STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT
PROGRAM REPORT FOR

Paxen Polk
Paxen Learning Corporation
(Contract Provider)
5151 S. Lakeland Drive,
Polk, Florida 33813

Review Date(s): May 22 - 23, 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 of Accountability, Lead Reviewer (Standard 1 and 4)
Linda Beckelheimer, Probation Circuit 9, Government Operations Consultant I (Standard 2)
Paul Czigan, Office of Program Accountability, Regional Monitor (Standard 3 and SPEP)
Bonita Williams, Office of Program Accountability, Regional Monitor (Standard 3)

Program Name: Paxen Polk
Provider Name: Paxen Learning Corporation
Location: Polk County / Circuit 10
Review Date(s): May 21 - 22, 2019

MQI Program Code: 6041
Contract Number: P2120
Number of Beds: 40
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
- _____ # Case Managers
- **1** # Clinical Staff
- _____ # Food Service Personnel
- _____ # Healthcare Staff
- _____ # Maintenance Personnel
- _____ # Program Supervisors
- _____ # Direct Care Staff
- **7** # Youth
- **2** # Other (listed by title): **program support specialists, 2 case managers**

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
- **10** # Health Records
- **10** # MH/SA Records
- **5** # Personnel Records
- **5** # Training Records/CORE
- **3** # Youth Records (Closed)
- **7** # 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

* 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 Polk is a day treatment program operated by Paxen Learning Corporation through a contract with the Department in Polk County, Florida. The program provides day treatment services to probation, minimum-risk commitment, and conditional release youth. The program is contracted to serve forty male and female youth, ages fourteen to nineteen. The program fosters each youth by providing Thinking for a Change (T4C) and Victim Impact Curriculum. The program is comprised of one program director, two case managers, one clinical coordinator, and three program support specialists. Mental health services are provided by the clinical coordinator. The program provides mental health and substance abuse treatment utilizing T4C and Victim Impact. 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 takes prescription medications during the time they are at the program. At the time of the annual compliance review, the program had two program support specialist vacancies.

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 screening. None of the five staff employed at the program were applicable. The program utilizes the Diana screening as their pre-employment assessment tool. The Annual Affidavit of Compliance with Level 2 Screening Standards was completed on January 3, 2019, prior to the January 31, 2019 deadline.

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 re-screening. The policy indicates the human resource compliance specialist conducts a five-year re-screening of all existing staff members, volunteers, and interns every five years after the initial screening date in accordance with the Department's policy. A five-year re-screening can be submitted up to twelve months before the actual five-year anniversary date. When a re-screening is submitted to the Background Screening Unit (BSU) at least ten business days prior to the five-year anniversary date but is not completed by the BSU on or before the anniversary date, the screening shall meet annual compliance review standards. The program did not have staff in need of a five-year re-screening.

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 did not have any Protective Action Response (PAR) incidents during this 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 has a policy and procedures specifying contracted non-residential staff are trained in accordance with Florida Administrative Code and staff shall satisfy pre-service/certification requirements within 180 days of hire. Staff who have not completed the essential skills training shall not have direct unsupervised contact with youth.

None of the staff were applicable for pre-service training. All staff were hired prior to the annual compliance review period. The program has two instructors qualified to provide Protective Action Response (PAR), first aid and cardiopulmonary resuscitation (CPR) training. 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.

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.*	

All five program staff were applicable for in-service training which one was a supervisor. All five staff members had more than the required twenty-four hours of annual training in 2018. Each staff had between forty-seven and a half to eighty-six hours of in-service training which included Protective Action Response (PAR), cardiopulmonary resuscitation (CPR), first aid, professionalism and ethics, suicide prevention, and all other required training. The supervisor 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 training based on the required topics on February 21, 2018. 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 annual compliance review, all indoor areas were found to be clean, neat, and well maintained. The program does not have grounds to landscape. All of the furnishings were in good repair. There was no graffiti on the walls, doors, or windows and no insect infestation. The bathrooms were observed to be clean, functional, free of mold and mildew with one bathroom for males and one for females. Each bathroom had operable toilets, wash basins with running water, antibacterial soap, and paper towels. The program's clinical coordinator's office is where individual counseling sessions are held. The program has a small conference room and a large main area where group meetings are conducted. Food and snacks are served in the main area. The program has two smaller offices utilized by the case managers and the program coordinator. There is a small kitchen and a room where the printer and program's bid store for the youth are located. The support specialists have desks on the perimeter of the main area. Six months of weekly sanitation and safety inspections of all internal and external areas and equipment were reviewed. The equipment was in working order. The program has a maintenance and housekeeping plan. All tasks were completed on a weekly basis by the youth who were 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 by the front door and by the back entrance. Both received an official inspection in June 2018. The program conducts weekly fire protection equipment checks which are included on the weekly sanitation and safety inspection form. 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 contained a record of annual fire safety inspections and the fire drills. The last fire safety inspection was conducted on January 2, 2019 by the Polk County Fire Department. The program passed the inspection with no violations found. The evacuation egress plan is located throughout the facility showing the specific routes of evacuation. The program staff reported they do not provide designated smoking areas as smoking is not allowed on program grounds. All five program staff completed fire safety training. Seven youth were interviewed and six youth indicated they were instructed on what to do during a fire. The seventh youth could not remember receiving training.

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 rates as non-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 which prohibits withholding food as a disciplinary measure. The program utilizes the tables and chairs in the main area where the group sessions are held, as a dining area. The area was found to be clean and orderly. Three 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. Seven youth and five staff interviews indicated youth and staff receive the same menu.

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

The program provides daily transportation of the youth to and from the program in program vehicles. Both youth and staff are required to wear their safety belts at all times. All program staff transporting youth had a current and valid Florida driver's license. The administrative assistant for the region conducts the driver's license checks monthly. Both program vehicles were in safe and sound condition, had current insurance and registration, and were kept locked when not in use. The program conducts inspections of the vehicles both daily and monthly. Seven youth and five staff interviews indicated youth are required to wear their seatbelts when being transported in the program's vehicles.

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

The program's contract specifies monthly reports to be sent to the Department which includes a monthly invoice, youth census, staff vacancy, Certified Minority Business Enterprise (CMBE) utilization and program fidelity, and quarterly expenditures. A review of the last six months reports indicated all reports were completed and submitted, as required. The youth listed on the program roster matched the census report in the Juvenile Justice Information System (JJIS). The program maintains a logbook and all entries documented the date and time of incident, name of youth and program staff involved, brief statement of pertinent information, name of person making entry with date, time of entry, and signature. The program's logbook documented significant program activities, events and incidents, Central Communications Center calls, youth searches, youth releases, youth returning from inactive status, youth admissions, Assessment of Suicide Risks, and power outages. Safety and security issues were highlighted. The program director reviewed logbooks on a bi-weekly basis during the annual compliance review period and noted any actions taken as a result of the review.

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 a policy and procedures regarding incident reporting. The program had two internal incident reports in the last six months. One incident was called into the Central Communications Center (CCC), as required within the required two-hour time frame. The program staff had a vehicle crash in which neither staff or youth were injured. The other report two youth had fought on campus and the staff contacted the CCC and were informed it was not a reportable event. Both incidents were documented in the logbook.

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 code of conduct which details all employees of the organization are expected to act in the organization's best interest, upholding the highest ethical standards. The program did not have any Central Communications Center (CCC), Florida Abuse Hotline or internal incidents wherein allegations were made against staff. A review of the records did not indicate there were instances of unreported abuse. Staff signed the code of conduct at the time of hire. The youth are informed of the Florida Abuse Hotline and CCC telephone numbers during the orientation process.
All five staff interviews indicated they would allow a youth to make a call to report abuse to the Florida Abuse Hotline or the CCC. Four staff stated the youth can ask any staff and the staff will assist the youth in making the call. One staff stated they would refer the youth to the supervisor to make the call. All seven youth interviews indicated they never had to call the Florida Abuse Hotline and stated staff are respectful toward them and other youth. The youth reported never witnessing a staff cursing or threatening youth.

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. The program does not use facility restrictions 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 and the program rules are posted throughout the facility. The schedule included structured activities and the staff indicated they had youth participate in various activities including dress for success, shopping on a budget, and college tours. All seven youth interviews indicated the youth were never able to punish another youth. Six youth stated they had never been placed in time out. One youth indicated being placed in time out. The youth was in an argument with another youth and was separated and placed in another room; however, the program reported the youth was separated from the other youth for program safety and was not in time out. The youth was provided food.

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 record for individual healthcare and individual management for each youth. Each individual management record contained the youth's name, Department of Juvenile Justice Identification (DJJID), date of birth, county of residence, committing offense, and were labeled confidential. The records were kept in locked file cabinet drawers in the case manager's office, which is marked as "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.	

In all seven youth records reviewed an orientation was completed within twenty-four hours of each youth's admission to the program. Case notes documented the date and time of the orientation, the youth receiving orientation documents, the handbook and introduction to the program staff, and tour of the facility. Orientation included the program 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 facility dress code.

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 regarding entry of medical, mental health, and suicide risk alerts into the Juvenile Justice Information System (JJIS). In addition, the program enters information on environmental stressors into the program logbook for all staff to review each day. This information is gathered by staff from the local weather advisory and includes heat index, likely precipitation, and high/low temperatures. All alert and environmental information is discussed at daily staffing meetings

Three youth records reviewed were applicable for alerts for medical issues and each were entered into the program's internal alert system upon staff learning of the chronic medical conditions. In each of the three applicable records reviewed, the youth were applicable for a suicide risk alert and each was entered in the internal alert system and 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 each of the three applicable records reviewed, a mental health alert was entered in JJIS and the internal alert system due to the youth being identified as having a mental disorder or acute emotional distress.

Five staff were interviewed on how they are informed of the youth's medical alerts. Four staff responded there is an alert book/medical alert binder which is reviewed often and located in the case manager's office. One staff indicated after every intake a print out of all medical alerts are placed in the binder which is reviewed and signed by staff. Two staff indicated after each intake is completed, the case manager will place the alert in the binder. The team is then verbally informed to review the medical binder when a new youth arrives or changes occur. One staff reported information is received while conducting or sitting in on an intake and through review and signing of the medical alert book.

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.	

Seven youth records were reviewed and six had the Positive Achievement Change Tool (PACT) full assessment completed by program staff within the first seven calendar days of admission. In one record, the PACT was completed four days late. The program stated this was due to an oversight.

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 receive referrals for youth prior to their discharge from a residential 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.	

Seven youth records were reviewed and the Positive Achievement Change Tool (PACT) full assessment was completed prior to the development of the initial Youth Empowered Success (YES) plan for each youth. The initial YES plan was developed and signed by all parties within fourteen days of the youth's admission to the program. Case notes clearly documented the youth, parent/guardian, and case manager were involved in the development of action steps and target dates for the completion of all sanctions and goals on the YES plan. The program also documented the parent/guardian and youth were informed 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. Seven youth were interviewed and indicated they participated in the development of the YES plan and received a copy.

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).	

Seven youth records were reviewed and each youth's court ordered sanctions were documented in the Juvenile Justice Information System (JJIS) youth requirements module. Each record 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 for each requirement. In each of the records reviewed, one of the top three criminogenic needs was created into a change goal 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 was completed. All youth requirements were included on the Youth Empowered Success (YES) plan and contained reasonable projected completion dates. Seven youth were interviewed if they were aware of the YES plan goals they were working on. Three youth stated they did not remember and four youth provided some of the goals they were working on 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.	

A review of the case notes of all seven youth records demonstrated compliance with youth, parent/guardian, and staff action steps contained in the Youth Empowered Success (YES) plan. In five youth records there was clear documentation of written and verbal reports being reviewed by the staff. Two records were not applicable. Case notes reviewed clearly demonstrated regular and quality contact with the youth and parent/guardian, documentation of all activities including face to face and telephone interactions with youth, parent/guardian, and providers.

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.	

Five of the seven youth records reviewed were applicable for ninety day updates to the youth's Youth Empowered Success (YES) Plan. In all five records reviewed, staff made the necessary updates to the youth requirements and change goals in the Juvenile Justice Information System (JJIS). A new YES plan was generated prior to the ninety day supervisory review. All updates requiring the input of the youth and parent/guardian were discussed and clearly documented in the case notes.

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.	

Five of the seven youth records reviewed were applicable for ninety day supervisory reviews of the youth's Youth Empowered Success (YES) Plan. In all five records reviewed, the supervisor conducted a review at least once every ninety days. The supervisor ensured the case manager updated the youth requirements and change goals in the Juvenile Justice Information System (JJIS). The youth was receiving appropriate supervision and interventions prior to the

supervisory review. Staff documented a review of the supervisory note and took appropriate action, when required.

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.	

Five of the seven youth open records reviewed were applicable for a Positive Achievement Change Tool (PACT) re-assessment. Three additional closed records were reviewed. In all applicable records the PACT full assessment was completed every 180 days. In the three closed records the PACT final assessment was also completed prior to program completion to document the youth's progress in meeting the criminogenic needs and court ordered sanctions. All three closed records had exit PACTs completed within fourteen days of the youth's release 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.	

All seven youth records reviewed had progress reports completed monthly. All reports included a cover letter and provided a brief description of the youth's overall performance and any extraordinary information about the youth. Youth were given the opportunity to review and provide comments. The reports were signed and dated by the youth and staff and reviewed and signed by the program director. In five of the seven records, the youth was on probation and the progress report was sent to the juvenile probation officer (JPO). In two of the records, the youth were on minimum risk commitment and copies of the progress report were forwarded to the JPO, state attorney (SA), youth's attorney, youth, and parent/guardian.

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; 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. For all three youth, a termination was recommended due to the youth completing all requirements. The juvenile probation officer (JPO) conducted a check for active warrants. The JPO is responsible for submitting all documentation requesting termination to the court. None of the records reviewed had a loss of jurisdiction; however, in such cases it is the responsibility of the JPO to complete all notifications and the required paperwork. The program will release the youth from their 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 has a policy and procedures implementing career education to include communication, interpersonal, and decision-making skills. The program Type 2 career education. All youth are offered career education while attending the program. Program staff stated the program did not have youth who had employability as one of their goals since the last annual compliance review; therefore, the program was not required to include documents facilitating employability in the youth records.

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 education services to 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 program's policy and procedures address the requirements of the clinical coordinator . The program has a clinical coordinator on staff responsible for coordinating and verifying implementation of necessary and appropriate mental health and substance abuse services to youth. The clinical coordinator holds credentials as a licensed mental health counselor (LMHC). Program interviews confirmed the clinical coordinator is an employee of the program. The clinical coordinator's job description includes essential functions such as maintain current licensure, provide mental health and or substance abuse assessments and treatment services, assess youth identified with suicide risk factors, conduct crisis assessments, and emergency mental health and/or substance abuse Baker Act proceedings for clinically indicated youth. Additional treatment services include individual and group counseling sessions, treatment and discharge planning, and associated documentation to support provision of services. The job description was signed by the incumbent on July 6, 2017 and the clinical supervisor July 7, 2017.

A review of sign-in sheets indicated the clinical coordinator was on-site once a week during the annual compliance review period. The sign-in sheets also revealed the coordinator was usually on-site Monday's, Thursday's, and varying times on Friday. The hours documented were usually between 10:00 a.m. to 6:00 p.m. with variations providing a sufficient amount of time to complete the necessary and appropriate services.
Staff interviews confirmed the clinical coordinator provides intake, assessment of suicide precautions, mental health and substance abuse evaluations, initial and individualized treatment and discharge plans, individual and group counseling, and when needed crisis counseling and interventions.

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 licensed clinical staff which is the clinical coordinator . The clinical coordinator holds a clear and active license as a licensed mental health counselor (LMHC) with the Department of Health, Bureau of Medical Quality Assurance and is a qualified supervisor for mental health counselors. The clinical coordinator license expiration date is March 31, 2021. In

addition, the clinical coordinator also holds credentials with the Florida Certification Board as a Certified Addictions Professional (CAP). The CAP credentials are valid through June 30, 2019.

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 address the requirements of non-licensed mental health and substance abuse counselors. The procedures indicate the program only utilizes licensed clinicians to provide services for mental health and substance abuse applicable youth; however, if the program chose to utilize non-licensed staff in the future the procedures also require staff hold the educational and pre-service experience required by the Department and for the licensed clinical coordinator to provide weekly supervision of non-licensed mental health and substance abuse clinical staff.

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 a policy and procedures to address the process of mental health and substance screening upon each youth's admission utilizing the Positive Achievement Change Tool (PACT), mental health and substance abuse report, and the Massachusetts Youth Screening Instrument, Second Version (MAYSI-2). A review of seven youth mental health records contained documentation the youth were screened upon admission with the MAYSI-2 and PACT. The MAYSI-2 screenings were administered by trained staff. The staff reviewed each youth information upon admission to assist in the screening process. The program provides mental health and substance abuse groups and individual sessions, new comprehensive evaluations, and psychosocial skills training. The program refers youth to outside agencies for extensive mental health services. In two of the seven youth records reviewed, the youth required an Assessment of Suicide Risk (ASR) based on the mental health and substance abuse screening. An additional record was provided for review. All three ASR's were completed on the day of admission after a referral was submitted by staff, the youth placed on precautionary observation, an alert entered in the juvenile justice information system (JJIS), and the program coordinator was notified.

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 to address the process of comprehensive evaluations for applicable youth entering the program. Seven youth mental health records were reviewed were two were applicable for a comprehensive evaluation. One additional youth record was provided for review. All three youth received a new comprehensive evaluation within thirty days of admission by the program's clinical coordinator. The mental health and substance abuse comprehensive evaluations included all required elements.

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 a policy and procedures to address the process of treatment being provided to all youth entering the program, if applicable. Upon admission, all seven youth were assigned to a treatment team to include the youth, parent/guardian (when allowable), clinical coordinator , case management, and program coordinator. All seven youth signed a substance abuse consent and release form upon admission. Two youth were applicable for substance abuse group and individual counseling One additional record was reviewed. All treatment progress notes were documented on the Department's form which included all requirements. There were no youth applicable for mental health services. Youth requiring services were referred to an outside agency.

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 a policy and procedures to address how treatment and discharge plans are to be completed for applicable youth entering the program. There were no youth applicable for an initial treatment plan at the time of admission; however, three youth required treatment planning following positive drug screens subsequent to their admission. Each of the three applicable

youth received an initial treatment plan as required and reviewed. Both youth signed and dated their initial and individualized mental health and substance abuse plans. The plans were signed by the clinical coordinator within ten days of completion. The treatment plans were reviewed every thirty days which was documented on the required Department form. Three closed youth mental health records were reviewed for discharge plans. All three youth records contained a discharge plan was completed at the exit meeting and the treatment team which included the clinical coordinator did not have recommendations for services. The youth was only discharged from treatment but not the program. The plan was discussed with the youth, parent/guardian and juvenile probation office (JPO) at the exit meeting. There were no youth on suicide precautions at the time of their discharge. The program provided a copy of the plan to the youth, parent/guardian, and JPO.

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's policy and procedures address the requirements of crisis interventions. The crisis intervention and assessment process included notification and alert, referral including self-referral and assessment, communication, supervision, and documentation and review. The mental health crisis intervention plan was signed and reviewed on August 1, 2018 by the 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.	

An interview with program staff and the clinical coordinator indicated the program did not have instances which required a crisis assessment or intervention during the annual compliance review period. The program has a process which includes youth presenting in a crisis situation are referred to the clinical coordinator for a crisis assessment and associated monitoring on mental health supervision until the assessment is completed. Procedures include staff will utilize the Department's sample form when performing a crisis assessment. A review of seven youth mental health records did not reveal crisis assessments were completed or situations which would have required a completion of a crisis assessment.

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's policy and procedures address the requirements for emergency mental health and substance abuse services. Procedures include immediate staff response, notifications, communication, supervision of youth, authorization to transport for emergency services, documentation, training including mock drills, and review process. The emergency mental health and substance abuse services procedures were reviewed and approved on August 1, 2018 by the director of day treatment services. An update was made to the How-to-Guide in September 2018 and all program staff were trained in the changes and signed a record of staff training and review on September 16, 2018.

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 or Marchman Acts 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 policy and procedures for the process of youth receiving suicide prevention services. Seven youth mental health records were reviewed and two youth were applicable for services. An additional record was reviewed. All three youth were placed on precautionary observation during the admission screening. Each record contained a referral for Assessment of Suicide Risk (ASR). All three youth were placed on precautionary observation due to an identified risk. The staff identified designated safe housing/observation areas within the facility. The facility does not have cells; therefore, the program does not use secure observation. The staff entered an alert in the Juvenile Justice Information System. The clinical coordinator provided supportive services and completed the ASRs in each youth's record. The clinical coordinator and the program coordinator held a conference to reduce level of supervision. None of the youth required a follow-up. Each youth was stepped down to standard supervision. The program did not have any off-site ASRs.

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 outlining the process of completion of suicide precaution observation logs. Three suicide precaution observation logs were reviewed. Each of the logs were signed by the shift supervisor and clinical coordinator. The checks were completed in thirty minute intervals for each log in real time.

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 policies and procedures in place to provide services under the suicide prevention plan. A review of the suicide prevention plan revealed it contained all required elements including identification and assessment, staff training, suicide precautions, levels of supervision, referral, communication, notification, documentation, immediate staff response and review process. The suicide prevention plan received an annual review on July 30, 2018 by the director of day treatment services.

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 policies and procedures in place to provide suicide prevention training. The program completed four emergency services drills, two of which involved a youth attempted suicide. Each drill documented staff involved and an administrator review. Four staff participated in all four mock emergency drills and three staff participated in three drills. The review team was unable to read the name of one staff participating in one drill.

Five staff were interviewed regarding their responsibilities in responding to youth expressing suicidal thoughts. All five indicated they would place the youth on constant sight and sound supervision. Four staff included they would notify the supervisor and parent/guardian, search the youth for sharp objects, document youth supervision, or some other action if a youth expressed suicidal thoughts. Other staff listed actions included communication between staff, contact the therapist, start the precautionary observation log, and send the referral to the clinical coordinator. Five staff were interviewed regarding the location of the knife for life. Each of the five staff identified the location as a file cabinet in the program coordinator’s office.

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.	

In all seven youth individual healthcare records (IHCR) reviewed, the youth was screened on the day of admission to determine if a condition requiring medical care existed to be addressed while in the program. The parent/guardian was present to address concerns or questions regarding medical conditions and all medical. Mental health and substance abuse information was documented in the IHCR. In one IHCR, the youth required an albuterol inhaler but a letter indicating the parent/guardian did not provide the program with the medication nor stated the youth did not need the medication was maintained in the IHCR. There were no youth admitted from a commitment program, but were on probation; therefore, none were applicable to have the health discharge summary or medication receipt disposition reports reviewed.

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 stating only medication management trained staff will accept prescribed medication from the parent/guardian. The program advised none of the youth are taking any medications while on-site, and they have not had any youth during the annual compliance review period. Seven youth records were reviewed for verification of medications. All seven youth were screened to determine their medication regimen. The program maintains Medication Distribution Log forms (MDL) in case a youth will be receiving medication while on-site.

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 procedures stating a licensed healthcare practitioner will train staff in the delivery of medications. Trained staff will adhere to the Five Rights of Medication Administration. None of the staff are allowed to administer medications. The trained staff are not permitted to perform other duties while supervising youth during self-administration. Youth have the right to approach staff and request medication at the designated dosage time or when needed.

All five staff were trained in assisting with self-administration of medication. During the annual compliance review, there were no distribution of medication to youth while on-site; therefore, the medication distribution log did not document delivery of medication. The program has a

medication distribution logbook which can be utilized and contains the staff training and log if a youth is in need of medication while on-site.

Five staff were interviewed and indicated they are all trained in assisting with self-administration of medication but have not had to do so. The staff stated they are informed through the alert binder regarding youth medical alerts. During the intake process information is received and placed in the binder including medication side effects. All seven youth indicated they do not take 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 policy and procedures indicating all medication is stored in a secured location behind two locks. The policy 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. This process is followed when medication is on-site. The program did not had any medications on-site during the annual compliance review period. The program maintains an area where medication is stored which is located in the program director's office file cabinet. The area is kept clean and free from moisture and extreme temperatures. There is a small lock box which is designated for youth medications inside of the file cabinet, as well as a refrigerator which was empty during the 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 policy and procedures indicating a comprehensive process for the provision of emergency care including current training of all direct care staff in the use of knife-for-life and automated external defibrillator (AED), if available.

The program did not have any documented episodic/emergency care since the last annual compliance review. The program maintains one first aid kit and one suicide response kit which both are located in the program director's office in a file cabinet. 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 kit validated it contained the required items, all being within the expiration date. The program does not have an AED on-site. The program coordinator conducts weekly checks of the knife-for-life and first aid kit utilizing the weekly safety and sanitation checklist to document the review. The emergency numbers are located in the staff's offices inaccessible to the youth. The program coordinator is responsible to provide information to the staff for potential emergency situations through group texts, emails, and meetings. In the event a death or serious adverse medical event should occur, a root-cause analysis would be conducted on the leadership level and then the program would be informed as to what could have been done differently if applicable. There were no death or serious adverse medical incidents occurred since the last annual compliance review. The program conducted 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 staff participating in the drill. The emergency medical drill included the demonstration of cardiopulmonary resuscitation (CPR).

Program Name: Paxen Polk
Provider Name: Paxen Learning Corporation
Location: Polk County / Circuit 10
Review Date(s): May 21 - 22, 2019

MQI Program Code: 6041
Contract Number: P2120
Number of Beds: 40
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.