STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT

PROGRAM REPORT FOR

Paxen Community Connections- Pasco

Paxen Learning Corporation

(Contract Provider)
8730 State Rd 52
Port Richey, Florida 34667

Review Date(s): March 19-20, 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:

Brenda Comadore, Office of Program of Accountability, Lead Reviewer (Standard 1)
Marvin (Skip) Bliss, Office of Program of Accountability, Regional Monitor (Standard 3)
Ronald Bright, Probation, Juvenile Probation Officer Supervisor (Standard 2)
Toni Del Regno, Office of Program of Accountability, Regional Monitor (Standard 4)
Amanda Nelson, Office of Program of Accountability, Regional Monitor (Standard 2)
Sherrie L. Wilson, Office of Program Accountability, Programming and Technical Assistance (SPEP)

Program Name: Paxen Community Connections
Provider Name: Paxen Learning Corporation
Location: Pasco County / Circuit 6
Review Date(s): March 19-20, 2019

MQI Program Code: 1258
Contract Number: P2120
Number of Beds: 22
Lead Reviewer Code: 172

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

NA # Clinical Staff
NA # Food Service Personnel
NA # Healthcare Staff
NA # Maintenance Personnel
_____ # Program Supervisors

2 # Direct Care Staff
3 # Youth
1 # Other (listed by title): **Regional Program Supervisor**

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
3 # Personnel Records
3 # 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)*	Satisfactory
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	Non-Applicable
2.13	Termination Release	Satisfactory
2.14	Career Education	Satisfactory
2.15	Educational Access	Non-Applicable

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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

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Program Overview

Paxen Community Connections - Pasco is a day treatment program operated by Paxen Learning corporation through a contract with the Department in Port Richey, Florida. The program provides day treatment services to probation and minimum-risk commitment. The program is contracted to serve twenty-two male and female youth, ages fourteen to nineteen. At the time of the annual compliance review there were eleven youth in the program. The program fosters each youth by providing evidence-based services, gender-responsive delinquency interventions, case management, community supervision, community service work projects, and Paxen's Life skills training. Transportation services are provided to and from the program, as well as snacks, and an evening meal. The program organizational chart consists of one program coordinator, one case manager, and three program support specialists. The program provides mental health and substance abuse treatment utilizing group interventions to include Thinking for a Change(T4C), Impact of Crime(IOC), Girl's Circle, and The Council for Boys and Young Men. 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 two vacancies, including one case manager and one program support specialist.

Strengths and Innovative Approaches

- Paxen exposes their youth to potential career paths through Paxen Learning Corp - Job Training and Vocation Rehabilitative Services, located in Hudson, Florida.
- The Community Connections representative developed a luncheon for youth and juvenile probation officers (JPO). The luncheon helps inspire youth and encourages collaboration between the youth and the JPO in a community setting by bringing them together for an afternoon of food, fun and fellowship. The youth at the Pasco location of Community Connections prepares the food and host the luncheon.
- Paxen continues to work with Pasco County School Board to provide general equivalency diploma (GED) education for the clients t once youth are deemed ready for the GED.

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 background screening of staff, volunteers, and interns prior to hire. The program did not have new hires or utilized volunteers or interns during the annual compliance review period. The program did not have eligible staff for initial background screening, since the last annual compliance review. The Annual Affidavit of Compliance with Level Two Screening Standards was submitted to the Background Screening Unit (BSU) on January 3, 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 program has a policy and procedures in place addressing five-year background rescreening's for staff, volunteers, mentors, and interns. One staff was eligible for a five-year rescreening. The program submitted a clearance request for rescreening to the Background Screening Unit (BSU) on September 20, 2018, forty-five days prior to expiration of the original BSU clearance and staff hire date.

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.	

There were no Protective Action Response (PAR) incidents during this annual compliance review period; 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.*	

The program did not hire any staff since the last annual compliance review. The program submitted a pre-service training plan to the Department's Office of Staff Development and Training on February 21, 2018. The pre-service/certification training plan requires all new staff to complete forty hours of Protective Action Response (PAR), cardiopulmonary resuscitation (CPR), first aid, professionalism and ethics, suicide prevention training, and emergency procedure training before having direct contact with youth. The pre-service/certification training plan included a list of course names, descriptions, objectives, and training hours for any instructor-led training, including sexual harassment and human diversity. All training was documented in the Department's Learning Management System (SkillPro).

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.*	

The program has an in-service training plan. The in-service training plan requires twenty-four hours of annual training and an annual in-service calendar. All staff are required to complete Protective Action Response (PAR), cardiopulmonary resuscitation (CPR), first aid, professionalism and ethics, and six hours of suicide prevention training. Supervisors are required to complete within the mandated training, an additional eight hours of training on the topics of management, leadership, personal accountability, staff relations, communication skills, and fiscal. All training is in accordance with Florida Administrative Code and the Department's Office of Staff Development and Training. Three records were reviewed and each training record contained more than the mandatory twenty-four hours of training including the required training courses. One of the three records reviewed was for a supervisory level staff and found the required eight hours of management training was not completed. All training was documented in the Department's Learning Management System (SkillPro). The annual training plan was submitted and approved by the Department's Office of Staff and Development Training on February 21, 2018. The program's current annual training calendar was also submitted and 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.	

The program has policy and procedures in place addressing program cleanliness and sanitation. A review of the sanitation and maintenance log confirmed the completion of weekly inspections of the facility's sanitation of all internal areas. Observation noted the indoor area was clean, free of pests, and well maintained. There were separate and gender-specific bathrooms for males and females. There was adequate space for private counseling and group meetings. The exterior of the facility is essentially a parking lot; however, it was clean and free of trash.

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 policy and procedures in place addressing fire prevention and evacuation procedures. The program has postings indicating no smoking in any area of the facility. There are evacuation egress plans strategically placed throughout the facility. Fire alarms and extinguishers are located throughout the facility. The fire extinguishers were current with monthly inspection tags attached. The Pasco County Fire and Rescue Department conducts annual inspections of all fire protection equipment. The extinguishers are checked weekly during the weekly sanitation and safety inspection by designated staff. All staff training records confirmed staff received training in fire prevention, fire equipment training, and fire drill participation. The fire safety log contained completion of an approved fire safety Inspection by Pasco County Fire Rescue. The facility maintenance log confirmed fire equipment is checked weekly by staff. The daily logbook, youth and staff interviews confirmed the program has monthly fire drills. Staff and youth confirmed they know what to do in the event of a fire emergency.

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

The program does not participate in water-related activities; therefore, this indicator is rated as non-applicable.

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

The program provides a safe and appropriate treatment environment, including daily snacks for youth. The program's kitchen has a refrigerator, microwave, adequate storage for youth snacks as was found to be clean, well-maintained, and pest-free. The same menu is offered for both youth and staff and is posted in the large group area near the door and in the kitchen. Provisions for special diets for health and religious needs are posted in the kitchen. Youth and staff interviews confirmed youth and staff are offered the same menu and no youth is denied food as a disciplinary measure.

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

The program has two vehicles, a 2012 and 2013 Ford van. Both vehicles are used to transport youth to and from the program weekly, Monday through Friday. Both vehicles had registration, proof of insurance, and regular up-to-date maintenance schedules. The vehicles' rear exit doors and seat belts were operational. The vehicles are also equipped with a travel bag containing a vehicle logbook, first aid kit, seatbelt cutter, and window punch, which remain in the program director's (PDs) office when not in use. Both vehicles were locked, in good condition, and contained a fire extinguisher in the pocket of the driver-side door. Drivers' licenses of all staff transporting youth, were valid and current. The program's human resource department checks all drivers licenses monthly and the Department of Motor Vehicle (DMV) records twice a year to ensure licenses are current and valid. All youth and staff interviews confirmed youth and staff are required to wear seat belts while the vehicle is in operation. Youth and staff also confirmed youth are not denied services or penalized because of lack of transportation.

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

The program maintains monthly statistical information on admissions, releases, transfers, absconds, abuse reports, medical and mental health emergencies. A daily log is maintained recording program events and incidents. A review of the program's log entries for the past six months reflected each entry contained a brief statement of pertinent information, name of staff and youth involved, the date and time of the event or incident, and the name of person making the entry. The log contains entries confirming the program director (PD) reviews the log on a bi-weekly basis. A review of the program's youth population census matched the Department's Juvenile Justice Information System (JJIS) census.

1.12 Incident Reporting (CCC) (Critical)	Satisfactory Compliance
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.	

The program has policy and procedures in place to meet the requirements regarding incident reporting. The policy covers internal and Central Communications Center (CCC) incidents. A review of the CCC reports for the past six months indicated the program had three reportable incidents. All three reports were in compliance with the CCC reporting procedures. The program had two reportable incidents last year and three this year, an increase of one. There were no grievances filed for this annual compliance review period and there were no additional incidents which should have been reported. Both youth and staff interviews confirmed youth are not denied access to a telephone to call the Florida Abuse Hotline.

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 and procedures in place to ensure the provisions of an abuse-free environment for the youth under their supervision. Three youth case management records were reviewed and each documented intake procedures which the program provided instructions to the youth and their parent/guardian on how to contact the Florida Abuse Hotline and the Department's Central Communications Center (CCC). The telephone numbers for the Florida Abuse Hotline and the CCC are included in the parent/youth handbook provided to the youth and the parent/guardian. Documentation indicates each youth and the parent/guardian acknowledged receipt of this information. The telephone numbers are posted in the main room or large group room of the facility. Unimpeded youth access to the office telephones to call the Florida Abuse Hotline or the CCC is documented in the program's policy and reported by all interviewed program staff and youth. All three interviewed staff reported never hearing a staff deny a youth the opportunity to call the Florida Abuse Hotline or the CCC. All three interviewed youth reported never requesting the opportunity to report abuse and never witnessed staff declining a youth the right to contact the Florida Abuse Hotline or the CCC since they have been in the program. There were no documented calls to the CCC to report allegations of abuse of youth by staff during the annual compliance review period. There were no occurrences in the reviewed staff or youth records of staff failing to report abuse. The Paxen Learning Corporation staff handbook and standard operating procedures outlines the staff code of conduct prohibiting any kind of abusive and/or disrespectful behavior towards youth. Three staff records were reviewed and each acknowledged the code of conduct. There were no occurrences in the staff or youth records of staff violation of the code of conduct nor allegations of abuse by any program staff during the annual compliance review period. Three staff members were interviewed and all three reported never observing another staff use profanity, threats, intimidation, or humiliation when speaking to a youth. Three randomly selected youth in the program were interviewed and all three reported staff are respectful, they do not threaten youth when speaking, and they have not heard staff use profanity when speaking to the youth. All three youth reported staff does not ask the youth to meet them on a social basis after school and all three youth reported they feel safe at the program.

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 written policy and procedures addressing the behavior management system (BMS) implemented in the program. Using principles of a token economy, the BMS uses skill cards, credit points, opportunities to earn verbal praise, certificates, or other reinforcers such as snack items in the program's bid store, and the ability to participate in special activities and outings. The program maintains all the youth skill cards in separate binders so they are readily available to all staff. Three binders were reviewed and contained weekly skill cards initialed by

the program staff, which documents the youth behavior for each weekly period. There is a posting of the behavioral expectations on the facility bulletin board. These expectations are posted to ensure youth are aware of program rules which the youth received in the handbook during intake/orientation. Consequences for non-compliance are documented in the case notes and on the youth's skill card. Negative consequences for minor misconduct includes verbal redirection, removal from the program activity, and counseling. There is documentation of staff meetings with the youth, the juvenile probation officer (JPO), the mental health therapist, and the parent/guardian focused on improving a youth's attendance. Major offenses could warrant meetings with the JPO, contact with law enforcement, and possible termination from the program based on the Effective Response Matrix provided by the Department. There was no documentation of any youth engaging in a serious offense. The program policy states if behavior infraction is critical in nature, the youth is removed from the general population to obtain counseling or discuss the potential consequences of their behavior. All critical infractions including program disruption and serious negative consequences, such as activity restrictions are to be documented in the facility logbook. The program does not use any form of privilege suspension or time out. All three youth interviewed during the review indicated they have never been placed in time out or experienced suspension of privileges. All three youth also indicated they never experienced restrictions resulting in the loss of regular meals, health care, religious needs, contact with parents/guardians, legal assistance, or staff assistance. None of the interviewed youth indicated never observing other youth having authority or the ability to discipline other 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 maintains all youth case management records in a metal, four-drawer cabinet in a locked office. The observed cabinet has a keyed lock and was located in a locked office. The cabinet storing the records is marked "confidential" with stickers. Each youth case management record is maintained in a binder marked "confidential" on the front cover and the binding. The records are organized in the five required sections; however, inside one of the three reviewed records one label was incorrectly labeled correspondence instead of miscellaneous. Each youth individual health care record was maintained in a file folder stamped "confidential", as required.

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.	

The program has a written policy and procedures in place which defines the process for the admission and orientation of youth referred to the program. Three open youth case management records were reviewed for documentation of the admission/intake and orientation process. All three records indicated the date and time of admission and orientation. All admissions, intake conferences, and orientations occurred on the same day for all records reviewed. A review of the three records demonstrated orientation was completed within the twenty-four time frame, as required. The corresponding Department's Juvenile Justice Information System (JJIS) Face Sheet and case notes for the reviewed records indicated the dates matched the documentation in the record for the date and time of the youth's admission to the program. The presence of the youth, the parent/guardian, and program staff during intake and orientation was clearly documented in the JJIS case notebook in two of the three records reviewed. One youth was eighteen years of age at the time of admission; therefore, the youth did not require a parent/guardian present during admission to the program. During the orientation process, each youth and parent/guardian are given a tour of the facility and an introduction to all program staff. The process allows both the youth and the parent/guardian to understand the services provided and expectations of the youth while in the program. In all three records, staff and youth initialed a checklist of information and materials which was reviewed during orientation. Once all checklist items are reviewed. the youth, staff, and parent/guardian signs and date the checklist which is maintained in each youth's record at the program. During the orientation process, each youth is provided a copy of the program's handbook which includes all orientation topics. Information addressed during orientation are introduction to staff, tour of the facility, review of the program's expectations, the daily schedule, youth goals and services, program calendar, attendance policy, importance of family involvement, emergency safety and evacuation procedures, emergency medical and mental health services, the behavior management system (BMS) to include positive reinforcement point system and negative consequences for critical behavior violations, youth rights and grievance procedures, a list of contraband items and materials, consequences for introducing contraband items, average length of stay to successfully complete the program, and dress code which prohibits any pictures/logos/emblems and writing depicting illegal activity, violence, profanity, gang logos, or nudity, bullying policy, transportation policy, the contact information to report abuse including the Florida Abuse Hotline, and a copy of the Effective Response Matrix.

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 written policy and procedures in place for the identification and documentation of medical, mental health, and suicide risk alerts. The program's policy for entering alerts includes placing an alert in the Department's Juvenile Justice Information System (JJIS), documentation in the logbook on the day of admission, and documenting the alert in the

program alert binder which staff acknowledges by signature. Allergy alerts are also posted on the program's refrigerator. Three open youth records were reviewed for this indicator. All three records indicated each youth was assessed as having risk for suicide. All records reflected a suicide alert was properly entered in the alert logbook and JJIS to indicate this risk. Youth were also placed on precautionary observation. Suicide alerts for these records were discontinued and youth were stepped down to standard supervision, according to the Assessment of Suicide Risk (ASR), as required. In two of the three reviewed records, a mental health alert was entered in JJIS regarding a diagnosed mental health disorder. The mental health alert was not discontinued on the two records based on a Crisis Assessment which indicated the mental health disorder is ongoing. The program maintains an alert binder which is reviewed daily by all staff. Three staff members were interviewed for this standard. All three staff stated they sign the alert logbook acknowledging the alert at intake. One staff member indicated alerts could also be found in the JJIS as well as the program's logbook

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.	

The program has a policy and procedures in place for the assessment of youth using the Positive Achievement Change Tool (PACT) full assessment which is completed within seven days of admission into the program. Three open records were reviewed for this indicator. All three records confirmed staff completed the PACT full assessment within seven days of the youth's 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.	

The program does not serve conditional release or post-commitment probation youth; 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.	

The program has written policy and procedures in place regarding the development of the Youth Empowered Success (YES) Plan. Three youth records and the Department's Juvenile Justice Information System (JJIS) were reviewed and verified a Positive Achievement Change Tool (PACT) assessment was developed prior to the YES Plan for each of the youth. The review records verified a YES Plan was developed within the required fourteen days of admission for two youth. Each YES Plan was signed by the youth's parent/guardian, program staff, and program supervisor. One of the youth's YES Plan was developed within the required fourteen days but was signed by the youth twenty-eight days late and signed by the parent/guardian fifteen days late. The program was not able to provide

a reason why the YES Plan was signed late. The JJIS case notes demonstrated each of the three youth records verified negotiations and cooperative development regarding the development of the YES Plan took place with each youth. Review of the case notes also confirmed each parent/guardian was informed of the importance of complying with the sanctions and goals of the plan through a written letter, which was included with their copy of the YES Plan. Three youth were interviewed and all indicated they participated in the development of their YES Plan.

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).	

There is a policy and procedures in place ensuring youth have appropriate and individualized target dates for each goal requirement on their Youth Empowered Success (YES) Plan. Three open youth records were reviewed for this indicator. In all three records, the court ordered sanctions were reflected on each youth's YES Plan. A review of all three records reflected the youth individualized target dates and action steps for the youth, the parent/guardian for youth under eighteen years of age, and the juvenile probation officer (JPO)/case manager (CM). The action steps included who was responsible, what action should be taken, and the frequency of the action in the YES Plan. All three records clearly had a target end date which was reasonable. All records reviewed had an individualized Positive Achievement Change Tool (PACT) Goal related to one of the youth's top three criminogenic needs. Three youth were interviewed for this indicator and all three youth indicated they were aware of the requirements and goals within their YES Plan.

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.	

Three records were reviewed for this indicator and all three records case notes indicated compliance with the Youth Empowered Success (YES) Plan from the youth, the parent/guardian, and collateral sources. All three records validated staff action steps on the YES Plan were monitored on each plan. Case notes were clearly documented in all three records. The staff were monitoring sanctions in each of the youth's home, school, workplace, and/or community. A review of each youth's YES Plan progress, non-compliance, and goal completion takes place during monthly treatment team meetings and is documented in the Department's Juvenile Justice Information System (JJIS) case notes, supervisor reviews, and progress reports. Contacts were made or attempted with both the youth and the parent/guardian to maintain regular and quality contacts and supervision.

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.	

There is a policy and procedures in place to ensure Youth Empowered Success (YES) Plans are reviewed and updates are made when appropriate to address any new youth needs at a minimum once every ninety-days. Three records were reviewed for this indicator and one record was not applicable to this indicator as the youth's admission date was less than ninety-days. In two of the three records reviewed, staff made the necessary updates to the youth requirements and Positive Achievement Change Tool (PACT) goals and created a new updated YES Plan prior to the supervisory ninety-day review. YES Plans were also updated to reflect the youth's progress within the program. This is clearly documented in each youth's record and in the Department's Juvenile Justice Information System (JJIS). None of the reviewed records r contained significant changes on the YES Plan updates; therefore, collaboration from the youth and the parent/guardian was not required.

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.	

The program has a policy and procedures in place addressing ninety-day supervisor reviews. This policy includes at minimum the supervisor will ensure the juvenile probation officer (JPO) and/or case manager (CM) will update the Positive Achievement Change Tool (PACT) goals and youth requirements prior to the supervisory review. Additionally, the policy mandates all open youth records have a completed supervisory review at minimum once every ninety-days. Three open records were reviewed for this indicator and one record was not applicable to this indicator as the youth's admission date was less than ninety-days. In two out of the three records reviewed, the supervisor appropriately completed a review of the previous ninety-days of supervision which was clearly documented in the Department's Juvenile Justice Information System (JJIS). In the applicable records, the supervisor confirmed staff were completing a PACT full reassessment prior to updating each youth requirements, PACT goals, and the Youth Empowered Success (YES) Plan. Each supervisory review addressed the youth's progress in the program and offered specific recommendations and guidance to the CM regarding time frames and youth goal completions. In the two remaining applicable records, the CM placed a case note in JJIS acknowledging the ninety-day supervisor review and took appropriate action, if necessary.

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.	

The program has a policy and procedures in place requiring a Positive Achievement Change Tool (PACT) full assessment to be completed within seven days of the youth's admission and every ninety-days thereafter, regardless of risk. This exceeds the indicator's minimum requirement of once every 180 days. Additionally, a full PACT final assessment will be completed upon the youth's successful completion or discharge from the program. Three closed youth records were reviewed for this indicator and all three records indicated a PACT reassessment was completed at minimum once every ninety-days. All three reviewed records included a PACT goal and completed a PACT full assessment regardless of the risk to re-offend. All PACT reassessments clearly mirrored the youth's current status, changes in behavior, and progress with goals and sanctions on the Youth Empowered Success (YES) Plan. All three closed reviewed records were in compliance as staff completed the final PACT in a timely manner and within the fourteen-day mandated timeframe. Any PACT completed within fourteen days of release shall be considered the exit PACT; therefore, the program follows this requirement as all records showed a PACT was completed on the date of discharge from the program.

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.	

The program has a policy and procedures in place regarding progress reports. Progress reports are to be completed at least once every ninety days. Two open records and one closed record were reviewed for this indicator. All reviewed records contained a completed progress report monthly. Each progress report gave an overview of the youth's progress with the Youth-Empowered Success (YES) Plan goals, program attendance, overall performance and participation in the program, any pending legal charges, and allowed a space for youth to provide comments. All three reviewed records reflected the progress report was reviewed by each youth and signed by the youth and staff member. A cover letter was not required, as none of the reviewed records contained a youth on minimum risk commitment; however, it was included with every progress report.

2.12 Education Transition Plan	Non-Applicable
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 educational services to the 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.*	

The program has a policy and procedures in place regarding terminations and release from the program. Three closed records were reviewed for the termination/release process. In all three closed records, it was clearly demonstrated in case notes the juvenile probation officer (JPO) worked together with program staff to facilitate each youth's release from the program. In all three records each youth remained on probation; therefore, it was not required for staff to complete a warrant check with local law enforcement. In all three records each youth and the parent/guardian received notification of release from the program. In all three closed records each youth and the parent/guardian received notification the youth would remain on supervised probation by the assigned JPO. In all three closed records the release from the program was completed in the Department's Juvenile Justice Information System (JJIS) in a timely manner.

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

The program provides Type 2 programming to provide skill building activities and life skills training exercises deigned to foster the development of skills necessary for youth to successfully seek and maintain employment. A review of the program's Pathways and Independent Living curricula showed a focus on developing vocational competency and social skills necessary to gain and retain employment. Some of the topics included in the curricula includes customer service skills, resolving conflict, managing stress, understanding procedures and benefits, workplace culture, working effectively, and communication skills. Three closed records and one open record were reviewed for this indicator. In all records reviewed, the program maintained documentation showing the program is teaching personal accountability skills and behaviors appropriate for students in all age groups and ability levels which lead to work habits to help maintain employment and living standards. All four records contained a sample completed employment application, résumé , appropriate documents essential to obtaining employment and documentation all parties are aware of the career education plan for each youth. The open record indicated employability as a Positive Achievement Change Tool (PACT) goal and the youth secured employment while in the program. The open record also reflected collaboration with staff at Career Source to assist the youth with obtaining employment. The closed records did not contain employability as a PACT goal.

2.15 Educational Access	Non-Applicable
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 to the youth; 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 designated mental health clinician authority (DMHCA) is a staff of Paxen and a licensed clinical social worker (LCSW) with the title of clinical coordinator. The clinical coordinator is responsible for coordinating and verifying implementation of mental health and substance abuse services. The program's policy states the clinical coordinator is to be on site a minimum of once a week and complete substance abuse and mental health evaluations, develop treatment plans, suicide risk assessments, discharges, and referrals. A review of the clinical coordinator log revealed the clinical coordinator was on site at least twice a week from September 2018 to March 2019. The clinical coordinator is to be licensed according to the requirements in Chapter 458 and 459, meeting the requirement of a LCSW. A copy of the current valid license was reviewed and expires on March 31, 2021.

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 a policy and procedures for ensuring mental health and substance abuse services are provided by individuals with appropriate licensure. Staffing shall be in accordance with the Department's contract and Rule 63N-1, F.A.C. The program does not employ non-licensed clinical staff. The designated mental health clinician authority (DMHCA) is a staff of Paxen and a licensed clinical social worker (LCSW) with the title of clinical coordinator. A review of the Department of Health's license website indicated the licensed mental health counselor (LMHC) is currently licensed with a license expiration date of 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's policy and procedures specify the program does not use non-licensed mental health clinicians for service delivery of mental health and substance abuse treatment services. The policy also states the designated mental health clinician authority (DMHCA) shall hold a license in accordance with contract and Rule 63N-1, F.A.C. Paxen staffs a licensed clinical social worker (LCSW) as their clinical coordinator.

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.	

Three open youth mental health and substance abuse records were reviewed for documentation of a comprehensive screening process ensuring a referral is made when youth have an identified mental health and/or substance need. All three youth records indicated the Positive Achievement Change Tool (PACT) and the Massachusetts Youth Screening Instrument - second version (MAYSI-2) were completed by a staff trained in the administration of the MAYSI-2 on the day of admission. Documentation of the title and staff completing the assessments, date and time of the assessment, a review of available information, and observations were documented as part of the screening process. All three youth mental health and substance abuse records had a PACT Mental Health and Substance Abuse Referral Summary completed automatically from the results of the PACT. All three youth were placed on precautionary observation and referred for an Assessment of Suicide Risk (ASR) based on intake screening documents. All three records contained an ASR completed the day of admission by the clinical coordinator. The program coordinator was notified and precautionary placement was provided for each youth until the ASR was completed and reviewed. Notification of the clinical coordinator was not required since the clinical coordinator was the individual completing the ASR. All three youth were removed from precautionary observation by the clinical coordinator following the results of the ASR and notifications made to the program's coordinator by the clinical coordinator. Suicide risk alerts were entered into Juvenile Justice Information System (JJIS), as required.

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 indicating all youth will receive a comprehensive mental health evaluation and/or comprehensive substance abuse evaluation within thirty days of referral; no youth shall receive an updated assessment. A total of three youth mental health/substance abuse (MHSA) records were reviewed for this indicator. All three youth were identified by screening, staff observation, or behavior after admission, and in need of further

evaluation and were referred for a comprehensive mental health evaluation and comprehensive substance abuse evaluation. The program combined the comprehensive mental health evaluation and comprehensive substance abuse evaluation into one document which captures the required information. All three youth had a comprehensive MHSA evaluation completed within thirty days of the referral by the clinical coordinator. There were no updates noted during the review due to all youth receiving a new 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.*	

A total of three youth mental health and substance abuse (MHSA) records were reviewed for this indicator. All three youth were assigned at admission to a multidisciplinary treatment team which included the youth, the parent/guardian, the clinical coordinator, a representative from case management, and the program coordinator. A medical staff is not required by contract. The treatment team is responsible for developing, reviewing and updating the youth's individualized MHSA treatment plan, and discharge treatment planning. Three of the records included the signed Substance Abuse Consent and Release forms MHSA 012 and MHSA 013. All three records included a MHSA initial treatment plan implemented the day of admission. All three youth had an individualized MHSA treatment plan completed within thirty days of admission. Each youth's case notes were documented on form MHSA 018 and completed with all required information. All three youth records reviewed were applicable for MHSA services based on the results of the comprehensive evaluation. All three MHSA youth records had a current Authority for Evaluation and Treatment (AET) form HS 002. Youth can receive specific clinical interventions and treatment methods such as individual therapy, group, or family therapy, behavioral therapy, psychoeducational training and medical/psychiatric services. All three applicable youth were receiving individual therapy, group, or family therapy, and behavioral therapy. No youth were receiving psychoeducational training and medical/psychiatric services as an identified need by the comprehensive assessment.

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.*	

Youth determined to have a serious mental disorder and/or substance abuse impairment and receiving mental health and/or substance abuse treatment in a program, must have an initial or

individualized mental health or substance abuse treatment plan. All youth who receive mental health and/or substance abuse treatment while in a day treatment program will have a discharge summary completed. A total of three youth mental health and substance abuse (MHSA) records were reviewed for this indicator. The three applicable MHSA records contained an initial treatment plan completed within the seven-day requirement. These plans were signed by the treatment team and clinical coordinator. The plans documented when mental MHSA services are to begin and the initial course of treatment. The initial treatment identified in all three youth records included the reason for referral, initial diagnosis or presenting symptoms, initial treatment methods, and initial treatment goals. All three applicable MHSA records contained the individualized MHSA treatment plan completed within thirty days of admission. All parties of each youth's treatment team signed and dated the plan containing all required elements including the youth's diagnosis, description of specific symptoms, measurable and achievable goals, and a list of services. Each service for each youth also had the amount, frequency, and duration for services provided. All plans were approved by the licensed mental health counselor (LMHC) in which two were approved within the thirty-day requirement and one was approved one day late.

Three closed youth records were reviewed for the discharge summary and all records contained a discharge summary with documentation of the discharge plan being discussed during the youth's exit in the Juvenile Justice Information System (JJIS). There were no youth released on suicide risk or precautions requiring a notification to the parent/guardian and the juvenile probation officer (JPO). A review of case notes for youth verified each youth, parent/guardian, and JPO received a copy of the discharge summary

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 written policy and procedures in place for mental health crisis intervention services. A review of the crisis intervention plans includes all required elements under Florida Administrative Code 63N-1.010 including notification and alert system, referral, and youth self-referral, communication, supervision, documentation and review, staff response, referral for services, including self-referral and assessments, mental health and substance abuse services to include transport for Baker Act and Marchman Act, documentation, training, review, general review process, and post-event review process. There were no crisis intervention services which were required during the time of the annual compliance review period.

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 regional director (RD) reported there were no youth in crisis within the last twelve months; however, the program is prepared to conduct a crisis assessment as staff are trained in crisis intervention and the use of the Department's form Mental Health and Substance Abuse (MHSA) 023. The program has a mental health crisis intervention and MHSA services emergency care plan which contains all elements, as required by the Department's and the program's contract. There were no crisis assessments during the annual compliance review period.

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 a written policy and procedures in place for implementing a care plan for emergency mental health and substance abuse MHSA services in accordance with Rule 63N-1 Florida Administrative Code (FAC). The emergency care plan contains all the required elements such as procedures for communications, supervision, authorization to transport for emergency services, documentation, training, mock drills, and a review process. The emergency MHSA care plan services policy was signed by the regional director (RD) on July 26, 2016. There were no emergency MHSA incidents needing services during the review period during the review period.

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 utilize a Baker Act or Marchman Act procedure during this review period; 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 written suicide prevention plan which addresses how suicide prevention services will be provided for youth in the program. Three open youth mental health and substance abuse (MHSA) records were reviewed. All three youth records reviewed were assessed during admission. The Assessment of Suicide Risk (ASR) was completed using the required Department form. All three youth were placed on standard supervision after completion of the ASR. The ASR was completed the same day of admission by the program's clinical coordinator. The Suicide Precaution Observation log was completed in its entirety. There were no incidents requiring off-site ASR. The three youth placed on precautionary observation during intake were entered into the logbook as placed on precautionary observation until seen by the primary therapist.

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.

A review of three youth mental health and substance abuse (MHSA) records found three Suicide Precaution Observation Logs. All three observation logs were completed and signed by the program's clinical coordinator during the intake assessment period. The supervision of the youth was documented on the observation logs in intervals of thirty minutes or less by the observing staff. In all cases this was performed by the clinical coordinator. The observations were documented in real time. Warning signs were observed and documented on the observation logs with no youth showing signs of mental distress. Safe housing requirements were documented in writing. Suicide Precaution Observation logs were completed for the duration the youth was on suicide precautions and signed by the clinical coordinator. All three youth placed on precautionary observation were documented in the facility logbook.

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 written plan detailing the suicide prevention procedure in accordance with Rule 63N-1, Florida Administrative Code. All program staff are trained on the plan. The plan includes the identification and assessment of youth at risk of suicide, staff training, suicide

precautions, levels of supervision, referral process including self-referrals, documentation, immediate staff response, review process, and safe housing. The levels of supervision being used are one-to-one supervision, constant supervision, and close supervision.

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 has a written policy and procedures in place which states 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. A review of three staff training records indicated all three staff received the required six hours of suicide prevention training. This training was divided into two sessions; one four-hour session and one two-hour session for a total of six hours of in-service training completed on the Department's suicide prevention course in the Department's Learning Management System (SkillPro). A review of four mock suicide drills were completed. The drills were documented on September 24, 2018, September 25, 2018, December 11, 2018 and December 12, 2018 for the quarterly reviews. The parties included the clinical coordinator, program coordinator, case manager, and direct care staff. Forms documented staff roles, nature of incident, corrective action, and narrative. The forms were signed by all staff involved and reviewed by the clinical coordinator and program coordinator.

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.	

The program has a written policy and procedures specifically outlining the requirement each youth are to be screened for health-related conditions at the time of the youth's admission and the procedures for conducting the screening. All medical screenings are completed by non-licensed staff utilizing the Day Treatment Health Care Screening form created by the provider. The reviewed policy requires the screening to include a review of the most recent Health Discharge Summary, (form HS 012) completed for the youth, if applicable. None of the youth in the program were admitted from another program; therefore, all three reviewed records were not applicable for the review of form HS 012. The program's policy requires parent/guardian attendance at the initial intake meeting. Accordingly, all three reviewed records documented the medical screening was conducted at intake with input from both the youth and the parent/guardian. A review of the screening form indicated the screening includes an assessment of the youth as to obvious current conditions including injury, illness, pregnancy, special needs such as hearing aids and/or eyeglasses, and prescribed medications. The Day Treatment Health Care Screening form also documents the youth's medical history, all known allergies, and any chronic medical conditions. The reviewed policy also asserts if the youth has any conditions which might prevent the use of safe restraint techniques such as the Protective Action Response (PAR), a master PAR instructor is included to participate in the development of an individualized plan which addresses the needs of the youth should a physical restraint is required. The program maintains a separate individual healthcare record (IHCR) for each youth which includes the Day Treatment Health Care Screening form. A separate individual healthcare plan is developed for each youth present with medical needs. Each plan, once developed is also maintained in the youth's IHCR. The youth's IHCR is maintained separately from the youth's case management record. A review of three youth IHCRs contained evidence each of the youth were medically screened upon admission.

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 written policy and procedures regarding medication screening and management. The policy mandates specific procedures for verification of all youth medications which are brought to the program with the youth or parent/guardian. During the medical screening process, the youth and the parent/guardian are interviewed on any current medication(s) the youth may be prescribed, particularly any medication required to be administered during the hours the youth is on-site. The policy states only medications prescribed from a licensed pharmacy with a current patient-specific label intact and in the original medication container can be accepted into the program. The parent/guardian of the youth must deliver the medication to a program staff trained in medication management. The

staff will immediately verify the medication is prescribed to the youth and the medication in the bottle is the prescribed medication. The trained staff will then review the pharmacy generated information including potential side effects of the medication with the youth, the parent/ guardian, and the site staff. According to the reviewed policy, this information is then maintained in the medication distribution log which documents staff assistance in the youth's self-administration of the medication. The medication information is also maintained in the youth's individual healthcare record (IHCR) to be updated, when appropriate. The program coordinator reported during the annual compliance review there were no youth admitted to the program who required medication to be administered while the youth was on-site. Thus, there were no records available for review to verify the program's practice regarding verification of medications. The reviewer did observe the program's binder with several copies of the Prescription Medication Verification Checklist, form HS 025 should the verification process need to be initiated.

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 written policy and specific procedures in place regarding staff delivery of medications and assistance with youth self-administration of medications. The policy clearly states program staff are not authorized to prescribe, dispense, or administer any medications to youth. If a youth must take medication during program hours, only non-health care trained staff are authorized to assist youth with the self-administration of medication.. The program's practice is to ensure all staff are trained regarding the delivery of medication and assistance with self-administration of oral medications by a licensed medical professional. The program provided documentation for review indicating the program coordinator and program support specialist each completed a training for non-healthcare staff assisting youth with self-administration of medications which involved a lecture, a question and answer period, and a written test conducted by a registered nurse (RN) on February 27, 2019. The program has at least one trained non-health care staff on-site during program hours to ensure the timely delivery of medications can occur, as necessary. The reviewed program policy states the trained staff will follow the Five Rights of Medication Administration and maintain control of all medication containers. The reviewed policy also outlines a structured process of medication delivery requiring the staff's full attention on the medication delivery and the youth's approach to the staff member on an individual basis, to initiate the delivery process. A medication distribution log is used to document the youth's delivery of medication. Both the youth and the staff initial the date and time each dosage was self-administered. A review of the medication distribution log sheet the program utilizes if a youth administered medication, indicates the sheet would contain the youth's name and photograph. The trained staff would review the youth's allergies, medication precautions, and discuss the possible side effects of the medication or any adverse reactions to the medications with the youth. The log is also used to maintain a perpetual inventory of the medications. The program's policy requires the medication distribution log to be reviewed weekly by the program coordinator for documentation accuracy. Each of the three staff responded to interview questions indicating they have not dispensed medications to a youth since prior to the last annual compliance review and each staff verified they completed training in medication delivery within the past year. None of the three interviewed youth indicated they have taken medication while 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 written policy and procedures in place to address proper storage of all prescribed medication, including medications which requires refrigeration. The program does not maintain any over-the-counter (OTC) medications on-site. The reviewed policy stipulates all youth medications are to be stored in a location free from moisture and/or extreme temperatures inaccessible to the youth. The program's policy states all medications are to be stored in a secure location behind two locks. During the annual compliance review, it was observed the program's practice is to store the medications in a key locked box which is maintained in a locked file cabinet. There is space available to ensure the separate storage of different types of medication such as oral medications, drops, or ointments. The locked file cabinet is located in a key locked office. Only staff trained in the delivery of medications have access to the keys to access the medications. The program also maintains a delegated mini-refrigerator equipped with a keyed padlock when there is medication requiring refrigeration for a youth in the program. All youth medications are inventoried upon receipt by program staff and a perpetual inventory is maintained on the medication distribution log each time a youth receives a dosage. The program's policy states the youth's parent/guardian will be provided any remaining prescription medication for the youth from the program staff when the youth is released from the program. During this time, the medication will be inventoried again and the staff and the parent/guardian will sign the document verifying transfer of the medication. The program coordinator reported the program did not have youth who required medication delivery on-site prior to the last annual compliance review.

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 written policy which specifies the procedures mandating how the program will respond to an urgent or emergency medical incident. The program staff are trained to facilitate an appropriate response to medical emergencies to include training annually and thereafter, in first aid and cardiopulmonary resuscitation (CPR) prior to any interaction with the youth. Training is also provided in suicide prevention including unannounced drills and initiating a 9-1-1 call for assistance. Additionally, in the case of a potential emergency involving program youth and staff such as severe weather, hostage situations, heat-related injuries, the program has a disaster preparedness plan for staff reference. A review of the training records for each of the two program staff confirmed, both the program coordinator and the program support specialist are currently certified in first aid and CPR. A review of drill logs indicated all program staff participated in quarterly mock emergency drills, which required practice of basic first aid, CPR, and/or the utilization of the suicide response kit. A review of all emergency drills since the last annual compliance review confirmed there was a mock medical drill conducted every three months in March, June, September, and December 2018 with all staff participating in the drill. There was also two suicide prevention drills in September and December 2018. Monthly fire and evacuation drills were also documented. Drills are documented on a form which contains the type of drill, the mock drill scenario, the names of all staff involved, a critique of the drill and, if appropriate a corrective action for the drill.

The program maintains two well stocked first aid kits and a suicide response kit which contains a knife-for-life, wire cutters, and needle nose pliers. Both kits are maintained in the program coordinator's office. A first aid kit is also maintained in each of the program's transport vehicles along with a fire extinguisher, a window punch, and a seat belt cutter. The Poison Information Center telephone number is located on the wall in the program coordinator's office, an area usually inaccessible to youth. The youth sometimes meet with staff in the program's coordinator office and if motivated could access the telephone numbers. The program does not have an automated external defibrillator (AED). The kits are monitored weekly on the Facility Maintenance Log completed by either the program coordinator or the program support specialist and replenished, as needed. A review of the Facility Maintenance Log verified the weekly checks are completed as required during a thorough check of the facility for cleanliness and safety measures.

The program coordinator reports there were no instances when the staff was required to provide episodic care to a youth in the program including minor first aid. There were no available records to review regarding the program's practice of episodic care and/or emergency response. Review of the episodic (first aid/emergency) Care Log binder indicated the log would require completion of the date of the incident, the youth involved, the type of incident, the treatment rendered and staff initials, and where the youth was referred to for additional treatment, if needed. The staff reported there were no instances when the provision of episodic care was required. A monthly log sheet in the Episodic (first aid/emergency) Care Log binder completed for each month since the beginning of fiscal year 2018/2019 indicated there were no episodic care services provided during each month.

The program has a written policy and procedures in place to address an emergent situation with a youth which requires off-site care. A review of the program's policy regarding off-site medical care list procedures for accessing appropriate care and documenting the provision of these services. The policy requires the staff to contact the youth's parent/guardian as soon as possible if a youth is transported off-site for medical care. Additionally, all attempts to contact the parent/guardian are to be documented in the Juvenile Justice Information System (JJIS) case notes. A review of the Off-Site Medical Care Checklist requires the staff to document the parent/guardian's, the juvenile probation officer's (JPO) telephone number, and the time each were contacted. The form also documents specific details regarding the injury/incident and the type of first aid administered to the youth. The bottom part of the Off-Site Medical Care Checklist details the supervisory review to be completed within twenty-four hours of the incident by the executive director or the regional program manager specifying if 9-1-1, the parent/guardian, and the JPO were contacted in a timely manner.

Program Name: Paxen Community Connections	MQI Program Code: 1258
Provider Name: Paxen Learning Corporation	Contract Number: P2120
Location: Pasco County / Circuit 6	Number of Beds: 22
Review Date(s): March 19-20, 2019	Lead Reviewer Code: 172

Overall Rating Summary

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