STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

PROGRAM REPORT FOR

Paxen Brevard
Paxen Learning Corporation
(Contract Provider)
285 N. Lake View Blvd.
Cocoa, Florida 32926

Review Date(s): April 9 - 10, 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 that 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 that 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 that 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:

Tamara Mahl-Adkins, Office of Program Accountability, Lead Reviewer (Standard1 and 2)
Pamela Adams, Office of Program Accountability, Regional Monitor (SPEP)
Teresa Andersen, Office of Program Accountability, Regional Deputy Supervisor (Standard 3 and 4)
Patricia Arroyo, Circuit 9 Probation and Community Supervision, Juvenile Probation Officer Supervisor (Standard 2)
Paul Czigan, Office of Program Accountability, Regional Monitor (Standard 3)

Program Name: Paxen Brevard
Provider Name: Paxen Learning Corporation
Location: Brevard County / Circuit 18
Review Date(s): April 9-10, 2019

MQI Program Code: 1264
Contract Number: P2120
Number of Beds: 15
Lead Reviewer Code: 156

Methodology

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 Intervention Services, (3) Mental Health and Substance Abuse Services, and (4) Medical Services, which are included in the Day Treatment Standards.

Persons Interviewed

- ☒ Program Director
- ☐ DJJ Monitor
- ☐ DHA or designee
- ☒ DMHCA or designee
- **1** # Case Managers
- _____ # Clinical Staff
- _____ # Food Service Personnel
- _____ # Healthcare Staff
- _____ # Maintenance Personnel
- **1** # Program Supervisors
- _____ # Direct Care Staff
- _____ # Youth
- **2** # Other (listed by title): **Regional staff**

Documents Reviewed

- ☐ Accreditation Reports
- ☒ Affidavit of Good Moral Character
- ☒ CCC Reports
- ☐ Confinement Reports
- ☐ Continuity of Operation Plan
- ☒ Contract Monitoring Reports
- ☒ Contract Scope of Services
- ☒ Egress Plans
- ☐ Escape Notification/Logs
- ☐ Exposure Control Plan
- ☒ Fire Drill Log
- ☒ Fire Inspection Report
- ☐ Fire Prevention Plan
- ☒ Grievance Process/Records
- ☒ Key Control Log
- ☒ Logbooks
- ☒ Medical and Mental Health Alerts
- ☐ PAR Reports
- ☒ Precautionary Observation Logs
- ☒ Program Schedules
- ☒ Sick Call Logs
- ☐ Supplemental Contracts
- ☒ Table of Organization
- ☐ Telephone Logs
- ☒ Vehicle Inspection Reports
- ☐ Visitation Logs
- ☒ Youth Handbook
- **3** # Health Records
- **3** # MH/SA Records
- **2** # Personnel Records
- **2** # Training Records/CORE
- **3** # Youth Records (Closed)
- **3** # Youth Records (Open)
- _____ # Other: _____

Observations During Review

- ☐ Admissions
- ☐ Confinement
- ☒ Facility and Grounds
- ☒ First Aid Kit(s)
- ☒ Group
- ☒ Meals
- ☐ Medical Clinic
- ☐ Medication Administration
- ☒ Posting of Abuse Hotline
- ☒ Program Activities
- ☐ Recreation
- ☐ Searches
- ☐ Security Video Tapes
- ☐ Sick Call
- ☒ Social Skill Modeling by Staff
- ☒ Staff Interactions with Youth
- ☒ Staff Supervision of Youth
- ☐ Tool Inventory and Storage
- ☐ Toxic Item Inventory and Storage
- ☐ Transition/Exit Conferences
- ☐ Treatment Team Meetings
- ☐ Use of Mechanical Restraints
- ☐ Youth Movement and Counts

Comments

Items not marked were either not applicable or not available for review.

Standard 1: Management Accountability
Day Treatment Rating Profile

Indicator Ratings

Standard 1 - Management Accountability		
1.01	Initial Background Screening*	Satisfactory
1.02	Five-Year Rescreening	Satisfactory
1.03	Protective Action Response (PAR)	Non-Applicable
1.04	Pre-Service/Certification Training	Satisfactory
1.05	In-Service Training	Satisfactory
1.06	Cleanliness and Sanatation	Satisfactory
1.07	Fire Prevention and Evacuation Procedures	Satisfactory
1.08	Water Activities	Non-Applicable
1.09	Food Services	Satisfactory
1.10	Transportation	Satisfactory
1.11	Administration	Satisfactory
1.12	Incident Reporting (CCC)*	Non-Applicable
1.13	Abuse-Free Enviorment*	Satisfactory
1.14	Behavior Management System	Satisfactory
1.15	Youth Record	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: Assessment and Intervention Services
Day Treatment Rating Profile

Indicator Ratings

Standard 2 - Assessment Services		
2.01	Admission and Orientation	Satisfactory
2.02	Medical, Mental Health, and Suicide Risk Alerts in JJIS	Satisfactory
2.03	Positive Achievement Change Tool (PACT) Full Assessment	Satisfactory
2.04	Transitional Planning/Reintegration*	Non-Applicable
2.05	Youth-Empowered Success (YES) Plan Development	Satisfactory
2.06	Youth Requreiment/PACT Goal Elements	Satisfactory
2.07	YES Plan Implementation/Supervision	Satisfactory
2.08	Ninety-Day YES Plan Updates	Satisfactory
2.09	Ninety-Day Supervisory Reviews	Satisfactory
2.10	PACT Reassessment	Satisfactory
2.11	Progress Reports	Satisfactory
2.12	Education Transition Plan	Satisfactory
2.13	Termination Release	Satisfactory
2.14	Career Education	Satisfactory
2.15	Educational Access	Satisfactory

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Standard 3: Mental Health and Substance Abuse Services
Day Treatment Rating Profile

Indicator Ratings

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

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Standard 4: Medical Services
Day Treatment Rating Profile

Indicator Ratings

Standard 4 - Medical, Mental Health, and Substance Abuse Services		
4.01	Medical Screening*	Satisfactory
4.02	Medication Management - Verification of Medications	Satisfactory
4.03	Medication Management - Delivery of Medications	Satisfactory
4.04	Medication Management - Medication Storage	Satisfactory
4.05	Episodic/Emergency Services	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).

Program Overview

Paxen Brevard is a day treatment program operated by Paxen Learning Corporation through a contract with the Department in Cocoa, Florida. The program provides day treatment services to probation, minimum-risk commitment, and conditional release youth. The program is contracted to serve fifteen male and female youth, ages fourteen to nineteen. The program fosters each youth by providing the Thinking for a Change curriculum. Program staff is comprised of a program coordinator, one case manager, and one community supervision specialist. Mental health and healthcare services are provided through one clinical coordinator, who is a licensed mental health clinician. The program provides mental health and substance abuse treatment utilizing Thinking for a Change, Truth About Drugs, and Victim Impact, in addition to individual sessions. The program's services are designated to address criminogenic risk factors, according to the youth's needs and risks. The program provides facility-based delinquency programming and treatment to include case management services, strategic interventions, restorative justice, gender-specific services, substance abuse testing, and food services. The program provides medical services for the youth in the program by screening the youth for medical concerns and assisting the youth with medications if the youth take prescription medications during the time they are at the program. At the time of the annual compliance review, the program had one vacancy, the community supervision specialist.

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. A contract provider may hire an employee to a position that 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 that he or she exhibits no behaviors that warrant the denial or termination of employment. An Annual Affidavit of Compliance with Level 2 Screening Standards is completed annually.	

The program has a policy and procedures regarding initial background screenings for staff, volunteers, mentors, and interns. One of the two staff employed at the program was applicable for an initial background screening. The staff had a completed background screening documented in the Agency for Healthcare Administration Clearinghouse prior to the date of hire and did not require an exemption. The program utilizes the Diana screening as their pre-employment assessment tool. The staff received the screening and had a passing score prior to hire. The staff was not listed on the program's Clearinghouse employee roster; however, the staff was added at the time of the annual compliance review.

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 program has a policy and procedures regarding five-year background rescreenings for staff, volunteers, mentors, and interns. The policy indicated the human resources compliance specialist conducts a five-year rescreening of all existing staff members, volunteers, and interns every five years after the initial screening date in accordance with the Department's policy. The program did not have any staff applicable for a five-year rescreening during the annual compliance review period.

1.03 Protective Action Response (PAR)	Non-Applicable
The program 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 program has not had any Protective Action Response (PAR) incidents since the last annual compliance review; therefore, this indicator rates as non-applicable.

1.04 Pre-Service/Certification Training	Satisfactory Compliance
Contracted non-residential staff are trained in accordance with Florida Administrative Code. Contracted non-residential staff satisfies pre-service/certification requirements specified by Florida Administrative Code within 180 days of hiring. *Contracted non-residential staff who have not completed essential skills training, as defined by Florida Administrative Code, do not have any direct contact with youth.* *Contracted non-residential staff who have not completed pre-service/certification training do not have direct, unsupervised contact with youth.*	

One of the two staff employed at the program was applicable for pre-service training. The staff had not been with the program for the full 180 days at the time of the annual compliance review; however, had already completed more than the required 120 hours of training. A total of 137 hours of training had been completed, which included Protective Action Response (PAR), cardiopulmonary resuscitation (CPR), first aid, professionalism and ethics, suicide prevention and emergency procedures training, as well as all other mandatory training. All training was documented in the Department's Learning Management System (SkillPro). There was documentation indicating the instructors for PAR, first aid, and CPR were certified trainers. The program submitted, in writing, a list of pre-service training to the Department's Office of Staff Development and Training including course names, descriptions, objectives, and training hours for any instructor-led training based on the required topics on February 21, 2018 for the annual compliance review period.

1.05 In-Service Training	Satisfactory Compliance
Contracted non-residential staff completes in-service training in accordance with Florida Administrative Code. Contracted non-residential staff must complete twenty-four hours of annual in-service training, beginning the calendar year after the staff has completed pre-service training. *Supervisory staff shall complete eight hours of training in the areas listed below, as part of the twenty-four hours of annual in-service training.*	

One of the two staff employed at the program was applicable for in-service training. The staff had a total of fifty-nine and a half hours of in-service training, which included Protective Action Response (PAR) update, cardiopulmonary resuscitation (CPR), First aid, professionalism and ethics, and suicide prevention, as well as all other required training. The one staff was a supervisor and also completed eight hours of training under the topics of management, leadership, personal accountability, employee relations, and fiscal. All in-service training was documented in the Department's Learning Management System (SkillPro). The program submitted, in writing, a list of in-service training to the Department's Office of Staff Development and Training including course names, descriptions, objectives, and training hours for any instructor-led trainings based on the required topics on February 21, 2018 for the annual compliance review period. The program has an annual in-service training calendar, which can be updated as changes occur.

1.06 Cleanliness and Sanitation	Satisfactory Compliance
The program provides a safe and appropriate treatment environment including maintenance and sanitation of the facility.	

During the program tour, as well as observations made during the two days the annual compliance review team was on-site, all indoor areas were found to be clean, neat, and well-maintained; the program has no grounds to landscape. All of the furnishings were in good repair, there was no graffiti on the walls, doors, or windows, nor any insect infestation. The bathrooms were observed to be clean, functional, free of mold and mildew, with one bathroom for males and one for females. The bathrooms had operable toilets, a wash basin with cold and warm water, antibacterial soap, and paper towels. On the first day of the annual compliance review, it was noted the bathroom for the males had part of the threshold sticking up, causing a trip hazard. The program was informed of the issue and immediately fixed the problem. The program has four offices where individual counseling sessions can be held and an open area where group meetings are conducted and food/snacks are served. Six months of weekly sanitation and safety inspections of all internal and external areas and equipment were reviewed; each inspection was conducted as required. The program had a maintenance and housekeeping plan; all tasks were completed on a weekly basis by the youth while supervised by staff.

1.07 Fire Prevention and Evacuation Procedures	Satisfactory Compliance
The program provides a safe and appropriate treatment environment including fire prevention and evacuation procedures.	

The program has two fire extinguishers, strategically located, with one by the front door and another in the kitchen; both received an official annual inspection in September 2018. The program has two vehicles, both had fire extinguishers which did not have an inspection completed; however, this is not required. The program conducts weekly fire protection equipment checks, which is included on the weekly sanitation and safety inspection form. A review of the safety inspection forms found the checks for the last four quarters were completed. A review of fire drills indicated the program conducted one drill a month for the last six months, as required; the program does not have shifts. The program maintained a fire safety log which is kept in the facility and contained a record of annual fire safety inspections and the fire drills. The last fire safety inspection was conducted on November 6, 2018. The program passed the inspection with no violations found. The evacuation egress plan is located throughout the facility, which identifies the specific routes of evacuation. The program does not provide any designated smoking areas, other than stating smoking is not allowed on program grounds. Both staff completed the fire safety training. Two youth interviews were conducted, as no additional youth were on-site during the annual compliance review, and each youth indicated they were instructed on what to do during a fire.

1.08 Water Activities	Non-applicable
The program provides a safe and appropriate treatment environment including procedures for water activities.	

The program has a policy and procedure stating they do not offer or authorize youth participation in water activities, therefore, this indicator is rated not applicable.

1.09 Food Services	Satisfactory Compliance
The program provides a safe and appropriate treatment environment including food service.	

The program has a policy and procedures regarding food service, including prohibiting the practice of withholding food as a disciplinary measure. The program utilizes the tables and chairs in the main area, where group sessions are held, as a dining area. The area was found to be clean and orderly. Two of the five youth currently on the program census had medical alerts posted on the refrigerator and were given alternative items as part of their meal, due to their allergies; these alerts are not accessible to youth. Three staff interviews, the two program staff and the clinical coordinator, were conducted and each staff indicated youth and staff receive the same menu. Two youth interviews were conducted, and each youth confirmed youth and staff receive the same menu, which is from local restaurants.

1.10 Transportation	Satisfactory Compliance
The program provides a safe and appropriate treatment environment including transportation.	

The program provides daily transportation for youth to and from the program, utilizing the program's two vehicles. The program requires youth and staff to wear their seatbelts at all times. The program does not have an outside contract to provide transportation. All program staff transporting youth have a current, valid Florida driver's license. The administrative assistant for the region conducts the driver's license checks monthly. Both of the vehicles were in safe and sound condition, had current insurance and registration, and were kept locked when not in use. The case manager conducts inspections of the vehicles, both daily and monthly. Two youth and three staff interviews were conducted and each indicated youth are required to wear their seatbelts when being transported.

1.11 Administration	Limited Compliance
The program provides a safe and appropriate treatment environment including administrative and operational oversight.	

The program's contract specifies monthly reports are to be sent to the Department, which includes invoicing documents, youth census, staff vacancy, Certified Minority Business Enterprise (CMBE) utilization, and program fidelity, as well as quarterly expenditures. A review of the last six months of reports indicated all of the reports were completed and submitted, as required. The youth listed on the program roster matched the census report in the Department's Juvenile Justice Information System (JJIS). The program maintained a logbook, which documented significant program activities, events, and incidents (weather and suicide risk), and safety and security issues were highlighted. The logbook entries documented the date and time of incident, name of youth and program staff involved, brief statement of pertinent information, name of staff making the entry with the date, time of entry, and signature. The program director reviewed logbooks on a bi-weekly basis consistently, except for eight weeks between October 9, 2018 and January 8, 2019. The program director logbook reviews documented what action was taken in response to events and statistical information.

1.12 Incident Reporting (CCC) (Critical)	Non-Applicable
The program provides a safe and appropriate treatment environment including transportation. Whenever a reportable incident occurs, the program notifies the Department's Central Communications Center (CCC) within two hours of the incident, or within two hours of becoming aware of the incident.	

There have not been any incidents reported to the Central Communications Center during the annual compliance review period; therefore, this indicator rates as "non-applicable."

1.13 Abuse-Free Environment (Critical)	Satisfactory Compliance
Any knowledge or suspicion of abuse, abandonment or neglect is reported to the Florida Abuse Hotline.	

The program has a policy/code of conduct which details all staff are expected to act in the program's best interest, upholding the highest ethical standards. The program did not have any Central Communications Center (CCC) reports, Florida Abuse Hotline reports, or internal incidents wherein allegations were made against staff during the annual compliance review period. A review of youth records did not indicate any instances of unreported abuse. The two reviewed staff records indicated both staff signed the code of conduct at the time of hire. The youth are informed of the Florida Abuse Hotline and CCC phone numbers during the orientation process. Three staff interviews, two program staff and the clinical coordinator, were conducted and each described the youth's access to the Florida Abuse Hotline. One of three staff indicated the youth have access to the numbers and can immediately call; the number is called right away by staff, and the abuse allegation is reported The second staff stated youth are given the opportunity to call without delay and the third staff said if youth say they need to call, then staff will have to offer them an available phone. Two youth were interviewed, and each indicated they have never witnessed any staff cursing or threatening youth, and they could call the Florida Abuse Hotline if they choose to do so, but have not had to.

1.14 Behavior Management System	Satisfactory Compliance
The program utilizes a behavior management system providing privileges and consequences to encourage youth to fulfill programmatic and education expectations. Consequences are fair and directly correlate with the behavior problem. The use of facility restriction does not exceed seven consecutive days. Disciplinary procedures are carried out promptly. Youth are not allowed to have control over or discipline other youth. Time-out is used in accordance with Florida Administrative Code. All behavior problems, time-outs, in-facility suspensions, and privilege suspensions are documented in the facility log and case file in accordance with Florida Administrative Code.	

The program has a behavior management system which includes providing privileges and consequences to encourage youth to fulfill programmatic expectations. Consequences are fair and directly correlate with the behavior problem. According to the program's facility operating procedures, the program does not use facility restrictions for more than seven consecutive days and disciplinary procedures are carried out promptly. Youth are not allowed to have control over or discipline other youth and the program does not utilize time-out. The program staff will explain to the youth the reason for the restriction prior to privilege suspension and give the youth an opportunity to explain the behavior leading to the suspension. The program has a document containing a mission statement including the Department's mission to reduce juvenile

crime, a description of the program's design, and educational goals and objectives. A daily activity schedule, which includes structured activities, and the program rules are posted throughout the facility. Two youth were interviewed, and each indicated they have never been placed in time out nor have they punished another youth.

1.15 Youth Records (Healthcare and Management)	Satisfactory Compliance
The program maintains an official case record, labeled "Confidential," for each youth, which consists of two separate files: ▪ *An individual healthcare record* ▪ *An individual management record.*	

The program has a separate youth records for each youth, which includes the individual healthcare and individual management records. A review of youth records found the individual management records contained the youth's name, Department identification (DJJID) number, date of birth, county of residence, and committing offense, and were labeled "confidential." The records were kept in a locked file cabinet in the case manager's office, also marked "confidential."

Standard 2: Assessment and Intervention Services

2.01 Admission and Orientation	Satisfactory Compliance
Facility orientation shall be conducted within twenty-four hours of a youth's admission to the facility. Case notes should document the date and time of the orientation and the youth received orientation documents.	

Three youth records were reviewed and each had documentation indicating the youth's orientation was completed within twenty-four hours of admission, which included the program's expectations and rules, behavior management system, daily activity schedule, emergency medical and mental health services, emergency safety and evacuation procedures, contraband items and consequences, a review of the performance planning process, average anticipated length of stay to successfully complete the program, and the program's dress code. The youth case notes documented the date and time of orientation, the youth receiving orientation documents, orientation to the handbook, and an introduction to the program staff and facility tour.

2.02 Medical Alerts, Mental Health Alerts, and Suicide Risk Alerts in JJIS	Satisfactory Compliance
The program shall alert staff of medical, mental health, and suicide risk issues that may affect the security and safety of the youth in the program.	

The program has a policy and procedures in place which requires documenting and sharing youth alerts and other pertinent information with program staff. Three youth records were reviewed, and each indicated the youth was placed on the internal alert system upon staff learning of a medical condition. In two records, the youth was placed on the program's alert system due to chronic medical conditions. In the remaining youth record, the youth had a suicide risk alert entered in the internal alert system, as well as the Department's Juvenile Justice Information System (JJIS) when the youth was identified during screening as a potential suicide risk. The alert was later closed after an Assessment of Suicide Risk (ASR) was completed and the youth was stepped down to standard supervision. In two records, the youth had a mental health alert entered into JJIS and the internal alert system. The program also has a daily process of informing the staff of environmental stressors by entering the information into the logbook based on weather advisory center information, including the high heat index. If needed based on the weather, any scheduled outside activity will be canceled, and replaced with an alternate indoor activity. During daily staff meetings, youth alerts and other program issues are shared with the staff and discussed. Three staff interviews, two program staff and the designated mental health clinical authority (DMHCA), were conducted and staff were asked to discuss how alerts are shared with them. One staff indicated once the youth referral is received, staff will go into JJIS and print out any alerts, review the youth's face sheet, and if there are any additional alerts to be added once the intake is completed, they will be added to JJIS and the internal alert system. The second staff said there is a medical binder with alerts, the youth's face sheet, and a separate binder for each youth in the case management office in a secure locker which also identifies alerts. The third staff said alerts are shared two ways, through review of JJIS and maintained in a binder kept by the program coordinator.

2.03 Positive Achievement Change Tool (PACT) Full Assessment	Satisfactory Compliance
The PACT Full Assessment is completed by program staff for all youth, regardless of risk to reoffend, within seven calendar days of admission.	

Three youth records were reviewed and each indicated the Positive Achievement Change Tool (PACT) Full Assessment was completed by program staff within the first seven calendar days of admission.

2.04 Transition Planning/Reintegration (Critical)	Non-Applicable
Program staff actively participates in the transitional planning process for youth who are being released from a residential program on conditional release (CR) or post-commitment probation (PCP). For conditional release and post-commitment probation youth, the YES Plan must address recommendations from the residential program during transition.	

Youth enrolled in the program on post-commitment program or conditional released are not referred prior to their release from a commitment program; therefore, this indicator rates as non-applicable.

2.05 Youth-Empowered Success (YES) Plan Development	Satisfactory Compliance
The YES Plan (Form DJJ/PACTFRM 4) is cooperatively developed for youth on Probation, Conditional Release, and Post-Commitment Probation. Youth and parent/guardian signatures do not indicate cooperative development of the YES Plan.	

Three youth records were reviewed and each indicated the Positive Achievement Change Tool (PACT) Full Assessment was completed prior to the development of the initial Youth Empowered Success (YES) plan. The initial YES plan was developed within fourteen days of the youth's admission to the program and signed by all parties including the youth, parent/guardian, program staff, and program director. The case notes documented involvement in the development of the YES Plan with the case manager/juvenile probation officer, youth, and parent/guardian. The program also documented informing the parent/guardian and youth of the importance of complying with the sanctions and goals of the plan. The case notes indicated the youth and parent/guardian were provided a copy of the initial YES plan upon their review and signature. Two youth interviews were conducted, as no additional youth were on-site during the annual compliance review, and both indicated they participated in the development of the YES plan and also received a copy of it.

2.06 Youth Requirement/PACT Goal Elements	Satisfactory Compliance
The YES Plan provides appropriate and individualized target dates for the completion of each youth requirement and PACT goal. All youth requirement and PACT goal action steps include the intervention plan elements (i.e., who, what, and how often).	

In each of the three youth records reviewed, the court-ordered sanctions were documented in the Department's Juvenile Justice Information System (JJIS) youth requirements module and contained at least one specific action step for the youth, parent/guardian, and case manager, clearly defining who is responsible, what action should be taken, and how often the action should be taken. At least one of the top three criminogenic needs were created as a Change Goal in JJIS and at least one specific action step for the youth, parent/guardian, and case

manager, clearly defining who is responsible, what action should be taken, and how often the action should be taken. All youth requirements were included on the Youth Empowered Success (YES) Plan and contained reasonable projected completion dates. Two youth interviews were conducted and indicated the youth knew some of their goals to work towards while at the program.

2.07 YES Plan Implementation/Supervision	Satisfactory Compliance
Youth on supervision (i.e., probation, conditional release, or post-commitment probation) are supervised in a manner ensuring compliance with the court order and completion of YES Plan (youth requirements and PACT goals). Case notes demonstrate compliance (or attempted compliance) with youth, parent/guardian, and staff action steps contained in the YES Plan.	

In each of the three youth records reviewed, the case notes demonstrated compliance with youth, parent/guardian, and staff action steps contained in the Youth Empowered Success (YES) Plan, as well as documenting verbal reports from collateral sources. The case notes included all activities, such as face-to-face interactions and telephone contacts with youth and parent/guardian to provide appropriate supervision, maintaining regular quality contacts with both the youth and parent/guardian.

2.08 Ninety-Day YES Plan Updates	Satisfactory Compliance
Staff adjust the YES Plan to reflect any new needs and progress made during the course of supervision. Staff must make necessary updates to youth requirements and PACT goals and save a new YES Plan in the Juvenile Justice Information System (JJIS) prior to ninety-day supervisory reviews. When updates are made to the YES Plan reasonably requiring the input of the youth and parent/guardian, this discussion is clearly documented in the case notes. Use of the "case notations" or a similar form the youth and/or parent/guardian initials to indicate the YES Plan was reviewed does not signify compliance. The case notes clearly document any communication regarding the YES Plan.	

One of three open youth records reviewed were applicable for a ninety-day Youth Empowered Success (YES) Plan update. The program had no further applicable open records; therefore, two closed records were reviewed. In all three applicable records, the staff made necessary updates to youth requirements and Change Goals in the Department's Juvenile Justice Information System (JJIS) and when reasonable input from youth and parent/guardian was required, the discussion was documented. A new YES Plan was completed in JJIS prior to the supervisory review.

2.09 Ninety-Day Supervisory Reviews	Satisfactory Compliance
Cases under supervision (i.e., probation, conditional release, post-commitment probation) are reviewed by the supervisor at least once every ninety calendar days. The supervisor ensures staff review any instructions given during the review, and ensures they were followed during the subsequent review.	

None of the open youth records reviewed were applicable for ninety-day supervisory reviews, as the reviews were not due at the time of the annual compliance review; therefore, three closed records were reviewed. In three closed records, the youth was on probation and the supervisor reviewed the case at least once every ninety days. The supervisor ensured the case manager updated the youth requirements and Change Goals in the Department's Juvenile Justice

Information System (JJIS) prior to the review and the youth was receiving appropriate supervision and interventions. The staff documented review of the supervisory note and where necessary, took action.

2.10 PACT Reassessment	Satisfactory Compliance
Staff complete PACT Reassessments for youth on probation, conditional release, and post-commitment probation, as well as minimum-risk non-residential commitment youth. Regardless of risk to reoffend, the PACT Full Assessment is completed every ninety days.	

None of the three open youth records reviewed were applicable for the Positive Achievement Change Toll (PACT) Reassessment being completed every 180 days. The program had no further applicable open records; therefore, three closed records were reviewed. In all four records, the PACT Reassessments were completed every 180 days or less. In one of the closed records, the Final PACT assessment was completed prior to program completion to document the youth's progress in meeting the criminogenic needs, as well as sanctions. In one other record, the Final PACT was documented as "unable to complete" in the Department's Juvenile Justice Information System (JJIS). The remaining record was missing the Exit PACT and the program staff indicated this was an oversight.

2.11 Progress Reports	Satisfactory Compliance
Progress reports are completed detailing the youth's progress with the youth requirements and PACT goals outlined in the YES Plan.	

In each of the three youth records reviewed, a progress report was completed every month. A cover letter was included in each report, which provided a brief description of the youth's overall performance and extraordinary information about the youth. All youth were given the opportunity to review the report and provide comments. The report was signed and dated by the youth, and staff who prepared the report, as well as reviewed and signed by the program director. In two of the three records, the youth was on probation and the progress report was sent to the youth's juvenile probation officer (JPO). In the third report, it was unable to be determined if the progress report was sent to the youth's JPO.

2.12 Education Transition Plan	Satisfactory Compliance
Staff and youth complete an Education Transition Plan prior to release including provisions for continuation of education and/or employment.	

The program does not provide education services to youth; therefore, this indicator rates as non-applicable.

2.13 Termination/Release	Satisfactory Compliance
The program shall recommend termination to the Department for youth on probation, conditional release, or post-commitment probation, as well as minimum-risk commitment youth, upon successful completion of court-ordered sanctions and substantial compliance with restitution and/or court fees. *For youth on probation, conditional release, or post-commitment probation, the program works with the JPO/CM to facilitate the release of the youth upon completion of the program.* *For youth on minimum-risk commitment or conditional release, staff completes the Pre-Release Notification and Acknowledgement (PRN) (DJJ/BCS Form 19) and follows the required procedure.*	

Three closed youth records were reviewed for termination/release. In one record, the program recommended termination due to completion of court-ordered sanctions and a check of active warrants was conducted by the juvenile probation officer (JPO) prior to release. In the other two records, a termination could not be requested as the youth were moved out of the county, and the program indicated no other youth had been successfully discharged since the last annual compliance review. None of the three closed records had a loss of jurisdiction. The program stated if a youth has a loss of jurisdiction, the assigned JPO will complete all of the notifications and paperwork and the youth will be removed from the program census at the time of jurisdiction loss.

2.14 Career Education	Satisfactory Compliance
Staff shall develop and implement a career education competency development program.	

The program provides career education as a Type 2 program, including teaching personal accountability skills and behaviors appropriate for youth in all age groups and ability levels to form work habits helping to maintain employment and living standards, as well orientation to a broad scope of career choices, based upon personal abilities, aptitudes and interests, and exploring and gaining knowledge of occupation options and the level of effort required to achieve them. The program's policy includes career education, such as communication, interpersonal and decision-making skills. The program exposes the youth to different experiences, such as taking youth to a historical building and nature trail, to observe a small engine plane, pet store, military museum, career source, and provide youth with a menu and let them search for the items at the grocery store. Three youth records were reviewed and in all three records, the youth had a completed sample employment application and a resume summarizing education, work experience, and career training, where applicable.

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

The program does not provide educational services; therefore, this indicator rates as non-applicable.

Standard 3: Mental Health and Substance Abuse Services

3.01 Designated Mental Health Clinician Authority or Clinical Coordinator	Satisfactory Compliance
Each program director is responsible for the administrative oversight and management of mental health and substance abuse services in the program. Programs with an operating capacity of 100 or more youth, or those providing specialized treatment services, must have a single licensed mental health professional designated as the Designated Mental Health Clinician Authority (DMHCA) who is responsible for coordinating and verifying implementation of necessary and appropriate mental health and substance abuse services in the program. Programs with an operating capacity of fewer than 100 youth or those not providing specialized treatment services, may have either a DMHCA or a Clinical Coordinator.	

The program employs a clinical coordinator, who is on-site weekly from 10:00 a.m. to 6:30 p.m. A review of weekly sign-in sheets validated the clinical coordinator was on-site, as required, for the last six months, with the exception of one week, when he was on vacation. During this one week, a pro re nata (PRN) mental health professional, who is a licensed mental health counselor (LMHC), from another program site was brought in; the PRN staff had a clear and active license expiring March 31, 2021. The clinical coordinator holds a clear and active license as a LMHC, expiring March 31, 2021. An interview with the clinical coordinator validated when he was on-site and what his primary role is. The clinical coordinator works in conjunction with the case manager to complete all mental health and substance abuse requirements. The clinical coordinator completes the Assessment of Suicide Risk (ASR) screening tool if youth entering the program have any suicide risk alerts. If the youth have any mental health diagnosis, he will complete the youth's initial treatment plan. The clinical coordinator is also responsible for completing individual and group therapy at the program; in addition, the case manager and program director facilitate group sessions. The clinical coordinator participates in each youth's treatment planning. Once the youth completes the program, the clinical coordinator finalizes the discharge information and makes any necessary referrals. He also facilitates the substance abuse group therapy, Truth About Drugs.

3.02 Licensed Mental Health and Substance Abuse Clinical Staff (Critical)	Satisfactory Compliance
The program director 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 program has one clinical staff member employed, the clinical coordinator, who provides all mental health and substance abuse services to the youth when they are on-site. The clinical coordinator is a licensed mental health counselor (LMHC), who has a clear and active license, expiring March 31, 2021. There was one week during the annual compliance review period when the LMHC was not on-site, and the pro re nata (PRN) mental health professional provided the mental health and substance abuse services. The PRN is a LMHC and holds a clear and active license, expiring March 31, 2021.

3.03 Non-Licensed Mental Health and Substance Abuse Clinical Staff	Satisfactory Compliance
The program director 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 program does not utilize any non-licensed clinical staff. The program's policy and procedures indicate the program only utilizes licensed mental health clinicians for all mental health and/or substance abuse treatment services.

3.04 Mental Health and Substance Abuse Admission Screening (Critical)	Satisfactory Compliance
The mental health and substance needs of youth are identified through a comprehensive screening process ensuring referrals are made when youth have identified mental health and/or substance abuse needs or are identified as a possible suicide risk.	

The program has policy and procedures regarding mental health and substance abuse screenings. A review of three records revealed each youth received a Massachusetts Youth Screening Instrument, Second Version (MAYSI-2) completed by a trained staff upon admission. Each MAYSI-2 was completed in the Department's Juvenile Justice Information System (JJIS) on the day of admission. The case notes indicated the screener reviewed all available information on the youth upon admission. In all three records, the youth received a referral for further assessment, two of which included an Assessment for Suicide Risk (ASR). In one of the two records, the MAYSI-2 had no indications of suicide risk, but the youth had recent suicide alerts in JJIS which indicated an ASR was warranted. The third youth had no hits on the MAYSI-2 for suicide ideation but had hits for trauma and required a mental health assessment. Both youth referred for an ASR were placed on precautionary observation (PO) and the program director was notified. Staff interviews indicated the program consistently refers youth for an ASR if the youth has hits on depression/anxiety. The program provided a distributed email to all program coordinators and clinical staff indicating the program process was to refer for an ASR if the youth has hits for depression/anxiety on the MAYSI-2.

3.05 Mental Health and Substance Abuse Assessment/Evaluation	Satisfactory Compliance
Youth identified by screening, staff observation, or behavior after admission and in need of further evaluation must be referred for a Comprehensive Mental Health Evaluation or Comprehensive Substance Abuse Evaluation or Updated Evaluation.	

The program has a policy and procedures regarding mental health and substance abuse assessments. A review of three youth records revealed each youth received a mental health and/or substance abuse evaluation completed by a licensed professional within thirty days of admission. The program utilizes the Substance Abuse Mental Health assessment sections two and three (SAMH 2-3) instrument modified to include elements to fulfill the requirement of the mental health and substance abuse evaluation. Each evaluation included most requirements; identifying information, relevant background information, behavioral observations, mental status exam, interview procedures, discussion of findings, and diagnostic impressions and recommendations. The applicable substance abuse evaluations also included patterns of alcohol and other drug abuse, impact of alcohol and other drug use on major life areas, and risk for continued alcohol and other drug use. Two of the three youth were applicable for a

substance abuse evaluation and which was completed. The reasons for performing the mental health and substance abuse assessment/evaluation for each of the three youth was listed as SAMH 2-3. None of the three mental health and substance abuse evaluations listed the reasons for the evaluation as the hits the youth had on the MAYSI-2 or the reasons listed on the associated referral by the screener. The program is in the process of modifying the procedures to include the referral reasons on the assessment.

3.06 Mental Health and Substance Abuse Treatment	Satisfactory Compliance
Mental health and substance abuse treatment planning in departmental facilities/programs focuses on providing mental health and/or substance abuse interventions and treatment to reduce or alleviate the youth's symptoms of mental disorder and/or substance abuse impairment and enable youth to function adequately in the juvenile justice setting. *The treatment team is responsible for assessing the youth's rehabilitative treatment needs and assisting in developing, reviewing, and updating the youth's individualized and initial mental health/substance abuse treatment plans.*	

The program has policy and procedures regarding mental health and substance abuse treatment. A review of three records revealed each youth received mental health and substance abuse treatment, including a team approach comprised of a representative of administration, case management, direct care staff, and parent/guardian. Two of the three youth were applicable for substance abuse treatment; each of the two records included consent for treatment and consent for disclosure of treatment information. The consents were completed on the recommended forms. Clinical staff documented treatment groups including sign-in sheets indicating the staff-to-youth ratio was consistently within required elements. Treatment was consistently provided by a licensed mental health professional.

3.07 Treatment and Discharge Planning	Satisfactory Compliance
Youth determined to have a serious mental disorder and/or substance abuse impairment, and are receiving mental health and/or substance abuse treatment in a program, must have an initial or individualized mental health or substance abuse treatment plan. When mental health or substance abuse treatment is initiated, an initial or individualized mental health/substance abuse treatment plan is completed. When both mental health and substance abuse treatment is initiated, an integrated mental health and substance abuse treatment plan is completed. *All youth who receive mental health and/or substance abuse treatment while in a day treatment program will 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 facility.*	

The program has policy and procedures regarding mental health and substance abuse treatment and discharge planning. One of the three youth received an initial treatment plan on the day of admission signed by all required parties including the licensed mental health provider. All three youth records contained an individualized mental health and substance abuse treatment plan completed following the evaluation. All three individualized treatment plans were signed and dated by the required parties including the licensed mental health professional. Two of the three records each required one mental health and substance abuse treatment plan review. One of the three records required two mental health and substance abuse treatment plan reviews. All four treatment plan reviews were completed within the time frame, documented on the required form, and signed by all required parties. A review of three closed youth records revealed two youth records contained a mental health and substance abuse treatment

discharge summary. One of the two had documentation an exit staffing was conducted. Case notes indicated the parent/guardian, youth, clinical coordinator and juvenile probation officer (JPO) were invited to an exit meeting to review progress, court ordered sanctions and probation terms. The case notes indicated an exit meeting was conducted on the date planned and indicated the clinical coordinator discussed the results of the mental health and substance abuse treatment discharge summary with the youth, parent/guardian, and JPO including recommendation for treatment following release. A copy of the discharge summary was provided to the youth, parent/guardian, and JPO. The second youth record indicated the parent/guardian, JPO, and clinical coordinator were invited to the exit staffing. The youth record contained a completed mental health and substance abuse treatment discharge summary. The youth was removed from his home and placed in a foster care location outside the program catchment area necessitating an unplanned discharge. Case notes indicated a copy of the discharge summary was emailed to the youth and parent/guardian subsequent to discharge. The third reviewed record revealed no mental health and substance abuse treatment discharge summary. Staff interviews indicated the youth presented no mental health issues requiring mental health and substance abuse treatment.

3.08 Mental Health Crisis Intervention Services (Critical)	**Satisfactory Compliance**
Every program 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 which would require mental health crisis interventions 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 program has a mental health crisis intervention services plan. The plan included all of the required elements; notification and alert system, referral and assessment, communication, supervision, documentation, and review. This plan was signed and reviewed on August 1, 2018 by the program's director of day treatment.

3.09 Crisis Assessments (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, or non-licensed mental health professional working under the direct supervision of a licensed mental health professional, 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 program director 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 instead of a Crisis Assessment and the procedures for a suicide risk alert must be followed.	

The program has a policy and procedures regarding crisis assessments. A review of three youth records revealed no crisis assessments had been completed. There was no documentation in the records indicating the need for a crisis assessment. Staff interviews revealed the program had no crisis assessments completed on any youth since the last annual compliance review; however, the program has procedures to provide crisis assessment when indicated and

includes a crisis assessment form and an assigned licensed mental health professional capable of providing the service. The crisis assessment form in place is the Department's Crisis Assessment (MHSA 023).

3.10 Emergency Mental Health and Substance Abuse Services (Critical)	Satisfactory Compliance
Youth determined to be an imminent danger to themselves or others due to mental health or substance abuse emergencies occurring in facility require emergency care provided in accordance with Rule 63N-1, F.A.C., and the facility's emergency care plan.	

The program has an emergency mental health and substance abuse service plan. The plan included all of the required elements; procedures for immediate staff response, notifications, communication, supervision of youth, authorization of transport for emergency services, transportation of emergency mental health and/or substance abuse evaluation and treatment, documentation, training including mock drills, and a review process. This plan was signed and reviewed on August 1, 2018 by the provider's director of day treatment.

3.11 Baker and Marchman Acts (Critical)	Non-Applicable
Individuals who are believed to be an imminent danger to themselves or others because of mental illness or substance abuse impairment require emergency mental health or substance abuse services.	

The program did not have any Baker or Marchman Acts since the last annual compliance review; therefore, this indicator rates as non-applicable.

3.12 Suicide Prevention Services (Critical)	Satisfactory Compliance
Suicide Precautions are the methods utilized for supervising, observing, monitoring, and housing youth identified through screenings, available information, or staff observations as having suicide risk factors. *Any youth exhibiting suicide risk behaviors must be placed on Suicide Precautions (Precautionary Observation), and a minimum of constant supervision.* *All youth identified as having suicide risk factors by screening, information obtained regarding the youth, or staff observations, must be placed on Suicide Precautions and receive an assessment of suicide risk.*	

The program has a policy and procedures regarding suicide prevention services. A review of three youth records revealed two of the youth were placed on precautionary observation (PO) upon admission by the staff who completed the Massachusetts Youth Screening Instrument, Second Version (MAYSI-2). There was documentation in each record the youth was maintained on PO consistently until an Assessment of Suicide Risk (ASR) was completed. The licensed mental health provider completed an ASR the same day as the referral, which was found in each of the two applicable youth records. Mental health staff provided consistent services to each of the youth. None of the youth required follow-up assessments or off-site ASRs as both were stepped down to standard supervision as the result of recommendations on the ASR completed by the clinical coordinator. The program's suicide prevention plan contains the

program's review process for every serious suicide attempt or serious self-inflicted injury and a mortality review for a completed suicide.

3.13 Suicide Precaution Observation Logs (Critical)	Satisfactory Compliance
Youth placed on suicide precautions must be maintained on one-to-one or constant supervision. The staff member assigned to observe the youth must provide the appropriate level of supervision and record observations of the youth's behavior at intervals no greater than thirty minutes.	

The program has a policy and procedures regarding completion of suicide precautions observation (PO) log. A review of two applicable youth records revealed each youth was placed on PO upon admission. There was documentation on each log the program coordinator and licensed mental health professional reviewed the form. Precautionary logs were completed on the required forms for the duration of the precautionary period. Observation checks were consistently found in thirty-minute increments. Documentation was made in real-time for one youth. PO observation documentation for the second youth was documented on the hour and half-hour.

3.14 Suicide Prevention Plan (Critical)	Satisfactory Compliance
The program 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 program has a Suicide Prevention Plan. The plan included all the required elements; identification and assessment of youth at risk of suicide, staff training, suicide precautions, level of supervision, referral, communication, notification, documentation, immediate staff response, and a review process. This plan was signed and reviewed on August 1, 2018 by the provider's director of day treatment.

3.15 Suicide Prevention Training (Critical)	Satisfactory Compliance
All staff who work with youth must be trained to recognize verbal and behavioral cues indicating suicide risk and suicide prevention and implementation of suicide precautions.	

The program completed four mock suicide drills since the last annual compliance review; in addition to four emergency/cardiopulmonary resuscitation (CPR) drills, one each quarter. Each drill was attended by all staff. Each emergency/CPR drill demonstrated the use of CPR, two of the suicide drills demonstrated the use of CPR/suicide response kit, and two demonstrated the use of first aid. Two staff were reviewed for suicide prevention training and each received six hours of suicide prevention training; two hours of web-based training and four of instructor-led training. Three staff were interviewed, two program staff and the clinical coordinator, and each indicated the suicide response kit is located in the program coordinator's office, in a locked cabinet. Each staff member specified in the event a youth expressed suicidal thoughts, they would notify the program coordinator and place the youth on constant sight and sound; two of the staff stated, in addition, they would contact the clinical coordinator, contact the parent/guardian, and check the youth for sharp objects.

Standard 4: Medical Services

4.01 Medical Screening (Critical)	Satisfactory Compliance
Youth are screened for health-related conditions at the time of admission to determine if the youth has any conditions requiring medical attention. The screening includes a review of the most recent Health Discharge Summary (Form HS 012) or Medication receipt/transfer disposition (Form HS 053), if applicable, and documented contact with the parent/guardian if there are any questions or concerns regarding the youth's medical condition. Screening may be performed by non-licensed staff during the admission process. All medical, mental health, and substance abuse information is documented in the youth's Individual Health Care Record.	

A review of three youth Individual Healthcare Records (IHCR) validated the program's medical screening process. Each youth received a medical screening on the day of admission. Of the three youth, none came from a commitment program, but rather were on probation; therefore, none were applicable to have the health discharge summary or medication receipt disposition reports reviewed. Each record contained documentation to validate the youth and parent/guardian were present for the intake process and all medical, mental health and substance abuse information was gathered and documented in each youth's IHCR.

4.02 Medication Management – Verification of Medications	Satisfactory Compliance
The program shall determine a youth's medication regimen upon admission to the program.	

The program has a policy and procedures documenting the program's medication verification process. Three youth records were reviewed for verification of medications. All three youth were screened to determine their medication regimen, only one youth was applicable for receiving medication on-site. The medication was an inhaler for asthma, and only on-site for as-needed use. The youth has not had to use the medication on-site while he has been at the program. The program maintains a Medication Distribution Log (MDL) for the youth's medication, which included the youth's picture, weekly supervisor review, name of medication, Department identification (DJJID) number, list of side effects, side effect monitoring, and prescribed dosage. Due to the medication being pro re nata (PRN), the documentation of medication distribution would be documented on the As-Needed Medication page of the MDL, which was located in the youth's medical record. No other youth received medication on-site since the last annual compliance review.

4.03 Medication Management – Delivery of Medications	Satisfactory Compliance
The program shall have a process in place to assist youth with self-administration of oral medications.	

The program has a policy and procedures documenting the process of delivery of medication. All three staff, the program coordinator, case manager and clinical coordinator, were trained on medication administration on February 27, 2019. According to the provider's director of day treatment, all staff are trained on medication administration as part of their pre-service training. There has not been any distribution of medication to youth, while on-site, since the last annual compliance review; therefore, the Medication Distribution Log (MDL) did not document delivery of any medication. The program coordinator does review the MDL weekly for the one youth who had the inhaler on site. Three staff were interviewed, two program staff and the clinical

coordinator, and one, the program coordinator, indicated she will administer medication to youth, but only in the event the proper procedures are followed. The other two indicated they do not administer medication to youth. Each staff indicated they are able to review medication side effects, if needed, by reviewing the youth medical binder/record. In addition, one staff indicated there is a side effect sheet printed out for each medication noting the side effects. Two youth were interviewed, additional youth were not on-site during the annual compliance review, and indicated they do not take medication at the program.

4.04 Medication Management – Medication Storage	Satisfactory Compliance
All medications (prescriptions, over-the-counter (OTC), topical, etc.) shall be stored in separate, secure (locked) areas inaccessible to youth and ensures proper inventory control.	

The program has a policy and procedures indicating all medication is stored in a secure location behind two locks. It further states all medication is to be provided to the parent/guardian upon the youth's release from the program and the return of the medication will be documented on the Medication Distribution Log (MDL); this process is followed when medication is on-site. The medication is stored in a locked box, in a locked cabinet, in the program coordinator's locked office. The program only had one mediation on-site during the annual compliance review; however, according to their policy, if they had multiple medications, they would store them according to pharmacy regulations. There were no controlled medications on-site and they have not had any on-site since the last annual compliance review. The program maintains a refrigerator for use of medication only; however, it was not in use, as they do not have any medication requiring refrigeration on-site.

4.05 Episodic/Emergency Services	Satisfactory Compliance
The program shall have a comprehensive process for the provision of Episodic Care, First Aid, and Emergency Care. The program shall be capable of facilitating an appropriate response to an emergency situation.	

The program has a policy and procedures documenting the program's process, noting staff shall utilize the episodic (first aid/emergency) care log when documenting any episodic/emergency care. The program has not had any documented episodic/emergency care since the last annual compliance review. The program maintains three first aid kits and a suicide response kit. A review of the suicide response kit validated it contained the required tools which were wire cutters, needle nosed pliers, and knife-for-life. A review of the first aid kits validated each contained the required items, all being within the expiration date. The program does not have an automated external defibrillator (AED) on-site. On a monthly basis, each first aid kit and suicide kit are reviewed by the program coordinator and this was validated by documentation provided by the program. The list of required items for each kit are reviewed; and for the first aid kits, items are replaced if anything is expired. The first aid kits and suicide response kits are kept in the program coordinator's office, locked in a cabinet. The program's policy and procedures indicate the emergency medical drills and mock suicide drills are to be conducted, at a minimum, on a quarterly basis. The program conducted both an emergency medical drill and mock suicide drill each quarter since the last annual compliance review. Each drill was documented on a form, noting the date and time of the drill, who conducted the drill, drill category, scenario, staff response (in narrative form), details of life saving measures used for suicide drills, the rating of the drill, trainer critique/corrective actions, and signature and date of signature of staff participating in the drill. Each drill was facilitated by the program coordinator. Each emergency medical drill included the demonstration of cardiopulmonary resuscitation

(CPR)/life saving measures. The program coordinator maintains a list of emergency numbers, including the Poison Information Center, posted in her office. All staff are informed of potential emergency situations through daily staff meetings and their internal medical alerts. A review of the episodic log binder, logbooks, and alerts validated there have been no medical emergencies or episodic care for any youth since the last annual compliance review.

Program Name: Paxen Brevard
Provider Name: Paxen Learning Corporation
Location: Brevard County / Circuit 18
Review Date(s): April 9-10, 2019

MQI Program Code: 1264
Contract Number: P2120
Number of Beds: 15
Lead Reviewer Code: 156

Overall Rating Summary

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