for each confinement report. The mental health staff only conducted their mental health review in one of the seven reports.

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

The center has facility operating procedures regarding Continuity of Operations Planning (COOP) drills. The team reviewed the facility disaster preparedness plan. The plan included all required elements. The center conducted two drills to include one hurricane drill prior to hurricane season. In addition, the team reviewed two chemical spill drills, two code purple (hostage) drills, three code brown (total evacuation) drills, and one statewide code brown drill.

A review of scenarios and critiques were provided in the drills conducted. All drill documentation included the type of drill, date and time of drill, location of drill, scenario, and findings. A review of logbooks verified drills were documented in the logbooks.

Five staff were interviewed regarding the drills in which they participated in the past six months. All five interviewed staff indicated they had participated in escape, fire, medical, and suicide types of drills in the past six months. Other drills staff indicated they participated in included weather, major disturbance, bomb threat, and chemical drills.

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

The center's escape prevention plan is in the policy and procedures and included the Department's policy and procedures regarding escapes. A review of the previous year of escape drills indicated the center conducted quarterly drills. The center conducted a total of twenty-eight drills in the past year in which one was not documented in the logbook.

None of the five reviewed in-service training records included training in escape prevention. Five staff interviews indicated they all participated in an escape drill in the past six months.

| 5.17 Fire Drills | Satisfactory Compliance |
|---|---|
| *Management has implemented a disaster preparedness plan and fire prevention plan.*<br><br>*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 a local fire official. The center had all of the fire extinguishers inspected on September 20, 2018.

The center conducted monthly fire drills on each shift, other than one shift in the past six months. One of the thirty drills conducted in the past six months was not documented in the logbook.

Five youth were interviewed if they knew what to do in case of fire. Four indicated they knew what to do in case of fire. One youth indicated they did not know what to do; however, instructions on what to do in case of fire are included in the orientation handbook provided to each youth upon admission. Five staff were interviewed regarding the drills in which they had participated. Five staff indicated they had participated in fire drills. Each of the five staff indicated fire drills are conducted monthly.