STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF QUALITY ASSURANCE
PROGRAM REPORT FOR

Residential Alternative for the Mentally Challenged
Twin Oaks Juvenile Development, Inc.
(Contract Provider)
742 SW Greenville Hills Road
Greenville, FL 32321

Review Date(s): July 13 - 15, 2010

PROMOTING CONTINUOUS IMPROVEMENT AND ACCOUNTABILITY
IN JUVENILE JUSTICE PROGRAMS AND SERVICES

FRANK PETERMAN, JR., SECRETARY
JEFF WENHOLD, BUREAU CHIEF
# Residential Performance Rating Profile

**Program Name:** Residential Alternative for the Mentally Challenged  
**QA Program Code:** 1085  
**Provider Name:** Twin Oaks Juvenile Development, Inc.  
**Contract Number:** B8D04  
**County/Circuit #:** Madison/Three  
**Number of Beds:** 48  
**Review Date(s):** July 13 - 15, 2010  
**Lead Reviewer Code:** 98

## Program Performance by Indicator/Standard

<table>
<thead>
<tr>
<th>Standard</th>
<th>Program Score</th>
<th>Max. Score</th>
<th>Rating %</th>
<th>Failed 0-59%</th>
<th>Minimal 60-69%</th>
<th>Acceptable 70-79%</th>
<th>Commendable 80-89%</th>
<th>Exceptional 90-100%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Management Accountability</td>
<td>64</td>
<td>90</td>
<td>71%</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>2. Intervention and Case Management</td>
<td>63</td>
<td>90</td>
<td>70%</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>3. Mental Health and Substance Abuse Services</td>
<td>53</td>
<td>80</td>
<td>66%</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
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<tr>
<td>4. Health Services</td>
<td>101</td>
<td>110</td>
<td>92%</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Safety and Security</td>
<td>64</td>
<td>90</td>
<td>71%</td>
<td>X</td>
<td>X</td>
<td>X</td>
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## Overall Program Performance

**ACCEPTABLE 75%**
Methodology

This review was conducted in accordance with Florida Administrative Code 63L-2 (Quality Assurance, 6/10/10 Hearing Draft), and focused on the areas of (1) Management Accountability, (2) Intervention and Case Management, (3) Mental Health and Substance Abuse Services, (4) Health Services, and (5) Safety and Security, which are included in the Residential Standards (July 2010).

Persons Interviewed

- Program Director
- DJJ Monitor
- DHA or designee
- DMHA or designee

2 # Case Managers
2 # Clinical Staff
6 # Food Service Personnel
2 # Healthcare Staff

1 # Maintenance Personnel
3 # Program Supervisors
____ # Other (listed by title): ____

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
- Health Records
- MH/SA Records
- Personnel Records
- Training Records/CORE
- Youth Records (Closed)
- Youth Records (Open)

7 # Other:

Surveys

7 # Youth
7 # Direct Care Staff
____ # 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.
Performance Ratings

Performance ratings were assigned to each indicator by the review team using the following definitions and numerical values defined by F.A.C. 63L-2.002(10)(a) (6/10/10 Hearing Draft):

<table>
<thead>
<tr>
<th>Rating</th>
<th>Description</th>
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<tbody>
<tr>
<td>Exceptional (10)</td>
<td>The program consistently meets all requirements, and a majority of the time exceeds most of the requirements, using either an innovative approach or exceptional performance that is efficient, effective, and readily apparent.</td>
</tr>
<tr>
<td>Commendable (8)</td>
<td>The program consistently meets all requirements without exception, or the program has not performed the activity being rated during the review period and exceeds procedural requirements and demonstrates the capacity to fulfill those requirements.</td>
</tr>
<tr>
<td>Acceptable (7)</td>
<td>The program consistently meets requirements, although a limited number of exceptions occur that are unrelated to the safety, security, or health of youth, or the program has not performed the activity being rated during the review period and meets all procedural requirements and demonstrates the capacity to fulfill those requirements.</td>
</tr>
<tr>
<td>Minimal (5)</td>
<td>The program does not meet requirements, including at least one of the following: an exception that jeopardizes the safety, security, or health of youth; frequent exceptions unrelated to the safety, security, or health of youth; or ineffective completion of the items, documents, or actions necessary to meet requirements.</td>
</tr>
<tr>
<td>Failed (0)</td>
<td>The items, documentation, or actions necessary to accomplish requirements are missing or are done so poorly that they do not constitute compliance with requirements, or there are frequent exceptions that jeopardize the safety, security, or health of youth.</td>
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</tbody>
</table>

Review Team

The Bureau of Quality Assurance 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:

Katina Horner, Lead Review Specialist, DJJ Bureau of Quality Assurance
Angela Forshee, Review Specialist, DJJ Bureau of Quality Assurance
Sharon Sykes, Technical Assistance Specialist, Office of Program Accountability
Sion Doman, Program Monitor, Office of Residential Services
Jacki Malone, Quality Improvement Specialist, Eckerd Youth Alternatives
Katrina Armstead, Restorative Justice Coordinator, Panther Success Center
Overview

Residential Alternative for the Mental Challenged (RAMC) is a forty-eight bed, staff secure program located on the Twin Oaks Vocational Academy campus. The program is operated by Twin Oaks Incorporated. RAMC shares administrative staff with Twin Oaks Vocational Academy. The management team consists of an executive director, three program directors, clinical director, chaplain, office manager, principal, training coordinator and personnel manager. The program serves youth who have been diagnosed with an I.Q. in the range of 40-69, have mild to moderate mental retardation and have corresponding adaptive skills deficit. The average length of stay is nine to twelve months.

The training coordinator is responsible for entering the training information into the DJJ CORE system for all Twin Oaks programs, which includes 249 employees. The training coordinator also facilitates trainings as well as manages and updates training calendars and training plans.

The facility maintains cottage logbooks for the three cottages on campus and a supervisor logbook is maintained as well. Shift reports are completed daily and e-mailed to the corporate office nightly. The program has several Central Communication Center (CCC) reports pending resolution.

1.01: Background Screening of Employees/Volunteers

- Six staff were applicable for five-year re-screenings. All six were past due. The requests for re-screens were submitted the first day the review team was on site.

1.02: Provision of an Abuse Free Environment

- There has been one substantiated report of unnecessary force during the review period. The staff member involved was suspended.
- A majority of seven youth surveyed reported staff use profanity. Two of seven said they were denied an abuse call. These two youth were interviewed separately and provided an opportunity to call the abuse hotline. Only one youth still wanted to and did call the abuse hotline.
1.03: Incident Reporting  Commendable (8)

- The program consistently met all requirements for this indicator without exception.

1.04: Protective Action Response (PAR)  Acceptable (7)

- Ten reports were reviewed. One report was missing a staff written statement.
- The program uses a post Protective Action Response (PAR) questionnaire. In a few cases, it was not filled out completely or was missing a page. A few of the reports had one to two “yes” or “no” boxes that were not checked.

1.05: Pre-Service/Certification Requirements  Commendable (8)

- The program consistently met all requirements for this indicator without exception.

1.06: In-Service Training Requirements  Acceptable (7)

- The program is on a corrective action plan from June 8, 2010 for not completing specialized training. The program has since trained most of the staff on the specialized training, using a power point presentation on the Title V, Americans with Disabilities Act.
- Three staff had suicide training, but not totaling the required six hours.

1.07: Logbook Maintenance  Acceptable (7)

- Two of the cottage logbooks were missing the hard covers on the front and back. One cottage logbook was missing the back hard cover.
- There were three loose pages. On two of these pages, the date could not be determined, as the pages were torn.

1.08: Internal Alert System  Acceptable (7)

- There were minor discrepancies between the Juvenile Justice Information System (JJIS) alerts and the program alerts.

1.09: Escapes  Commendable (8)

- The program consistently met all requirements for this indicator without exception.

**Standard 2: Intervention and Case Management**
Overview

Oversight of case management services is the responsibility of the clinical director. The program employs three case managers, who are responsible for initial classification, assessments, performance plan development, monthly performance summaries, and transitional planning.

Formal treatment team reviews are conducted monthly; the case managers are the treatment team leaders. The case managers facilitate educational groups. During formal treatment team reviews, the youth complete a survey and self-report. Additionally, during formal reviews, the mental health department provides a written overview of the youth’s performance. Parent participation during bi-weekly reviews was evident. The case managers also provide supportive counseling to youth and parents.

The program utilizes both the Positive Achievement Change Tool (PACT) at admission and the Residential-Positive Achievement Change Tool (R-PACT) for re-assessments. Youth have access to weekly visitation, telephone calls and religious activities. There is a grievance system in place for the youth as well. Staff had been trained on the program’s grievance process.

2.01: Classification
Acceptable (7)

- Some of the classification forms reviewed were incomplete. The reason for assigning room placement was often noted as “new youth”.
- There was no indication whether youth were placed in a single room or in a room with a youth of similar age or physical characteristics.
- Three classification forms were completed the day after the youth’s arrival and one classification form was dated the day before the youth’s arrival.

2.02: Assessment
Acceptable (7)

- One Residential Positive Achievement Change Tool (R-PACT) assessment was not completed within the required time frame.
- Four files were applicable for R-PACT re-assessments and three were completed more than ninety days after the initial R-PACT.

2.03: Intervention and Treatment Team
Acceptable (7)

- Two files did not document bi-weekly reviews as required. One youth’s file only had two reviews, one formal and one informal.
- The internal forms used by the case managers did not provide a narrative of the youth’s progress.

2.04: Performance Plan
Acceptable (7)

- One youth’s performance plan was not completed within thirty days of admission.
- One file noted all performance plans goals as complete, and there were no revisions or a transition plan for the youth.
- One of the seven plans reviewed included transitional goals.
2.05: Performance Review and Reporting  
Minimal (5)

- The program is completing summaries every thirty days after youth’s arrival; however, it is not at the committing Judge’s request.
- The summaries did not clearly report the youth’s progress. The level of motivation to change was not addressed in any of the files reviewed. In three files, interaction with peers was not addressed.
- Three closed files were reviewed for release summary requirements. The release summaries did not document justification for release in any of the three cases.

2.06: Parent/Guardian Communication  
Commendable (8)

- The program consistently met all requirements for this indicator without exception.

2.07: Transition Planning and Release  
Acceptable (7)

- Three closed files were reviewed for transition planning and release. One file did not contain exit staffing documentation.
- Two applicable files did not contain notification of the youth’s release to the victim(s).

2.08: Grievance Process  
Acceptable (7)

- Seven youth were surveyed and four said they have filed a grievance before. Two youth rated the system as poor and one said it was very poor.

2.09: Gang Prevention and Intervention  
Commendable (8)

- The program consistently met all requirements for this indicator without exception.

Standard 3: Mental Health and Substance Abuse Services

Overview

The program has a Designated Mental Health Authority (DMHA) identified in writing, who is also the program’s Clinical Director. The DMHA is a Licensed Mental Health Counselor (LMHC) employed full-time by the provider. The DMHA was recently hired on April 15, 2010. The DMHA is on-call twenty-four hours a day, seven days a week and provides weekly clinical supervision for four unlicensed therapists. Observations of a supervision meeting and documentation reviewed found that a sample of work is reviewed and directions, instructions, and recommendations regarding services are provided. The program also contracts with a licensed
Psychologist to provide clinical services, including testing, evaluation, and intervention; this contract has been in place since June 25, 2010.

The program uses the Massachusetts Youth Screening Instrument, Version 2 (MAYSI-2) to screen youth upon admission to the program. According to program policy and practice, a Clinical Counselor assesses each youth within twenty-four hours of admission. All youth, regardless of hits on initial screenings, are formally referred for further assessment using an Assessment of Suicide Risk (ASR) form. Clinical staff complete ASRs in consultation with the DMHA. Additional documentation verified all clinical staff had been trained by the DMHA to conduct ASRs, with each completing at least twenty hours of training and five co-assisted assessments, as required.

The program uses three instruments to conduct a new in-depth assessment of each youth: a Biopsychosocial Assessment, a Substance Abuse Assessment, and an Interpretive Summary. All were completed within twenty-five days of admission and signed by the DMHA as a reviewer within three days of completion.

According to the program’s contract, specialized services to be provided include Mental Health Overlay Services (MHOS) and Developmental Disability Services. The MHOS funding is included in the per diem; the program does not have to prepare separate documentation or invoices for the MHOS funding. Interviews with various program staff, including the executive director, the program director, and the DMHA, found ambiguity regarding the requirement for MHOS services. Although, a review of youth files, interviews with youth and clinical staff, and observations of groups found that the program is, in fact, providing services that meet MHOS criteria.

3.01: Designated Mental Health Authority (DJJ Program) 
Commendable (8)

- The program consistently met all requirements for this indicator without exception.

3.02: Mental Health and Substance Abuse Admission Screening 
Acceptable (7)

- The Case Managers are responsible for administering the Massachusetts Youth Screening Instrument, Version 2 (MAYSI-2). Of the seven files reviewed, three different Case Managers completed the screenings. Documentation of training was not provided for one of them; this person is no longer employed with the program.
- Of the seven MAYSI-2s reviewed, two were completed the day after admission one was completed two days after admission.

3.03: Mental Health and Substance Abuse Assessment/Evaluation 
Commendable (8)

- The program consistently met all requirements for this indicator without exception.

3.04: Treatment Plan, Treatment Team, and Service Delivery 
Minimal (5)

- In three cases for youth who had been admitted on psychotropic medications, there were no pharmacological interventions specified on the plans.
• In three cases, youth who were prescribed psychotropic medication during their stay at the program did not have any pharmacological interventions identified on their plans. Following the prescription, in all cases, an addendum was added to identify the pharmacological intervention between two to five months after the fact.
• Clinical progress notes documenting the initial treatment planning process were not present in two of the seven files reviewed.
• One file did not contain the required number of reviews. In four cases, reviews were not conducted at least every thirty days.
• Only one of seven treatment plans reviewed contained a parent signature. Documented ongoing efforts to obtain parent signatures were not present.
• Pertaining to language used in treatment plan documents, specifically as it relates to comprehension of content by developmentally disabled youth, a review of monitoring summaries completed at the program found that over forty percent of youth did not understand language contained in their treatment plans.
• Some plans and progress notes were vague and included incomplete sentences.

3.05: Suicide Prevention

| Minimal (5) |

• The program’s tracking system did not provide information regarding the proper implementation of precautions or staff training needs, as required.
• Logbook documentation did not contain details of findings and recommendations of ASRs administered.
• JJIS alerts for youth on suicide precautions were not entered in a timely manner, often done several days after the fact.
• Five instances of youth who had been placed on suicide precautions were reviewed. Follow-Up ASRs were done randomly rather than at a fixed frequency. There were cases in which no follow-up assessment was completed, even for youth with documented warning signs.
• It was also noted that crisis assessment forms were sometimes completed rather than follow-up ASR forms.
• Notification to parents/guardians and Juvenile Probation Officers (JPO) were not consistently documented. The JPO was not notified in any of the cases; the parent was not contacted in three cases.
• A review of time logs for youth on suicide precautions found there was no documented designation of safe housing areas or activities. It was also noted that staff using the forms often did not use an ‘am’ and ‘pm’ notation or military time to clearly identify time of day.
• The contents of the suicide prevention kits were not limited to the required items (knife-for-life, wire cutters, and needle-nosed pliers). Various items, including screw drivers, soap, scissors, goggles, plastic bags, gauze, mothballs, and loose screws and bolts were all found inside the kits.
• When observed, none of the kits were found sealed when not in use, nor were they inventoried once the seal was broken. Kits were not kept in an easily accessible location; they were kept in a bag inside of a locked cabinet, inside of a locked office, inside of locked cottages. No kits were kept in any other location on-site other than the cottages. It was also noted that the key to the locked cabinet in each cottage was kept in a soap dish on top of each cabinet.
• Suicide drills did not present a mock emergency scenario using youth to gauge staff response, but was limited to an imagined situation in all instances. Staff participating in the drills were not identified, nor was response time, actions, and other details.

3.06: Mental Health Crisis Intervention

Acceptable (7)

• There were some delays in this process. Documentation reviewed for one case showed a youth was referred by medical staff following reports of visual and auditory hallucinations. There was no follow-up done for over fourteen hours, at which time the DMHA ordered an assessment to be conducted.
• Notification to parents/guardians and JPOs were not consistently documented.

3.07: Emergency Services

Commendable (8)

• The program consistently met all requirements for this indicator without exception.

3.08: Specialized Treatment Services

Minimal (5)

• The program is not consistently meeting contractual or clinical requirements for services for developmentally disabled clients. The program did not have a licensed psychologist or Certified Behavioral Analyst from February 2010 to June 2010.
• It was also found that the program did not adhere to the 1:10 clinical staff to caseload ratio required by the DJJ Mental Health and Substance Abuse Services Manual (Appendix W, page 4). At the time of the review clinical staff had caseloads of up to 14 youth.
• It was also found that youth handbooks, treatment plans, and other program materials were not written using language or terminology to facilitate youth comprehension.

Standard 4: Health Services

Overview

The program contracts with a Pediatrician to serve as the Designated Health Authority (DHA). The DHA is responsible for oversight of all healthcare at the program, which is monitored by a collaborative health team. A licensed Advanced Registered Nurse Practitioner (ARNP) is employed full time by the facility and serves as the designee for the DHA. The DHA is on-site once per week; hours are determined by clinic needs. The ARNP supervises a staff of seven, which includes two Registered Nurses (RN), three full-time Licensed Practical Nurses (LPN), one part-time LPN, and a clinic coordinator. The program maintains independent contracts with Premier Medical Services in Perry (a walk-in clinic and the DHA’s practice) and a dentist. The ARNP is a Certified Correctional Health Professional. The nursing staff is shared between the three Twin Oaks Vocational Academy programs. RAMC has nursing staff on site seven days a
week. The addition of the clinic coordinator has increased the medical staff’s ability to track all medical care, parental notifications, and ensure that alerts are updated and entered into JJIS.

The DHA is on-site weekly to conduct record reviews, chronic healthcare follow-ups, acute condition evaluations and administrative duties as needed. The ARNP is on site five to six days per week and performs comprehensive physical assessments, periodic evaluations, sick call/acute need evaluations, and other procedures deemed within the scope of practice as outlined through a collaborative agreement with the DHA. The nursing staff perform facility entry physical health screens, review health related histories, administer medications, provide daily sick call, and administer episodic and emergency care within the nursing scope of practice. In addition, nursing staff provide health care education to all youth upon admission and as needs arise.

The program has obtained a Class II-B Pharmacy license (3/25/10) and employs a full time pharmacist, who provides oversight to medication dispensing, administration, inventories, and disposal.

The program has a professional agreement with the Taylor County Health Department for dental services.

### 4.01: Designated Health Authority

- The contract with the DHA describes his role, hours and service delivery. The program employs a full time licensed ARNP who has a collaborative agreement with the DHA to serve as his designee. The collaborative agreement specifies the ARNP’s role and service deliverables. On-call provisions were evident. The on-call system begins with the nurse on-call, then the DHA designee, then the DHA.
- The DHA is responsible, as is the DHA designee, for annual review of Health Services Operating Guidelines, the Exposure Control Plan, and treatment protocols.
- The ARNP has developed a user-friendly flow chart for medical protocols. The chart is written in very basic language for staff. The flow chart is accompanied by a training outline and power point.

### 4.02: Healthcare Admission Screening

- Youth are taken directly to the clinic upon arrival at the program for initial healthcare screenings. Youth do not join the general program population until the medical department has completed the initial screening process.
- File reviews showed Facility Entry Physical Health Screenings were completed by nursing staff on the day of admission. All youth were oriented to health care services upon admission as well.
- The Designated Health Authority is notified of all admissions. Any youth requiring further medical evaluation is seen by the ARNP or referred to the DHA during the next weekly visit.
- A system is in place to ensure that any youth needing emergency care is immediately transported to the Emergency Room (15 minutes away) or, if not life threatening, taken to Premier Medical Walk-In Clinic (30 minutes) for assessment.
- All medical records reviewed contained a single page synopsis of pertinent social, psychological and medical information that included medical alerts, heat index alerts and
medical orders. The synopsis is reviewed with the shift supervisor and direct care staff at the time of admission. Staff sign to acknowledge that they have received the information and a copy accompanies the youth to the cottage. Log books reviewed documented alerts, allergies, and medical orders as well.

### 4.03: Comprehensive Physical Assessment

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<th>Acceptable (7)</th>
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- In three of seven records reviewed, the Comprehensive Physical Assessment (CPA) was not dated properly, i.e. the DHA did not complete the date or miswrote the date. In one of the three files, a RN completed the CPA and the DHA signed over the RN’s signature and did not date the signature.

### 4.04: Sexually Transmitted Diseases

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<th>Exceptional (10)</th>
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- All youth are evaluated for sexually transmitted diseases upon admission. The evaluation is documented on the Facility Entry Level Health Care Screen, the Infectious and Communicable Disease Form, and in the chronological notes.
- If a youth declines further assessment, records reflected that the nursing staff will approach the youth again about repeating the evaluation once the youth has adjusted to the program. This is documented in the chronological notes and was evident in six of seven youth records reviewed.
- All youth are offered testing, counseling and linkage to services for HIV/AIDS. The program has a Certificate of Registration for the provision of counseling, testing and linkage services. The ARNP and one of the LPN’s are certified to provide counseling, testing and linkage (Florida 500 and 501 Course).
- Any testing provided to youth is maintained confidential. The results are placed in a sealed envelope with a signature across the seal and placed in the Individual Healthcare Record.
- The program maintains an arrangement with the Taylor County Department of Health for additional support if needed.

### 4.05: Sick Call

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<th>Commendable (8)</th>
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- The program consistently met all requirements for this indicator without exception.

### 4.06: Medication Administration

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<th>Commendable (8)</th>
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- The program consistently met all requirements for this indicator without exception.

### 4.07: Medication Control

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<th>Exceptional (10)</th>
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- Prescription medications are stored in a locked cabinet in a locked room (health clinic). Controlled substances are stored separately. Access to the health clinic is limited to the medical staff and director of the program. Informal interviews and shift supervisor reports showed only the medical staff have keys to the medical cabinets.
• Perpetual inventories of prescription medication are conducted daily during medication pass. Inventories are done shift-to-shift by the medical staff as well. Perpetual inventories with running balances are maintained on all controlled substances.
• Oral medications are stored separately from topical medications. Medications requiring refrigeration are stored in a secured refrigerator in the health clinic.
• Over-the-counter (OTC) medications are stored in a cabinet in the health clinic and are sorted by type. Liquids are stored on a separate shelf from creams and ointments. Only shift supervisors and medical staff administer OTC medications. Over-the-counter medications are placed by type in clear zip lock plastic bags and the count is recorded on the front. They are then stored in a locked cabinet in the shift supervisor office. There are no OTC medications stored on the living units. Shift supervisors complete an inventory at the end of each shift and document this on the shift supervisor inventory form. An email is sent to the DHA’s designee confirming the inventory numbers; the form is placed in the DHA designee’s mailbox for review and filing the next day.
• Documentation reflects that all Shift Supervisors have received training in medication administration.
• Syringes and sharps are counted whenever used, using perpetual inventory, as well as weekly by medical staff.
• The pharmacist provides signature accountability and ensures appropriate destruction and documentation when conducting medication and sharp disposal.
• There is a system in place for conducting the weekly inventory of prescription and OTC medications. Medical staff alternate inventory responsibility from event to event. The same person will not conduct the inventory two times in a row to ensure a quality check on inventories.
• Any discrepancy in the inventory results in an incident report to the DHA designee, who then investigates the discrepancy. Discrepancies are reported to the Risk, Health and Safety committee (Quality Improvement).
• Inventories were reviewed for consistency, accuracy and frequencies. All met requirements.

4.08: Infection Control

Commendable (8)

• The program consistently met all requirements for this indicator without exception.

4.09: Chronic Illness Treatment

Exceptional (10)

• Youth were identified with chronic conditions in six of seven files reviewed. Two of the youth were being treated for and abnormal body mass index (BMI). All youth with chronic conditions are seen by the DHA or DHA designee on a regular basis – the frequency is based on the status of the condition or established medical protocols.
• In all applicable records reviewed, youth were seen frequently but not less than one time per three months. Chronic illnesses are tracked on the sick call index log form, which provides identification of a chronic condition and prompts staff for follow-up and scheduling the next appointment.
• There were no lapses in care observed. All medical interventions and evaluations were documented on chronological notes.
• The ARNP has developed user-friendly flow charts for specific chronic conditions.
4.10: Episodic and Emergency Care  
Exceptional (10)

- The program has developed an episodic care template that ensures all requirements are documented. The form is completed by the medical staff and shift supervisors whenever episodic or emergency care is provided.
- A total of 27 episodic care events were compared against the Episodic Care Log; all were recorded. The log serves as a record and tracking tool to ensure follow up, parental notification and resolution.
- Emergency mock medical drills were conducted more frequently than required. The ARNP has developed emergency drill formats that identify a specific medical condition, the action steps involved in responding to that condition, and a critique of time frames. The staff involved in the drill identify the date, shift, location, and time that the mock medical event occurred as well as the symptoms the mock patient states or exhibits. The staff is required to number the action steps in the order that they accomplished them (the steps are scrambled on the form). The critique requires staff to fill in the times that significant responses/interventions occur. The medical staff then evaluate the medical response overall. Conditions addressed in the drills include, but are not limited to, cardiac arrest, hypoglycemic episode, broken bone, open head injury, and heat exhaustion. The drills are reviewed in Quality Improvement/Management meetings as well.

4.11: Consent and Notification  
Exceptional (10)

- All youth had a current authority for evaluation and treatment (AET) form signed by the parent and youth’s juvenile probation officer (JPO). If a youth is eighteen or older, the appropriate AET was on file.
- Procedures are in place to notify parents of changes in medications, medical conditions, and off-site events. Notification occurred by phone and in writing on all required incidences.
- Notification of general medical care is initiated upon the youth’s admission to the program. Any additional notifications are made by phone. A review of seven records revealed consistent documentation of verbal consents, requests for written consents, and follow-up when written consents are not returned.
- The initiation of psychotropic medication is accomplished through certified and regular mail. This has been a recent change due to parents not opening certified letters as a way of avoiding legal problems. The medical staff send out dual notices and have noticed an increase in receipt of written consents for psychotropic medications after doing so.
- Notifications and consents are documented on a parent notification form and in the medical chronological note. Updates/follow-ups are documented, initialed and dated on the original parent notification form and in the medical chronological note.

4.12: Prenatal/Neonatal Care  
Non-Applicable (NA)

- The program only serves male youth.
Standard 5: Safety and Security

Overview

The Director is responsible for oversight of safety and security provided at the program (tool management, flammable, poisonous and toxic items, and water safety). The program shares two maintenance specialists with another Twin Oaks program to meet the requirements of safety and physical plant areas. While the program has video surveillance, the quality, or lack thereof, limits the program’s ability to effectively utilize this system.

The program operates on two twelve hour shifts per day, from 6am – 6pm and 6pm – 6am. Staff communication is accomplished using two-way radios, shift meetings and logbooks maintained by the shift supervisors and individual cottages.

The program uses a token economy for its behavior management system. Youth earn good days with positive behavior and are awarded using a level system, point store and an opportunity to join the program’s student government once a certain level is obtained. Consequences are imposed by staff and reviewed by the youth’s treatment team. The program does not use room restriction, controlled observation, or maintain a behavior management unit.

5.01: Supervision of Youth

Acceptable (7)

- Logbooks reviewed did not document searches after outside recreation.
- The review team was unable to confirm, by video, if ten-minute bed checks were being conducted due to the lack of quality of the camera system in one of the cottages.

5.02: Key Control

Commendable (8)

- The program consistently met all requirements for this indicator without exception.

5.03: Contraband and Searches

Exceptional (10)

- The program has several systems in place.
- The facility grounds are searched three times per day.
- A contraband search of all rooms is completed almost daily for all cottages.
- Beginning at 10pm, an hourly perimeter check is completed by each cottage.
- Youth are frisk searched after meals, class, work detail, and groups.
- Youth are stripped searched after work detail on the Twin Oaks Vocational Academy campus and during the admission process. Strip searches are documented in the DOT logbook, supervisor logbook and on an internal form.
5.04: Transportation  
Acceptable (7)

- According to the Executive Director and a transporter, youth are sometimes transported in non-secured vehicles owned by the program.

5.05: Tool Management  
Acceptable (7)

- There was no documentation of risk assessments for youth who use tools (mops and brooms) on a regular basis. The risk assessments were completed when tools were used for DOT projects.

5.06: Disaster and Continuity of Operations Planning  
Acceptable (7)

- The program's Disaster and Continuity of Operations plan did not address specific procedures for fire, fire prevention and evacuation, severe weather, disturbance, riots, bomb threats, hostage situations, chemical spills, flooding and terrorist acts or threats.

5.07: Flammable, Poisonous, and Toxic Items  
Commendable (8)

- The program consistently met all requirements for this indicator without exception.

5.08: Water Safety  
Minimal (5)

- The swim tests provided by the program did not include a completed assessment of each applicable youth's swimming ability, as the section identifying the youth's swimming ability was left blank.

5.09: Behavior Management System  
Minimal (5)

- While the program’s behavior management system is clearly written, the description is not simple enough for the population served.
- During several staff and youth interviews, there appeared to be some confusion as to how the system works. According to statements made by the staff and youth, the system recently changed and the point store is now different than what is stated in the handbook and policy. The majority of youth and staff interviewed do not agree with how the system worked.

5.10: Behavior Management Unit  
Non-Applicable (NA)

- The program does not have a behavior management unit.

5.11: Controlled Observation  
Non-Applicable (NA)

- The program does not use controlled observation.
## Overall Program Performance

<table>
<thead>
<tr>
<th>Failed</th>
<th>Minimal</th>
<th>Acceptable</th>
<th>Commendable</th>
<th>Exceptional</th>
</tr>
</thead>
</table>

ACCEPTABLE  75%