Heidi W. Abbott, Chair
David R. Hines, Vice Chair
Karen Cooper-Collins, Secretary
Tyren Frazier
Michael N. Herring
Helivi L. Holland
Robyn Diehl McDougle
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COMMONWEALTH *of* VIRGINIA

Board of Juvenile Justice

DRAFT MEETING MINUTES

September 19, 2016

Main Street Centre
600 East Main Street, 12th Floor, Conference Room South
Richmond, Virginia 23219

Board Members Present: Heidi Abbott, Tyren Frazier, Michael Herring, Helivi Holland, Robyn McDougle

Board Members Absent: Karen Cooper-Collins, David Hines, Dana Schrad, Jennifer Woolard

Department of Juvenile Justice (Department) Staff Present: Ken Bailey, Andrew "Andy" K. Block, Jr., Jessica Berdichevsky (Attorney General's Office), Valerie Boykin, Patrick Bridge, Lisa Floyd, Daryl Francis, Wendy Hoffman, Jack Ledden, Margaret O'Shea (Attorney General's Office), Kristen Peterson, Deron Phipps, Janet Van Cuyk

Guests Present: Will Egen (Commission on Youth), Valerie Slater (Legal Aid Justice Center), Amy Woolard (Legal Aid Justice Center)

CALL TO ORDER
Chairperson Heidi Abbott called the meeting to order at 9:41 a.m.

INTRODUCTIONS
Chairperson Abbott welcomed all that were present and asked for introductions.

APPROVAL of June 15, 2016, MINUTES
The minutes of the June 15, 2016, Board meeting were provided for approval. On MOTION duly made by Helivi Holland and seconded by Robyn McDougle, the Board approved the minutes as presented. Motion carried.

PUBLIC COMMENT PERIOD
There was no public comment.

DIRECTOR'S CERTIFICATION ACTIONS
Ken Bailey, Certification Manager, Department

Included in the Board packet are the individual audit reports and a summary of the Director's certification actions completed on June 23, 2016.

Beaumont Juvenile Correctional Center (Beaumont JCC): Beaumont JCC had several deficiencies in its audit with three being critical regulatory requirements. The Certification Unit reported that at the last status visit to Beaumont JCC, all deficiencies had been corrected. The Director certified Beaumont JCC for three years.

Bon Air JCC: Bon Air JCC has been through a tremendous amount of change in the past three years with heavy staff turnover, including, but not limited to, superintendents and administrative staff, along with many programmatic changes. The audit found 16 deficiencies with 6 being critical regulatory requirements. The first monitoring visit reported deficiencies with one major critical regulatory requirement on staff not completing CPR training. The Certification Unit conducted a consultation visit with Bon Air JCC personnel. The visit included the superintendent of another juvenile facility, who reviewed Bon Air JCC's corrective action plan and provided advice regarding revisions and implementation of procedures. Bon Air JCC management received the information and made adjustments.

The latest Bon Air JCC monitoring report has been provided to the Board (attached to the notes). The critical regulatory requirements have been corrected and Bon Air JCC is in compliance. There are two minor deficiencies related to recordkeeping of room confinement forms. Since the monitoring visit, Bon Air JCC has changed the process and dedicated personnel to document and retain room confinement forms. In his certification actions, Director Block extended the certification status of Bon Air JCC until January 2017. The Certification Unit will perform monitoring visits every two months with the next visit scheduled in early October.

Chairperson Abbott asked the current status of Bon Air JCC.

Mr. Bailey responded that Bon Air JCC is in compliance and is a certified facility. Director Block extended the current certification of Bon Air JCC to January 2017. The Director will review the monitoring reports and a decision on the certification status of Bon Air JCC will be made in January 2017.

Chairperson Abbott asked what gives the Department assurance that Bon Air JCC is able to fix the problems knowing there are continued staff shortages and on-going transformation changes.

Jack Ledden, Deputy Director of Residential Services for the Department, responded that during his tenure with the Department, Bon Air JCC has had six Superintendents and no Assistant Superintendents. As the facilities changed from the correctional model to the community treatment model (CTM), Bon Air JCC had four out of five formerly titled captain positions missing and no employee to fill the role as the facility's formerly titled major position. Personnel who should have been monitoring areas were not present or in inactive positions. The Department has converted 15 of its 17 units to the CTM, and staff has stabilized. Bon Air JCC now has Resident Specialists I and II,

Community Managers, Community Coordinators, Assistant Superintendents, and a Superintendent that has been at Bon Air JCC for more than a year. Mr. Ledden believes that, with upper management stabilizing, Bon Air JCC will see a huge improvement.

Chairperson Abbott asked Mr. Bailey if he and his team are focused on Bon Air JCC's audits and compliance issues.

Mr. Bailey replied that his team is watching closely and, if issues arise, the Certification Unit will bring it directly to Deputy Director Ledden's and Director Block's attention for immediate action. Thus far, progress looks good.

Board Member Helivi Holland asked how many Assistant Superintendents are at Bon Air JCC.

Mr. Ledden replied that there is currently one Assistant Superintendent at Bon Air JCC. Bon Air will have two Assistant Superintendents under the current consolidation plan that includes the newly developed Operations' Manager and a Community Manager, which are similar to the position of Assistant Superintendent.

Crossroads Community Youth Home (Crossroads): The audit of Crossroads in Williamsburg found eleven deficiencies with three classified as critical regulatory requirements. The Certification Unit conducted monitoring visits wherein no critical violations found, and Crossroads was certified by Director Block for one year. The Certification Unit is working closely with Crossroads' new program director to provide her a better understanding of the regulatory and audit requirements.

Chairperson Abbott asked if the monitoring visits are always announced.

Mr. Bailey replied that, yes, the monitoring visits are announced in order for key staff to be present that day.

Director Block noted that, in situations like Crossroads, when issues are flagged, the Certification Unit increases monitoring and oversight. If a facility is decertified, then the youth are not able to stay at that facility, which could cause problems.

Mr. Bailey followed up by saying, ordinarily, the Certification Unit makes one or two monitoring visits a year; but when a program is experiencing problems, the Certification Unit increases their level of assistance. For instance, with Crossroads, the Certification Unit will conduct two monitoring visits between now and January; and, with Bon Air JCC, a monitoring visit will be conducted every two months.

Fairfax Shelter Care II: The audit of Fairfax Shelter Care II found three areas of non-compliance; none were critical deficiencies. The Certification Unit found two deficiencies on their recent status visit not determinably on restraints and the daily log. Director Block certified Fairfax Shelter Care II for three years and asked the Certification Unit to perform a monitoring visit in December to measure their compliance with the logbook entries and to present the report to Director Block in January.

New River Juvenile Detention Home: The audit of the New River Juvenile Detention Home found two minor deficiencies. The Certification Unit found all deficiencies corrected in their follow-up monitoring visit.

Richmond Juvenile Detention Center: Richmond Juvenile Detention Center demonstrated 100% compliance in their recent audit and was certified for three years. Mr. Bailey and the Board all agreed that the Richmond Juvenile Detention Center has come a long way in its progress from closing for a year.

Shenandoah Valley Juvenile Center: Shenandoah Valley Juvenile Center had two deficiencies in their audit. They had an escape a year ago and cut off recreation until security enhancements were made to their recreation yard. All enhancements were corrected and youth now have the opportunity for outdoor physical activity. Shenandoah Valley Juvenile Center has been certified for three years.

There were no further questions from the Board.

REGULATORY UPDATE
Kristen Peterson, Regulatory Coordinator, Department

Included in the Board packet is a summary of the Department's five regulatory actions currently under review.

The Board had no questions.

VIRGINIA JUVENILE DENTENTION ASSOCIATION VARIANCE REQUEST EXTENSION FOR 6VAC35-101-200 (C)
Kristen Peterson, Regulatory Coordinator, Department

At the September 10, 2014, meeting, the Board issued a blanket variance for a two-year period to the Virginia Juvenile Detention Association (VJDA) applicable to the 24 locally- and commission-operated juvenile secure detention centers (JDCs). The variance was set to expire on September 10, 2016; Director Block issued a waiver to continue the exception from the regulatory requirement pending further consideration by the Board. The variance is to the regulatory requirement in 6VAC35-101-200 (C) that all direct care staff employed at JDCs receive at least 40 hours of annual refresher training. The VJDA is requesting that part-time and relief direct care staff be exempt from the 40 hours of annual refresher training requirement. The part-time direct care staff would still need to complete training in seven specific topics, required in the regulation, that include: (1) suicide prevention; (2) standard precautions; (3) professional relationships; (4) staff and resident interaction; (5) residents' rights; (6) child abuse, neglect, and mandatory reporting; and (7) behavior intervention procedures.

Included in the Board packet is the Department's summary memorandum and the VJDA letter requesting the extension of the variance.

Janet Van Cuyk, Legislative and Research Manager for the Department, noted that, when this variance request was heard by the Board in September 2014, there was a lot of discussion and the vote to approve was not unanimous. The Board passed the variance request on a 3 to 2 vote. Ms. Van

Cuyk proffered that the position of the VJDA is to provide part-time, direct care staff annual refresher training on the seven specified areas. The part-time direct care staff would not receive the "soft skills" training such as career advancement and management training. VJDA contends that (i) part-time, direct care staff are not in the facilities to build their professional development but to keep the residents safe and (ii) it is an undue burden to fit annual training into a part-time employee's schedule.

Ms. Peterson noted that the requested duration of the variance request is for five years or when the Department amends the *Regulation Governing Juvenile Secure Detention Centers*, whichever occurs first. Ms. Van Cuyk reminded the Board the period for which they granted the request in 2014 was for two-years.

Board Member Robyn McDougle asked if the Department normally requests five years as the duration for a variance. Board Member McDougle noted that in 2014, the Board granted a two-year variance because of the Board's concerns with the request.

Ms. Van Cuyk answered that the Department uses five years as a default; however, with all recent requests, the Board has never granted a five-year duration for a variance.

Board Member Tyren Frazier asked the number of training hours part-time JDC staff receive.

Ms. Van Cuyk said according to VJDA, the number of training hours depends on each JDC's training module, which would include the seven specified areas and any other training VJDA or the facility decides part-time direct care staff need. VJDA did not provide an average number of hours for its training programs; however, VJDA has a Department of Criminal Justice Services (DCJS) grant to bolster training in four models available for the facilities to use (e.g., adolescent brain development).

Mr. Bailey acknowledged that during JDC audits, the Certification Unit has found no deficiencies in training for part-time, direct care staff. Facilities have different methods of ensuring that training is completed, such as using computer-based training. The Certification Unit has been satisfied in their audits that part-time, direct care staff are receiving the appropriate training required.

Board Member Michael Herring said that it makes sense that there is a variation by facility on account of resources; however, if there were a plaintiff's claim, the lack of uniformity in training standards could be an issue. Otherwise, the state might have to defend the claim on the basis of the facility resources, which is not a strong position of defense.

Ms. Van Cuyk said that the determination of the training plan is specific to the locality or commission-operated JDC, and the liability would rest either with the locality or the commission. She stated that it is her understanding that VJDA is beginning to look at using the DCJS grant have some training available to all facilities with their option to use.

Board Member McDougle talked about DCJS having oversight over law enforcement training standards, but with VJDA, there is no outside organization making sure the standards are followed.

Ms. Van Cuyk remarked that the Commonwealth does not have oversight for JDCs similar to that provided for by DCJS. The Board sets the minimum training hours, the Department's Certification Unit conducts facility audits to ensure compliance, and the Department Director certifies to the minimum standards.

Board Member McDougle asked if the minimum standards are the seven specified topic areas. Ms. Van Cuyk said that was correct and the quality assurance falls on the locality or commission.

Chairperson Abbott asked about CPR and other specific training, remarking that in the past the Certification Unit has found training to be an issue in the audits with some being critical deficiencies.

Ms. Van Cuyk said that the standard for detention centers is to have one person in the building at all times trained in CPR; not all staff needs to be trained in CPR. There are other training requirements in the regulation that address specific areas such as the administration of medication and physical and mechanical restraints.

Director Block noted that the Department is standing in for VJDA, who, due to a scheduling miscommunication on the Department's side, were unable to have representatives present at this meeting. If the variance is not extended, this may have an impact on JDC operations.

Board Member Holland stated that she voted against the variance request at the September 2014 Board meeting. Board Member Holland thought that, since the 2014 variance was granted for two years, VJDA would have had time to complete the study and the training regulations of 40 hours would have changed without another variance. Unfortunately that has not happened.

Ms. Van Cuyk noted that the delay in processing the changes is not the fault of VJDA. Due to her unit's staff turnover and workload shortages. The review of residential regulations could not move forward until the Department filled the position of Regulatory Coordinator. Ms. Peterson is now spearheading the workgroup to review the regulation and make the necessary changes. The workgroup has already completed its review of the training regulatory requirements and will be presenting their recommendations to the Board at one of the upcoming Board meetings.

Board Member Holland reiterated her concerns that there needs to be uniform training standards established for all JDCs. It is not feasible to arbitrarily say we will not require 40 hours of training and then not indicate the number of training hours to be audited to ensure the facility is in compliance. Some facilities could do one hour training and cover all seven subjects to complete their training requirement for the year. These personnel are responsible for taking care of children, and there should be uniform standards.

Ms. Van Cuyk said that it is not unprecedented for the Board to not set a specific number of required training hours. In 2011, non-residential regulations for the court service units (CSUs) were amended to remove the 40 hour annual training requirement and require training as necessary to achieve job competencies. The decision for this change was based on the logic that experienced staff that have been employed with the Department for long periods do not necessarily need to use their time fulfilling minimum training requirements. VJDA brings this issue forward again by asking why a

specified number of hours for soft skills training is needed when there generally is not a facility-based career projection for part-time and relief employees.

Board Member McDougle asked about the best practices of other states in this area.

Ms. Van Cuyk remarked that the American Correctional Association training standard is 40 hours for full-time staff and certain specific enumerations for part-time staff, with no specific annual retraining hours for part-time staff.

Board Member Holland discussed the differences in the localities on the meaning of "part-time" and the importance of completing the training requirement for employees working 29 hours a week. Board Member Holland also noted that employees, who worked in a place for long periods of time, often develop a mindset of not needing training. This could be part of the problem. Sometimes long-term employees need more training than employees employed only a year. Board Member Holland noted continued concerns with this variance request.

Board Member Frazier asked, if the Board takes no action on the variance request at this meeting, what would be the consequences.

Ms. Van Cuyk replied that the JDCs with part-time staff who have not met the 40-hour training requirement would be in non-compliance starting tomorrow.

Board Member McDougle asked Mr. Bailey whether JDCs would be non-compliant on audit if the Board did not vote for the variance.

Board Member Frazier followed up by asking whether this provision is a critical regulatory requirement.

Mr. Bailey said that certain training components are critical. The Certification Unit would deal with this situation from the date the variance expired. Starting on that date, the Certification Unit would assess the 40 hours being used to provide mandatory training plus any other training that facility chooses to put in its training plan.

Board Member Frazier requested a sample of two or three JDCs training programs and the average retraining hours implemented for part-time, direct care staff. Board Member McDougle requested the information provided to be a representative sample, possibly all JDCs.

The Board would like this information to review prior to the next Board meeting on November 14, 2016. The Board agreed to grant a temporary extension of the VJDA's variance, effective today; so the JDCs would not be out of compliance with the regulatory training requirement. The Board will then take up the issue at the November 14 Board meeting.

On MOTION duly made by Board Member Frazier and seconded by Board Member McDougle that the Board extend the variance until the November Board meeting, with the understanding that the Board will receive information on hours devoted to training among part-time employees in JDCs. The Motion carried. All Board members agreed to extend the variance issued on September 10, 2014,

pursuant to 6VAC35-20-92 of the *Regulation Governing the Monitoring, Approval, and Certification of Juvenile Justice Programs and Facilities* to allow the twenty-four local and regional juvenile secure detention centers throughout the Commonwealth to exempt part-time direct care employees from meeting the 40 hours of annual retraining mandate set out in 6VAC35-101-200 (C) of the *Regulation Governing Juvenile Secure Detention Centers* until the November 14th Board meeting.

Department Variance Request for 6VAC35-71-10, -540, and -830, Regulation Governing Juvenile Correctional Centers (JCC)
Janet Van Cuyk, Legislative and Research Manager, Department

This variance is requested on behalf of the two, Department-operated JCCs deemed necessary to accommodate the Department's operational changes relating to the transformation to the Community Treatment Model (CTM). The current regulation became effective on July 1, 2014. The current regulation defines "direct care staff" as individuals who are responsible for caring for residents, implementing the behavior management program, and maintaining the security of the facility. Those three components are required to meet the current regulatory definition of direct care staff. When the regulation became effective, the Department had the juvenile correctional officer (JCO) position. Due to the implementation of the CTM, however, there are no longer JCO positions in the Department. In determining the future of the juvenile correctional model, the Department reviewed position descriptions and bifurcated what was formerly the JCO position into two groups. The first group consists of Resident Specialists (RS) and Resident Specialists II (RS II) who meet the definition of direct care staff. The second group includes security specialists who only satisfy two required components of direct care staff and do not meet the regulatory definition of direct care staff.

In looking at the job responsibilities for the security specialists, a primary job function would be the routine or non-routine transportation of residents. This could be for work release, court dates, or medical appointments. Unfortunately, the JCC regulation requires all residents to be under the active supervision of direct care staff at all times. This means security staff do not meet that definition and would not be able to transport JCC residents outside the presence of a direct care staff in an RS or RS II position. When residents are transported, there are at least two staff present, and a 1:4 ratio of staff to residents. If nine residents are being transported, there must be three direct care staff present. The residents are in handcuffs and leg restraints during transportation, and staff are trained on how to use that equipment. All direct care staff and security staff receive 120 hours of training prior to working directly with residents.

The variance request would allow residents to be transported, under the supervision of security series staff, security specialists or supervisors, even though these positions would not meet the definition of "direct care staff" and are not responsible for implementing the behavior management program during transportation.

Board Member Frazier questioned whether, presently, the RS or security specialist may transport residents. Board Member Frazier followed up by asking the difference in training requirements for each position.

Ms. Van Cuyk answered (i) as the transformation is still underway, the remaining JCO positions have not been converted to security specialists; so they still meet the definition in their training and employee work profiles as direct care staff; (ii) the training for RS employees will include requirements above what is required for security specialists, but that has yet to be defined; however, since security specialists who transport residents will be alone with residents, they will still meet the Board's minimum training requirements (just not the additional things for RS who engage every day with the residents in a non-perfunctory way). Absent the variance, for transporting residents, the Department could have one security specialist but would need a RS to be present at all times (and, thus, removed from JCC supervision responsibilities). The RS is trained specifically to engage with residents and has increased job responsibilities, such as implementing the behavior management program, in addition to basic core responsibilities for maintaining security.

Ms. Van Cuyk stated that the Department requests a variance to the three sections of the regulatory regulations (6VAC35-71-10, -540, and -830) to allow security staff to transport both routine and emergency residents outside the presence of direct care staff.

Chairperson Abbott asked the duration of the variance.

Ms. Van Cuyk stated that the Department is asking for five years. The regulations are actively under review; however, the last review took approximately four years.

Board Member Frazier and Board Member McDougle asked about risk and liability.

Ms. Van Cuyk said that when the Department looked at how others in secure custody are transported, generally, it is not by direct care staff. The Department has not assessed any liability issues and has only assessed the financial impact.

Board Member Herring asked Ms. Van Cuyk to clarify whether the two staff requirement during transport means that a minimum of two staff must be present regardless of the number of residents, or is it always a ratio of 2:1.

Ms. Van Cuyk answered that it is a 1:4 ratio of staff to residents with a minimum of 2:1 ratio.

Director Block said part of the reason for the two staff present requirement is that in the event of an escape, there will be one staff to help return the resident and another staff to supervise the other residents.

Board Member Herring said that this variance makes sense on the assumption that there is no provision of care under the structured program or behavior management program during transportation and that security personnel are otherwise trained consistent with direct care personnel on things like health care. If any of those assumptions are not true, it does not make sense.

Ms. Van Cuyk stated that she agreed with Board Member Herring's assumptions.

Board Member McDougle noted that, after earlier discussions on the previous variance, she would like to confirm that training for JDC staff and the Department are different, as they are two separate entities.

Ms. Van Cuyk said that the training requirement for initial training for JDC staff is 40 hours in their first year. The training requirement for Department staff is 120 hours prior to working directly with residents.

Board Member Frazier asked if this variance request was due to positions changing from JCOs to RS/RS II and security specialists. Ms. Van Cuyk said Board Member Frazier's assumption was correct.

Board Member McDougle asked whether the reason for the duration of the variance being five years is due to the likelihood that the regulatory process could take years. Ms. Van Cuyk said that, in general, the regulatory review process lasts 18 to 24 months.

A MOTION duly made by Board Member McDougle and seconded by Board Member Frazier, pursuant to 6VAC35-20-92 of the *Regulation Governing the Monitoring, Approval, and Certification of Juvenile Justice Programs and Facilities*, to approve the variance to the regulatory requirement provided in the Regulation Governing Juvenile Correctional Centers (6VAC35-71) that only staff classified as direct care staff may actively supervise residents during routine and emergency transportation. This variance shall authorize security staff to actively supervise residents during routine and emergency transportation. This variance is to remain in effect until 6VAC35-71 is amended or for three years, whichever occurs first. Motion carried.

DIRECTOR'S COMMENTS
Andy Block, Director, Department

The number of intakes in the Court Service Units (CSU), the number of youth on probation, the number of youth in local detention centers, and the number of detention eligible offenses at intake all continue to decline. These are positive trends.

The community side is looking more closely at data-driven decision making and evidence-based practices. The Department was recently awarded a grant from the DCJS to expand the Effective Practices in Community Supervision (EPICS) training. EPICS is essentially an approach to probation that has been studied and piloted through the University of Cincinnati. In Virginia, there are 19 jurisdictions in some stage of EPICS training, and six more have been added with the help of the grant. This allows probation officers to become more than case monitors/managers and encourages them to provide interventions similar to those used in the facilities.

The Department is using a risk assessment tool when making case disposition recommendations. It is a great tool if used correctly. To ensure that the Department continues to have fidelity with this tool, the Department is organizing a large train-the-trainer on this topic. This will allow the Department's employees to travel to CSUs to make sure employees are using the tools correctly.

The Department is very excited about its new program that provides transportation assistance to families to enable them to visit children in our care. This service is being funded by the Office of

Juvenile Justice Delinquency Prevention reentry grant. Transportation assistance is provided twice a month with ridership close to 100 people since the program began late this summer.

The Department has developed the Leadership Training Institute for the supervisory level. The training provides insight into leadership skills and management and how to apply it to evidence-based work. The participants in this training complete capstone projects.

The residents in the facilities are organizing a student government, which will give them more ownership of their stay with the Department. A group of residents from Bon Air and Beaumont met with the Governor and his executive policy staff to discuss setting up a student government. The residents provided a PowerPoint presentation and the group talked about constitutions and voting. Governor McAuliffe spent time with the residents and each left with a copy of the Virginia Constitution signed by the Governor and the First Lady.

The Task Force on Juvenile Correctional Centers has released its interim report on optimal facility design. The report, along with additional information on the Task Force, can be found on the Department's website (www.djj.virginia.gov). Once the interim report was submitted, the Department became eligible to receive funding for the design phase of the Chesapeake facility.

Intake at Beaumont is no longer performed, which has reduced the population. The Department is on track for a June 30, 2017, closure of Beaumont and consolidation with the Bon Air campus.

The state's revenue forecast for this year was not accurate. There has been a revised forecast and all state agencies have been asked to develop a savings plan. It is hard to predict what will happen and how it will affect the Department.

The Department has converted 15 units to the CTM in our facilities. The Commission on Youth staff visited our facilities last week.

BOARD COMMENTS
The Board had no comments.

NEXT MEETING
The next meeting is scheduled for November 14, 2016, at the Main Street Centre, 600 East Main Street in Richmond.

ADJOURNMENT
Chairperson Abbott adjourned the meeting at 10:58 a.m.

Monitoring Report
Bon Air Juvenile Correctional Center

On June 23, 2016, the current certification status of Bon Air Juvenile Correctional Center was extended to January 31, 2017, with status reports every two months on areas currently in noncompliance. Below are the areas that were in non-compliance at the status visit conducted on May, 11, 2016, and the current status determined during a review on August 9, 2016. Another review will be conducted in October 2016.

In summary, the critical regulatory requirements are now in compliance. Two non-critical regulatory requirements remain in non-compliance.

- **6VAC35-71-1140 (B). Room confinement.**
  - There were no confinement forms or documentation of confinements was incomplete in eight out of 10 applicable incidents reviewed.

- **6VAC35-71-1140 (E). Room confinement.**
  - There was no documentation of a report to a position above the level of superintendent when a resident was confined for more than 72 hours in one out of one applicable incident reviewed.

After the August 9th review it was determined that the corrective action plan was not functional in the proper accountability of confinement forms. Instead of multiple persons being responsible for the forms, the responsibility has been delegated to one person. The October review will determine if this new approach will solve the issue.

6VAC35-71-170 (D). Retraining. CRITICAL
All direct care staff shall receive training sufficient to maintain a current certification in first aid and cardiopulmonary resuscitation.

Audit Finding February 11, 2016:
There was no documentation that four out of 15 direct care staff maintained certification in first aid and cardiopulmonary resuscitation during one or more years during the audit period.

Program Response

Cause:
This issue was caused by a lack of consistency in workforce due to staff shortages and staff changing positions. Staff returning from extended leave or who had been recently injured was inadequately tracked to ensure that all training qualifications had been met for the year. Additionally, the critical functions of the facility's training officer did not get reassigned as the training officer shifted roles to the department's training facility.

Effect on Program:
Recognizing that training is vitally important for staff growth and development and to maintain a safe and secure environment; not promoting and supporting staff's training efforts could potentially impede safety and increase risk factors for residents and other staff.

Planned Corrective Action:

- The facility has developed a supervisor's checklist to ensure that supervisor responsibilities such as mandated training are completed timely and can be tracked during and after an employee's extended leave. Full implementation will occur by March 31, 2016.
- Beginning March 1, 2016, supervisors will utilize the department's training spreadsheet on the shared drive to assist with planning and tracking certifications for first aid and cardiopulmonary resuscitation (CPR).
- The superintendent has designated one staff to coordinate training and to track hours/requirements for direct care staff needing first aid and CPR. The designated person will work with supervisors to ensure direct care staff receive training before the certification expiration date.
- In the event, that the direct care staff is on extended leave (e.g. military leave, FMLA, VSDP) or their approved modified work status prevents them from completing first aid and CPR, the supervisor will use the supervisor checklist to track compliance of this issue until the employee returns to full duty.
- In the event of a direct care staff not attending the training (i.e. call-out, no/show), the supervisor will address the absent with the employee. This incident will be formally documented. The facility designated training staff will work with the supervisor to reschedule that staff member.
- The facility will continue to consult and utilize the designated instructor at the DJJ Training Academy to assist with scheduling and training needs.
- Staff will be trained in *SOP VOL IV-4.1-1.09, Orientation and Training*, by March 31, 2016. The training confirmation will be filed in the employee's fact file and will be forwarded to the compliance office.
- On March 14, 2016, the superintendent advised department heads of these corrective actions.

Completion Date:
Corrective action shall be implemented no later than March 31, 2016.

Person Responsible:
Douglas Vargo, Superintendent Sr.

Current Status on May 11, 2016: Not Compliant
There was no documentation that 16 direct care staff had a current certification in first aid and cardiopulmonary resuscitation.

Current Status on August 9, 2016: Compliant
All applicable staff is currently certified in first aid and cardiopulmonary resuscitation.

6VAC35-71-280 (B). Buildings and inspections. CRITICAL
A current copy of the facility's annual inspection by fire prevention authorities indicating that all buildings and equipment are maintained in accordance with the Virginia Statewide Fire Prevention Code (13VAC5-51) shall be maintained. If the fire prevention authorities have failed to timely inspect the facility's buildings and equipment, the facility shall maintain documentation of its request to schedule the annual inspection, as well as documentation of any necessary follow-up. For this subsection, the definition of annual shall be defined by the Virginia Department of Fire Programs, State Fire Marshal's Office.

Audit Finding February 11, 2016:
Fire inspections at the facility were conducted on March 5, 2013, May 13, 2014, and June 30, 2015, during the audit period. There were more than 13 months between the 2013 and 2014 inspections.

Program Response

Cause:
This issue was caused by staff oversight in the delivery of the fire safety program.

Effect on Program:
Compliance with fire prevention regulations, inspection requirements, and practices, including periodic fire drills, will ensure the safety of residents, staff, and visitors. Not adhering to departmental procedure undermines this goal.

Planned Corrective Action:

1. The safety officer will utilize the established tracking system to ensure timely requests to the Fire Marshal's Office to conduct annual fire and life safety code compliance inspections of the facility.
2. The safety officer will place a request to the Fire Marshal's Office before the conclusion of the tenth month from the last inspection.
   a. All requests to the fire marshal will be documented in writing and a copy shall be forwarded to the operations manager.
   b. If the local fire marshal fails to timely inspect the facility's buildings and equipment, the safety officer will maintain documentation of its request to schedule the annual inspection, as well as documentation of any necessary follow-up.
   c. By the eleventh month from the last inspection, the superintendent will be notified by the operations manager on the pending status of the annual inspection.
3. Copies of the fire marshal's report, along with the findings and recommendations, are distributed to the appropriate facility administrative team members and supervisors. The safety officer along with his supervisor, the operations manager, is responsible for monitoring all follow up activities.

Completion Date:
Corrective action shall be implemented no later than February 29, 2016.

Person Responsible:
Douglas Vargo, Superintendent Sr.

Current Status on May 11, 2016: Not Determinable:
The last fire inspection was conducted on June 30, 2015, and the annual inspection is due by July 2016. A request was sent to the Fire Marshall on May 11, 2016, for the next annual inspection.

Current Status on August 9, 2016: Compliant
Fire inspections were conducted at the facility on May 31, 2016 by the Fire Marshall.

6VAC35-71-790 (F). Individual service plans.
Copies of the individual service plan shall be provided to the (i) resident; (ii) parents or legal guardians, as appropriate and applicable, and (iii) placing agency.

Audit Finding February 11, 2016:
There was no documentation that the residents, their parents or the placing agency were provided copies of the service plan in five out of nine applicable case records reviewed.

Program Response

Cause:
This issue was caused by a misapplication of procedure. There were insufficient checks and balances to address the deficiencies.

Effect on Program:
When copies of the individual service plan are not provided to the resident, the parents or legal guardians, and placing agency, the resident's support system is unaware of the targeted goals for the youth; thus, they are unable to assist with fostering progress with the resident.

Planned Corrective Action:
- The initial comprehensive reentry case plan (CRCP) will be mailed by the CAP counselor to the parent or legal guardian (or social worker, if applicable) and PO within 30 days of admission. The intake community coordinator will verify that a copy has been mailed to applicable parties.
- Annually, the assigned counselor will mail the plan to the parent or legal guardian (or social worker, if applicable) and PO. The community coordinator will verify that a copy has been mailed to applicable parties. The community manager will assist with any issues to ensure the prompt mailing of the CRCP.
- During the month of February, the assigned counselor will bring their assigned caseload into compliance by addressing any previously identified deficiencies such as mailing the individual service plans to the parent or legal guardian (or social worker, if applicable) and PO.
- Beginning in March and each month thereafter resident files will be audited by the assigned community coordinator using the approved audit form.
- Quarterly, resident files will be audited by the assigned community manager using the approved audit form. This effort will be conducted in conjunction with the counselor. Remedial training will be conducted and documented in instances of noncompliance.
- On March 11, 2016, case management staff and administrators were formally trained on the department's new procedures as outlined in the Reentry and Intervention Manual for Committed and Paroled Juveniles.

Completion Date:
Corrective action shall be implemented no later than March 16, 2016.

Person Responsible:
Douglas Vargo, Superintendent Sr.

Current Status on May 11, 2016: Not Compliant
There was no documentation that the parent/guardian and/or placing agency was provided a

copy of the service plan in six out of 13 applicable case records reviewed.

Current Status on August 9, 2016: Compliant
Five applicable case records were reviewed and were compliant.

6VAC35-71-1140 (B). Room confinement.
Whenever a resident is confined to a locked room, including but not limited to being placed in isolation, staff shall check the resident visually at least every 30 minutes and more frequently if indicated by the circumstances.

Audit Finding February 11, 2016:
There was no documentation of confinement forms in 11 out of 16 incidents reviewed in which residents were confined to their rooms.

Program Response

Cause:
This issue was caused by a lack of consistency in workforce due to staff changing positions and staff on extended leave. Additionally, staff had insufficient training to support the operational demands resulting in documentation being mishandled and lost.

Effect on Program:
Not adhering to departmental procedure undermines the order, safety, and security of staff and residents assigned to the facility.

Planned Corrective Action:
- In February 2016, the facility developed a new file management system to maintain and track generated security documents.
- Beginning in March, each community coordinator will create and maintain a security file that includes confinement monitoring documentation for each resident on their caseload. These files will be maintained throughout the resident's facility stay. When the resident is transferred to another unit, the file will be forwarded to the next assigned community coordinator. Upon release, the entire file will be forwarded to the records office.
- The community manager or designee will conduct weekly audits of the confinement monitoring documentation. Discrepancies will be reported in writing to the applicable community manager.
- The community manager will assist in locating any missing documents. The assigned supervisor will conduct remedial training to staff when errors are noted.
- On a quarterly basis, the community manager in conjunction with the compliance manager and community coordinator will conduct a file review of each resident's security file.
- On March 14, 2016, training will be conducted with community coordinators and community managers.

Completion Date:
Corrective action shall be implemented no later than March 15, 2016.

Person Responsible:
Douglas Vargo, Superintendent Sr.

Current Status on May 11, 2016: Not Compliant
There was no documentation of confinement forms in five out of 10 incidents reviewed in which residents were confined to their rooms.

Current Status on August 9, 2016: Non-compliant
There were no confinement forms or documentation of confinements was incomplete in eight out of 10 applicable incidents reviewed.

6VAC35-71-1140 (E). Room confinement.
If the confinement extends to more than 72 hours, the (i) confinement and (ii) the steps being taken or planned to resolve the situation shall be immediately reported to the department staff, in a position above the level of superintendent, as designated in written procedures. If this report is made verbally, it shall be followed immediately with a written, faxed, or secure email report in accordance with written procedures.

Audit Finding February 11, 2016:
There was no documentation that written communication was sent to department staff in a position above the superintendent in two out of two applicable incidents reviewed.

Program Response

Cause:
This issue was caused by a lack of consistency in workforce due to staff changing positions and staff on extended leave. Additionally, staff had insufficient training to support the operational demands resulting in documentation being mishandled and lost.

Effect on Program:
Not adhering to departmental procedure undermines the order, safety, and security of staff and residents assigned to the facility.

Planned Corrective Action:
- In February 2016, the facility developed a new file management system to maintain and track generated security documents.
- Beginning in March, each community coordinator will create and maintain a security file that includes confinement monitoring documentation and approvals for each resident on their caseload. These files will be maintained throughout the resident's facility stay. When the resident is transferred to another unit, the file will be forwarded to the next assigned community coordinator.
- In the event of a sanction of segregation above 72:00 hours, the hearing officer, hearing officer designee, or security manager will complete the Disciplinary Segregation Approval form. The Disciplinary Segregation Approval form, original discipline report (DR), and supporting documents will be submitted to the superintendent or designee and the deputy director of residential services for review and approval.
- The emails approving and/or denying the segregation will be printed by the hearing officer, hearing officer designee, or security manager and attached to the Disciplinary Segregation Approval form.
- The community manager or designee will conduct weekly audits of the confinement monitoring documentation. Discrepancies will be reported in writing to the applicable community manager.

- The community manager will assist in locating any missing documents. The assigned supervisor will conduct remedial training to staff when errors are noted.
- On March 14, 2016, training will be conducted with community coordinators and community managers.

Completion Date:
Corrective action shall be implemented no later than March 15, 2016.

Person Responsible:
Douglas Vargo, Superintendent Sr.

Current Status on May 11, 2016: Not Determinable
There were no applicable incidents reported.

Current Status on August 9, 2016: Non-compliant
There was no documentation of a report to a position above the level of superintendent when a resident was confined for more than 72 hours in one out of one applicable incident reviewed.