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COMMONWEALTH *of* VIRGINIA

Board of Juvenile Justice

BOARD MEETING

September 16, 2020 ☙ Virtual

A G E N D A

9:30 a.m. Board Meeting

1. CALL TO ORDER and INTRODUCTIONS

2. CONSIDERATION of the June 24, 2020, MINUTES (Pages 4-33)

3. PUBLIC COMMENT

4. DIRECTOR'S CERTIFICATION ACTIONS (Pages 34-80)
Ken Bailey, Certifications Manager, Department of Juvenile Justice

5. OTHER BUSINESS

A. Board Elections (Page 81)
James Towey, Legislative and Regulatory Affairs Manager, Department of Juvenile Justice

B. Review of Board Bylaws (Pages 82-89)
James Towey, Legislative and Regulatory Affairs, Department of Juvenile Justice

- Proposed amendment in accordance with Chapter 526 of the 2020 General Assembly (HB 1648)
- Proposed amendment in accordance with Chapter 599 of the 2020 General Assembly (SB 20)

C. Consideration of the Program Design and Planning Study for Prince William County Juvenile Detention Center and Molinari Juvenile Shelter (Pages 90-112)
Angela Valentine, Chief Deputy Director, Department of Juvenile Justice, Courtney Tierney and Ian Sansoni, Prince William County, and Carrie Henaghan, Moseley Architects

D. Consideration of the Virginia Juvenile Community Crime Control Act Plans for the City of Richmond, the City of Lynchburg, and the York County Commission (Pages 113-114)
Beth Stinnett, Statewide Program Manager, Department of Juvenile Justice

E. Consideration of Request to Authorize Fast-Track Regulatory Action and Variance to Amend Truancy Diversion Provision, 6VAC35-150-335 (Pages 115-122)
Kristen Peterson, Regulatory and Policy Coordinator, Department of Juvenile Justice

F. Consideration of Request to Initiate NOIRA to Carry Out SB 20 Directive (Pages 123-126)
Kristen Peterson, Regulatory and Policy Coordinator, Department of Juvenile Justice

G. Yvonne B. Miller High School Plan for Reopening (Pages 129-145)
Dr. Melinda Boone, Deputy Director of Education, Department of Juvenile Justice

6. **DIRECTOR REMARKS AND BOARD COMMENTS**

7. **NEXT MEETING DATE:** November 4, 2020, at 9:30 a.m.

8. **ADJOURNMENT**

GUIDELINES FOR PUBLIC COMMENT

1. The Board of Juvenile Justice is pleased to receive public comment at each of its regular meetings. In order to allow the Board sufficient time for its other business, the total time allotted to public comment will be limited to thirty (30) minutes at the beginning of the meeting with additional time allotted at the end of the meeting for individuals who have not had a chance to be heard. Speakers will be limited to 5 minutes each with shorter time frames provided at the Chair's discretion to accommodate large numbers of speakers.

2. Those wishing to speak to the Board are strongly encouraged to contact Wendy Hoffman at 804-588-3903 or wendy.hoffman@djj.virginia.gov three or more business days prior to the meeting. Persons not registered prior to the day of the Board meeting will speak after those who have pre-registered. Normally, speakers will be scheduled in the order that their requests are received. Where issues involving a variety of views are presented before the Board, the Board reserves the right to allocate the time available so as to insure that the Board hears from different points of view on any particular issue. Groups wishing to address a single subject are urged to designate a spokesperson. Speakers are urged to confine their comments to topics relevant to the Board's purview.

3. In order to make the limited time available most effective, speakers are urged to provide multiple written copies of their comments or other material amplifying their views. Please provide at least 15 written copies if you are able.

COMMONWEALTH OF VIRGINIA

Board of Juvenile Justice

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DRAFT MEETING MINUTES

June 24, 2020 ☙ Virtual Meeting

Pursuant to amendments to the Budget Bill approved on April 24, 2020 and set forth in Item 4.0-0.1 and in light of the Governor's declaration of a state emergency to curb the spread of COVID-19, the Board of Juvenile Justice met by virtual videoconference at its June 24, 2020 meeting. The Board considered a virtual video meeting necessary due to concerns that the nature and continuing spread of the virus throughout the Commonwealth rendered meeting at a single location unsafe for Board members, Department of Juvenile Justice personnel, and members of the public.

Board Members Present: Tyren Frazier, Robyn McDougle, Dana Schrad, Gregory Underwood, Robert (Tito) Vilchez, and Jennifer Woolard

Board Members Absent: David Hines, Scott Kizner, and Quwanisha Roman

Department of Juvenile Justice (Department) Staff Present: Ken Bailey, Melinda Boone, Valerie Boykin, Ken Davis, Mike Favale, Wendy Hoffman, Joyce Holmon, Linda McWilliams, Margaret O'Shea (Attorney General's Office), Jamie Patten, Kristen Peterson, James Towey, and Angela Valentine

CALL TO ORDER

Board Chair Jennifer Woolard called the meeting to order at 9:34 a.m.

INTRODUCTIONS

Chairperson Woolard welcomed all who were present and asked for Board member introductions. Director Valerie Boykin, along with Department staff and the Attorney General's Office representative, made their introductions. Due to the media platform used for the meeting, guests were not able to make introductions.

PUBLIC COMMENT PERIOD

There was no public comment. The public had an opportunity to sign up for public comment through the Department's website.

DIRECTOR'S CERTIFICATION ACTIONS

Ken Bailey, Certifications Manager, Department

Mr. Bailey directed the Board to the Board packet, which contained the individual audit reports and a summary of the Director's certification actions completed for April 15, 2020. Mr. Bailey announced the results of this round of audits were the best in many years.

The audit for the Northwestern Regional Juvenile Detention Center and Post-dispositional Program found one area of non-compliance involving a tuberculosis screening form not correctly signed by medical staff. The monitoring visit indicated the deficiency was corrected and the program was in compliance.

Sheltercare of Northern Virginia and Rappahannock Juvenile Detention Center and Post-dispositional Program received a letter of congratulations for 100% compliance and were certified until April 2023. This was an impressive accomplishment due to the influx in population in the Rappahannock Program.

The audit for the 1st District Court Service Unit found one area of non-compliance related to commitment information not included in some cover letters. The monitoring visit indicated the deficiency was corrected and the unit was certified until April 2023.

The 2nd District Court Service Unit received a letter of congratulations for 100% compliance and was certified until March 2023.

The audit for the 8th District Court Service Unit found three areas of non-compliance related to missing components in the social history supervision plans, missing supervisory reviews, and contacts during commitment. The Certification Team requested that the findings regarding contacts during commitment be referred to the Regional Program Manager for further monitoring. The unit was certified until March 2023.

The audit for the 13th District Court Service Unit found two areas of non-compliance related to the lack of documentation in several supervision plans and commitment cases. The monitoring visit indicated the deficiencies were fully corrected and the unit was certified until March 2023.

The 28th District Court Service Unit received a letter of congratulations for 100% compliance and was certified until March 2023.

Board Member Greg Underwood asked how long it takes to perform an audit, how many staff are on the audit team, and whether the Department provides notice before inspections.

Mr. Bailey answered that the number of team members and time vary according to the size of the facility. Audit teams range from six to ten staff. The Certification Team provides a six-month notification of the scheduled audit and reviews documentation covering a three-year period. Monitoring visits may take place with little notice to review a few regulatory requirements. In theory, the Department expects these programs to be in 100% compliance all the time.

APPROVAL OF March 11, 2020, MINUTES

The minutes of the March 11, 2020, Board meeting were provided for approval. On motion duly made by Robyn McDougle and seconded by Tito Vilchez, the Board approved the minutes as presented. Mr. Frazier – Yea; Ms. McDougle – Yea; Ms. Schrad – Yea; Mr. Underwood – Yea; Mr. Vilchez – Yea; and Ms. Woolard abstained from voting due to her absence from the March meeting.

OTHER BUSINESS

Virginia Juvenile Community Crime Control Act (VJCCCA) Plan Approvals

Beth Stinnett, Statewide Program Manager, Department

Beth Stinnett provided information on the VJCCCA plans for the Board's approval.

VJCCCA History – Background

The VJCCCA was enacted in 1995 to restructure funding for juvenile justice programming and provide localities with funding to impact juvenile crime. Areas of focus included diversion, early intervention, and detention alternatives. VJCCCA funding came in the 1990s, when capital construction campaigns were underway and localities were looking to either build juvenile detention centers or expand capacities due to overcrowding. An initial area of emphasis was to ensure localities had access to funding for secure detention alternatives, which continue to be the heaviest category utilized. VJCCCA provides localities the flexibility and autonomy to build out services and programming that meet their unique needs.

Organization and Operations

VJCCCA is a voluntary program with all 133 cities and counties throughout the Commonwealth participating this year, which traditionally has been true. VJCCCA establishes a formula grant that provides funds to each locality in Virginia along with a state allocation. Some localities require a maintenance of effort (MOE), and other localities elect to contribute additional funds to the budget.

The state allocation is $10.3 million, and inclusive of the MOE and additional local contributions, $20.6 million will be invested in juvenile programming at the local level this year. The Department provides technical assistance, administrative oversight, and monitoring of approved plans.

Each locality submits a grant application or proposed plan for the biennium. The current biennium ends on June 30, 2020. The new two-year biennium will conclude on June 30, 2022.

This has been a planning year for localities who use data for their decisions. The Department publishes its Data Resource Guide online that has great research information. The locality utilizes data during the planning process from sources such as the detention assessment instrument, override data, intake data, and types of crimes committed.

Governance
The planning process is collaborative, and localities can work with key stakeholders such as the Community and Policy Management Team chairs, the local court service unit directors, and the local judges of the Juvenile and Domestic Relations court.

Program Operations
Each locality determines the management of their plan and, with the funding received, could either hire local government staff to essentially serve as a publically funded provider (direct service provider) or contract out to purchase services through a private provider. This gives the locality flexibility.

The Department received applications from every city and county in the Commonwealth as individual plans or as combined plans with adjacent localities.

The Department continues to see heavy utilization of crime control funds to support detention alternatives. More than 60 different localities submitted plans that included either outreach detention or electronic monitoring detention. More than 30 localities also included purchase of shelter care beds as a detention alternative.

This year, due to the impact of the virus, localities developed creative ways to serve young people and their families. Some restructured their funding to adapt services to be delivered remotely, similar to telemedicine. Localities purchased new equipment to allow for safety needs and still provide high quality services to young people.

This year, the Department assisted localities in removing the case management category from their plan. The Board received a presentation on the Department's standardized dispositional matrix (SDM) that has restructured how young people are served in the juvenile justice system. Case management is now the responsibility of the court service unit. Localities used local government staff to provide case

management services to young people alongside the court service unit. The Department needed to help eliminate this redundancy as court service units have assumed responsibility for case management by using the SDM. This allowed the locality to maximize their funding and redistribute to different services.

In 2019, the General Assembly passed House Bill 1771 that allows VJCCCA funding to be spent on non-DJJ use as a category called preventive services. Last year, no localities elected to add preventive services to their plan because it was a new category and it was in the middle of the two-year biennium. A number of localities indicated an interest in adding preventive services to their plan this year. This is the beginning of a new plan year, and the localities took advantage of last year to restructure their plans in order to do more early intervention and prevention work.

The Department employs VJCCCA specialists who review applications and either approve or make recommendations to the plan. Ms. Stinnett and her team come before the Board prepared to share results of those reviews and make recommendations for the Board to adopt plans.

The following are the Board's options:

- Approve the plan as submitted for the full year biennium through June 30, 2022.
- Approve the plan for only the first year of the biennium through June 30, 2021.
- Approve the previously approved plan, which will allow the locality to carry the plan forward for a short period. The locality will be able to continue to improve upon the plan.
- Not approve the plan as submitted.

Page 53 of the Board packet contains the full budget for $10.3 million and $20.6 million and explains how funding is allocated across localities. The second spreadsheet shows the raw data of more than 300 programs and services funded by VJCCCA this year. The raw data is broken down by funding streams, type of programming, and the amount of money allocated for each program category.

Ms. Stinnett reviewed the Board motions:

- First Motion: There are 133 cities and counties in the Commonwealth organized as either a combined plan or an individual plan with one single fiscal agent. The Department recommends adopting the plan for the full two-year biennium for 119 localities through June 30, 2022.

- Second Motion: The Department recommends the adoption of thirteen locality plans for year one of the two-year biennium through June 30, 2021. Adopting for one year does not mean not adopting it in an incremental way. The listed localities have elected to add the new category of preventive services to their plan. The Department believes this takes deliberate and guided implementation. It includes the adoption of a new evidence-based tool, new practices on how

to capture and track non-DJJ cases that maintain confidentiality, and not mixing the population data. The Department favored adopting the plan for one year in order to provide guidance on the implementation and adopting year two of the plan next year. The Frederick Combined Plan is the first in the state to implement an achievement center (Washington, D.C.), and this will require guided implementation. It has great promise, and may become a model for other parts of the state. The Martinsville Combined Plan is adding a category of shelter care, which will be a regional approach and provide a detention alternative, which is needed in the western part of the state.

- Third Motion: The City of Lynchburg is requesting not to take action on their new plan and instead to carry forward the previously approved plan adopted two years ago for one additional quarter. This locality has not met all the requirements for planning, including meeting as a group, and the Department has not received letters of support from the locality's juvenile judge or court service unit director. The locality has a meeting scheduled for later this week. The City of Lynchburg may have been impacted by the pandemic, but needs to come together as a locality for planning purposes in order to seek out the requirement for court service unit and judicial support. The Department is asking the Board to allow the City of Lynchburg more time and to carry forward their current plan until the next Board meeting.

The following localities (119) have submitted VJCCCA Plans for FY 2021 and FY 2022 with balanced budgets for both years. Localities participating in combined plans are grouped by fiscal agent. These plans have been reviewed by staff and are recommended for approval by the Board for fiscal years 2021 and 2022 of the 2021-2022 biennium:

- Accomack, Northampton
- Alexandria
- Amelia
- Amherst
- Arlington, Falls Church
- Bath
- Bedford County
- Campbell
- Caroline
- Charlotte, Appomattox, Buckingham, Cumberland, Lunenburg, Prince Edward
- Chesterfield
- Colonial Heights
- Craig, Culpeper
- Dinwiddie
- Emporia, Brunswick, Greensville, Sussex
- Fairfax County/Cit
- Fauquier
- Floyd
- Fluvanna
- Franklin County
- Fredericksburg
- Giles
- Goochland
- Grayson, Carroll, Galax
- Greene
- Halifax
- Hanover
- Highland
- Hopewell
- King George, King William, Charles City, King and Queen, Middlesex, New Kent
- Lexington, Buena Vista, Rockbridge, Alleghany, Covington, Botetourt
- Loudoun
- Louisa
- Madison
- Manassas Park
- Mecklenburg
- Montgomery
- Nelson
- Newport News
- Norfolk
- Nottoway
- Orange
- Page
- Petersburg
- Pittsylvania
- Powhatan
- Prince George
- Prince William
- Pulaski
- Radford
- Rappahannock
- Richmond
- Roanoke City
- Roanoke County, Salem City
- Rockingham, Harrisonburg

- Shenandoah
- Spotsylvania
- Stafford
- Warren
- Washington, Bristol, Smyth, Russell, Buchanan, Dickenson, Lee, Norton, Scott, Tazewell, Wise
- Waynesboro, Augusta, Staunton
- Westmoreland, Essex, Lancaster, Northumberland, Richmond County
- Wythe, Bland
- York, James City, Gloucester, Williamsburg, Mathews, Poquoson
- TYSC: Isle of Wight, Southampton, Chesapeake, Franklin City, Portsmouth, Suffolk, Virginia Beach

On motion duly made by Dana Schrad and seconded by Robyn McDougle, the Board of Juvenile Justice approved the above listed VJCCCA plans for the 2021 and 2022 fiscal years. Mr. Frazier – Yea; Ms. McDougle – Yea; Ms. Schrad – Yea; Mr. Underwood – Yea; Mr. Vilchez – Yea; and Ms. Woolard - Yea.

The following localities (13) have submitted VJCCCA Plans with a balanced budget for FY 2021. These plans have been reviewed by staff and are recommended for approval by the Board for the 2021 fiscal year of the 2021-2022 biennium.

- **Charlottesville VJCCCA (combined plan) Includes:** Charlottesville, Albemarle
- **Danville VJCCCA Includes:** Danville
- **Frederick VJCCCA (combined plan) Includes:** Frederick, Clarke, Winchester
- **Hampton VJCCCA Includes:** Hampton
- **Henrico VJCCCA Includes:** Henrico
- **Manassas VJCCCA Includes:** Manassas
- **Martinsville VJCCCA (combined plan) Includes:** Martinsville, Henry, Patrick
- **Surry VJCCCA Includes:** Surry

On motion duly made by Jennifer Woolard and seconded by Tito Vilchez, the Board of Juvenile Justice approved the above listed VJCCCA Plans for the fiscal year 2021. Mr. Frazier – Yea; Ms. McDougle – Yea; Ms. Schrad – Yea; Mr. Underwood – Yea; Mr. Vilchez – Yea; and Ms. Woolard - Yea.

The following locality has not yet met all proposed plan submission requirements and has not completed required planning activities. It is recommended that the locality's FY 2020 plan be carried forward for one additional quarter, through September 16, 2020, to allow time for the locality to convene its planning members and develop a revised plan. The revised plan will be presented at the September Board of Juvenile Justice meeting.

Lynchburg - Fiscal Agent: Lynchburg

On motion duly made by Tyren Frazier and seconded by Dana Shrad, the Board of Juvenile Justice approved the FY 2020 plan for one additional quarter through September 16. Mr. Frazier – Yea; Ms. McDougle – Yea; Ms. Schrad – Yea; Mr. Underwood – Yea; Mr. Vilchez – Yea; and Ms. Woolard - Yea.

REQUEST AUTHORIZATION TO SUBMIT AMENDMENTS TO THE REGULATION GOVERNING JUVENILE CORRECTIONAL CENTERS TO THE FINAL STAGE OF THE REGULATORY PROCESS

Kristen Peterson, Regulatory and Policy Coordinator, Department

Background

In June 2016, the Board granted the Department permission to initiate the first stage of the regulatory process for a comprehensive review of the juvenile correctional centers regulation. The Department convened a workgroup to review the regulation and develop proposed amendments.

In November 2017 and January 2018, the Board authorized the proposed amendments to advance to the Proposed Stage of the regulatory process. At the proposed stage, the regulation has undergone Executive Branch review and the Attorney General's office has opined that the regulation is consistent with state law and does not conflict with federal law. The Department of Planning and Budget has completed their economic impact analysis and determined that the proposed amendments will not have a significant economic impact on localities, state agencies, or small businesses. The Governor's Office and the Secretary of Public Safety and Homeland Security also completed a review and approved the regulation to move through the process. There was a sixty-day public comment period, in which the Department received one set of comments from the disAbility Law Center of Virginia. Taking into consideration all that information and considering how the Department has evolved, the workgroup reconvened to develop additional proposed amendments. The Department requests the Board approve the proposed amendments and advance the regulations to the Final Stage of the regulatory process.

Five Critical Areas

The presentation focuses on five critical areas: (1) room confinement, (2) scope of the regulatory chapter and the facilities that are subject to these regulatory requirements, (3) grievances, (4) mechanical restraints, and (5) the Juvenile Justice Delinquency Prevention Act and pregnant residents.

Background of Proposed Changes

Ms. Peterson reminded the Board of the change to the regulatory provisions developed by the Virginia Code Commission in 2016. When developing regulations, state agencies may not incorporate reference documents that were developed by the agency. The regulation contains many statements that require compliance "in accordance with written procedure." Because the Department developed these written procedures, such provisions violate the incorporation by reference rule. Many changes proposed are to address the incorporation by reference rule. Ms. Peterson will not focus on those changes.

Expanded Definition of Room Confinement

Current Requirement	Change at Proposed Stage	Change at Final Stage
-No existing definition for room confinement.	Room confinement = involuntary placement of resident in his room or other designated room. -Exclusions: • Confinement while sleeping. • Timeout periods • Confinement during lockdowns. -Identifies permitted purposes of room confinement.	*(Pg. 79-80)* - Expands room confinement exclusions to include confinement in order to: • Allow residents to shower safely; • Conduct facility counts; • Execute shift changes. -Permitted purposes moved to Room Confinement section (1140).

The existing regulation does not define room confinement. The workgroup originally sought to exclude those types of confinement that look like room confinement but should not be subject to the same restrictions and limitations. For example, the workgroup originally recommended exclusions from room confinement for sleeping and during a timeout period. A timeout period is a program restriction that allows staff to move residents away from a source of reinforcement until the problematic behavior has been addressed. The timeout period tends to last no longer than 60 minutes. The timeout period can be served outside the resident's room; therefore, the workgroup thought that this particular type of confinement should not be subject to the confinement provisions.

Similarly, confinement for lockdown is handled with separate provisions that impose specific requirements. Lockdown means that groups of residents or all residents are restricted to an area within the facility or an area within their housing unit or their rooms for purposes of addressing certain emergencies or issues that the facility may experience such as tensions, riot activity, or if staff need to search the facility for missing tools. Those specific instances also are excluded from the proposed definition of room confinement.

The workgroup has now identified additional types of confinement that should be subject to the exclusion. The first type is confinement for purposes of allowing residents to shower. Under the existing written procedure, residents must shower individually. There is one staff member on the unit responsible for escorting the resident to the shower and supervising him while showering, and one direct care employee on the unit responsible for overseeing the remaining youth on the unit. However, if the resident in the shower experiences a crisis, the other staff member is called to provide assistance, and the remaining residents are not confined for that temporary period, the staff member would not be able to assist the resident in the shower. The workgroup believes it is necessary to secure the

residents in their rooms while each individual resident showers in order to ensure safety and security and to make sure that the facility complies with the Prison Rape Elimination Act.

The second proposed exclusion is confinement for purposes of allowing or conducting facility counts. Bon Air currently conducts four counts per day to determine and ensure residents are all accounted for in the facility. The easiest and most efficient means of obtaining an accurate count is to ensure that the residents are stationary. The best way to make sure residents are stationary is to secure them in their rooms for a temporary period. The recommendation of the workgroup is to exclude confinement for purposes of conducting facility counts from the definition of room confinement.

Finally, there are certain tasks that need to be accomplished as part of shift change. For example, keys must be exchanged, and equipment must be tested and updated before the outgoing staff can leave the facility for the day. Communications may need to occur between incoming and outgoing staff to convey that day's unit activities outside the hearing of the residents. The workgroup recommended excluding confinement for the purposes of executing shift changes from the definition of room confinement.

Permitted Justification for Room Confinement

Current Requirement	Change at Proposed Stage	Change at Final Stage
-Written procedures govern how and when residents may be placed in room confinement.	-Allowed room confinement only : • If a resident's actions threaten facility security or the safety and security of residents, staff or others in the facility. • To prevent property damage with intent to fashion object that threatens facility safety or security.	*(Pg. 120)* - Expands property damage justification. • No longer requires intent to fashion item threatening facility safety/security. • Allows room confinement to prevent property damage to real or personal property that would threaten facility security or safety.

The current regulation states that written procedure shall govern how and when residents can be placed in room confinement. At the Proposed Stage, the workgroup wanted to limit the use of room confinement and impose it only as long as necessary to address whatever threat necessitated the room confinement. The workgroup added language at the Proposed Stage to abolish the use of room confinement as a disciplinary sanction. If a resident commits an infraction that cannot be addressed through the informal process, the resident may be entitled to a hearing, and if the resident is determined guilty of the offense, the resident can be sanctioned with room confinement. At the Proposed Stage, the workgroup abolished the use of room confinement and allowed room confinement only in two specific scenarios: (i) if the actions of the resident threaten facility security or the safety and

security of residents, staff, or others, and (ii) to prevent property damage, but only if the resident intended to fashion an object that threatens facility safety and security.

The Department is concerned that the provision was too narrowly written and may cause unintended consequences. If a resident is engaged in property damage, they are likely to be upset and out of control. The example used in workgroup discussions was a resident smashing a television; however, the resident may not be doing this with the requisite intent of fashioning a weapon, and in that particular scenario, the facility would not be able to utilize room confinement as a tool to stop that behavior and to separate the resident from the situation because the regulatory provision is too narrowly written. The workgroup's recommendation for the Final Stage is that the provision no longer require an intent to fashion an item threatening facility safety and security, but rather that room confinement be permitted in order to prevent property damage to real or personal property that would threaten facility security or safety.

Chairperson Woolard remembered the Board spent a great deal of time discussing room confinement, and the Board made it clear that room confinement for disciplinary purposes is not allowed. It is understood that under certain circumstances, like immediate safety concerns, room confinement might be justified. Although Ms. Peterson asserts that the provision was too narrowly drawn, Chairperson Woolard worried that damaging property could be considered as a threat to safety and security under any circumstance. Chairperson Woolard asked what concern drove this proposed change, and asked Ms. Peterson to elaborate on the discussion around expanding the property damage justification.

Ms. Peterson responded that the Proposed Stage provision allowing room confinement only if a resident had the intent of fashioning an object to be used as a weapon was too narrow. There could be instances where residents are engaging in property damage and the behavior itself is threatening to facility safety and security and the damage is supplemental to the threatening behavior.

Chairperson Woolard asked for more information. If a resident is engaging in property damage, and that property damage threatens the security and safety of others, then that scenario falls under the first element of the Proposed Stage provision allowing room confinement if a resident's actions threaten facility security or the safety and security of residents, staff, or others in the facility. The second part of the Proposed Stage provision requiring intent to fashion an object is essentially covering behavior that has not yet occurred, where the resident is engaged in property damage in order to do harm, for example, breaking a television in order to take a shard of glass to threaten safety. Breaking the television is not in itself a threat to safety, but it is clear the resident is trying to threaten safety. Chairperson Woolard expressed confusion with the request to expand the property damage justification since if the property damage in itself is threatening, that is already covered in the existing provision.

Ms. Peterson answered that the workgroup had another concern with the narrow property damage language. The workgroup tried to construe the regulation similarly to how the General Assembly construes statutes. If the legislation speaks to a specific issue in a statute, then anything else that might evolve from that specific issue is interpreted as the General Assembly not intending to address that issue. The change in the provision is saying that if there is property damage that is incidental to the resident's threatening behavior, then that property damage in itself would prevent facility staff from using room confinement.

Chairperson Woolard remained concerned and believed it is not necessary to expand the property damage justification and that doing so may open the door to property damage becoming a broader justification for room confinement. The Board spent a large amount of time focused on intentionally narrowing room confinement for disciplinary purposes.

Deputy Director of Residential Services Joyce Holmon said the Department could revert to the language in the Proposed Stage without great difficulty.

Chairperson Woolard believed the language in the Proposed Stage covers the kinds of issues raised in the subsequent discussion and is confident that the language in the Proposed Stage can cover the emergency safety circumstance Ms. Peterson described.

Board Member Tyren Frazier said that he was okay with the neutral language.

Chairperson Woolard wanted verification that shower, count, and shift change, are included within the exclusions. Ms. Peterson confirmed, explaining the workgroup's intent to ensure that those three additional types of confinement are excluded from the definition of room confinement. Chairperson Woolard asked Ms. Peterson to remind the Board of the parameters placed on room confinement.

Ms. Peterson responded that under the Board-approved proposed amendments in Section 1140, mental health staff are required to visit the resident daily in room confinement. A staff member needs to visit with the resident within the first three hours of them being placed in room confinement. If the resident is in confinement for at least six hours, an additional staff member must visit and engage with the resident. If the resident is confined for more than six hours, then the resident must have two additional visits from staff members. Residents must be checked once every 15 minutes while they are in room confinement, but that provision applies anytime a resident is behind locked doors. The Superintendent or his designee must make personal contact with the resident every day the resident is confined.

Ms. Peterson concluded that because the use of room confinement has been narrowed, if these terms are not excluded in the definition of room confinement, then the facility would not be permitted to place residents in their rooms for these purposes even for a temporary period of time. Even if excluded

from the room confinement definition, residents are still required to be checked every 15 minutes and must be able to communicate verbally while confined. The regulation in the Proposed Stage states that a direct care staff actively supervise residents wherever present in the facility. The definition of "active supervision" contained in Section 10 is that direct care staff will check on the resident at least once every 15 minutes. The workgroup thinks that covers the check-in mandate.

Opportunities During Room Confinement

Current Requirement	Change at Proposed Stage	Change at Final Stage
-Confined residents shall be afforded opportunity for at least one hour of exercise outside room every calendar day with some exceptions. -Segregation units shall receive conditions approximating general population.	-Staff must provide confined residents with the same opportunities as other residents on the unit. • Includes "as much time out of their room as security considerations allow." -Also must provide at least one hour of large muscle activity daily, with some exceptions.	*(Pg. 120)* - Strikes requirement for same opportunities as other residents. -Requires staff to provide residents with services while confined: • Medical and mental health treatment; • Education • Daily opportunities for bathing • Daily nutrition • Daily opportunity for one hour of large muscle activity with some exceptions (retained in subdivision B(4)).

In the existing regulation, confined residents shall be afforded at least one hour of exercise outside of their room every calendar day with certain exceptions.

Existing regulatory provisions speak to providing opportunities for residents while confined. Section 1160 of the regulation requires residents in administrative segregation units to receive conditions approximating those of the general population. There are no comparable provisions for residents placed in room confinement. The workgroup wanted to ensure at the Proposed Stage that staff was not depriving residents of their rights during confinement. The way the workgroup sought to accomplish that was to mirror the language regarding residents in segregation. At the Proposed Stage, the workgroup drafted that staff had to provide confined residents with the same opportunities as other residents in the unit. The workgroup took it a bit further and said that this needs to include as much time out of their room as security considerations allow. Also at the Proposed Stage, the workgroup clarified that the hour of physical activity outside of the residents' rooms needed to be large muscle activity.

The workgroup was concerned with the requirement that confined residents receive the same opportunities as other residents on the unit. The workgroup believed that staff would not be able to

comply because when residents are placed in room confinement there are certain opportunities that simply cannot be provided to residents, for instance, the opportunity to engage and interact with other residents on their unit.

The workgroup also was concerned with the requirement that the facility give the resident as much time out of his room as security considerations allow. The Department's goal is to reduce the use of room confinement, using it only for as long as the threat that necessitated the room confinement is present. Once that threat disappears, the resident should be released from room confinement. By having language requiring residents to receive as much time out of their rooms as security considerations allow, and if the security considerations allow the resident to receive a significant amount of time out of their rooms, then arguably the resident should be released from room confinement. The workgroup believed this language is somewhat inconsistent with the overall objective that they were trying to reach with respect to room confinement.

At the final stage, the workgroup thought a better solution was to identify the rights that residents remain entitled to, regardless of whether or not they are confined, including, to the extent necessary, medical and mental health treatment, education, daily opportunities for bathing, three nutritionally balanced meals a day and an evening snack, and one hour of large muscle activity (with the exceptions that are currently in place).

Chairperson Woolard appreciated the driving force of consistency with the overall regulatory objective, but asked Ms. Peterson to explain the logic behind enumerating specific areas that residents should be provided and not others. For example, communication with family is not explicitly listed, but it is a philosophy the Department promotes and improves upon as much as possible. If the opportunities available during confinement are not specifically enumerated, then there is a potential that the opportunity will not be provided. What is gained by explicitly enumerating some opportunities rather than requiring the same opportunities as other residents in the housing unit? Chairperson Woolard also asked for additional clarification about removing language requiring the resident to be given as much time out of his room as security considerations allow and worried that the recommended amendments might provide a loophole to get around the goal of allowing residents opportunities to be outside their rooms.

Ms. Peterson responded that the workgroup was trying to convey that if there are significant opportunities for the resident to be out of room confinement, there is an argument to be made that the threat necessitating room confinement has been removed. Therefore, steps should be taken to release the resident from room confinement. The language currently in place says "as much time out of their rooms as security considerations allow." The objective should be de-escalation of the resident and removing them from the situation as soon as the threat that necessitated room confinement has abated.

Ms. Peterson said that she does understand the concern. With respect to the Chairperson's first question about enumerating the individual requirements, Ms. Peterson thinks the language is too broad. The agency could be deemed noncompliant in instances where staff are not providing the resident with the same opportunities as other residents in the general population. The facility simply cannot provide some opportunities to residents in room confinement. The workgroup tried to move away from imposing provisions that were impossible for staff to comply with and instead to address specifically the residents' most fundamental rights and ensure they are protected..

Ms. Peterson continued that in terms of regulatory construction, the Virginia Code Commission indicates that the language, "including," means "including but not limited to," and recommended an amendment to subsection E of the regulation on page 120 of the Board packet to provide, "if a resident is placed in room confinement, the resident shall be provided opportunities including, but not limited to..." and indicate those opportunities. This would prevent the interpretation that staff need not provide residents with opportunities not highlighted in the regulation.

Chairperson Woolard understood the concern that this language could be interpreted to say that everything should be the same for youth in room confinement as for youth not in room confinement, but did not think this was the intent of the language originally. Chairperson Woolard asked for a slight modification to the original language so staff would not feel compelled to make everything the same in order to meet the regulation. The phrase "as security considerations allow" perhaps could apply to the entire phrase as opposed to just the time out of their room. It might be reasonable to say security considerations would not allow youth to come out of their room and mingle with other residents while in room confinement. Chairperson Woolard said she does not want the Department to feel trapped, but believed room confinement will be used in a legitimate and narrow way.

Deputy Director Holmon said that she was struggling with the Chairperson Wooldard's suggestion to retain the "same" terminology. The committee did not intend to provide the "same" opportunities because what facilitated the need for confinement was a security risk.

Chairperson Woolard responded that the residents are in room confinement for safety and security concerns and that any deprivation that the confined youth are experiencing compared to youth not in confinement would be related to safety and security concerns. The confined youth would have all these opportunities except for the fact that they are in confinement because of an immediate safety or security piece.

Board Member Frazier agreed and said if the requirements for confinement are met and the confined youth is no longer a security risk, the resident should be removed from confinement and returned to everyday movement within the unit.

Chairperson Woolard reiterated her concern that there might be things youth can experience while in room confinement and could still be presenting a security and safety risk that would prevent their release from room confinement. If the confined youth are not presenting safety and security risks, by definition they can exit room confinement and if not, policy is not being followed. Chairperson Woolard did not see this as an either/or situation.

Board Member Frazier agreed that he does not want the regulation to be confusing or misinterpreted so that the agency becomes liable for not allowing movement as stated in the regulation.

Chairperson Woolard marked this proposed change and in the interest of time asked Ms. Peterson to continue.

Confinement Exceeding Five Days

Current Requirement	Change at Proposed Stage	Change at Final Stage
-Room confinement during isolation shall not exceed five consecutive days. -No time limit for other forms of room confinement.	-Case management review for confinement in excess of 5 days. • Facility-level committee review at next scheduled meeting immediately after 5 day-period. • Referral to division-level review committee upon determination to continue confinement. • Repeat process until one committee recommends review. • Deputy Director may reduce frequency/waive division review.	-Declines to adopt dLCV amendments. *(Pg. 121)* - Establishes time frame for division-level review. • Division-level review must occur within seven business days following referral. • Deputy Director must justify and document reason(s) for waiving division review.

The existing regulatory provision prohibits room confinement during isolation beyond five consecutive days. By the Department's definition, isolation means disciplinary room confinement. The amendments at the proposed stage abolish disciplinary room restriction. Currently, there is no time limit on other forms of room confinement. The workgroup at the Proposed Stage acknowledged that residents could serve room confinement for extended periods of time if the threat continues to persist and wanted to ensure that a case management review process is in place to address the continued room confinement after that five-day period. At the Proposed Stage, the workgroup recommends a case management review process involving an initial facility-level review, which is the institutional review

conducted by the Institutional Classification Review Committee (ICRC). The ICRC conducts their review at the next scheduled meeting immediately following the expiration of the five-day period under the amendment at the Proposed Stage. If ICRC determines that the confinement should continue, then the case would be referred to the division-level review, which is the Central Classification Review Committee (CCRC). The CCRC conducts a similar analysis and makes a determination. At the Proposed Stage, these reviews recur until such time as the resident is ready to be released from room confinement.

The Department received public comment from the disAbility Law Center of Virginia regarding this provision recommending that both committee reviews be completed within two business days. From a logistical standpoint, the Department thinks that this recommendation is not feasible and recommends that the division-level review (CCRC) be completed no later than seven business days following the referral from the institutional-level review (ICRC). This is necessary because the division-level committee (CCRC) includes key Department staff and is not limited to institutional staff. The committees meet once a week given their schedules. Therefore, the referral potentially could occur on the day the CCRC meets, and they would not be able to address the case review on that day: it would take another week for the group to address the case. The recommendation of the workgroup was to acknowledge the process and to impose a seven-business-day deadline for the division-level review (CCRC). Additionally, at the Proposed Stage, the Deputy Director is authorized to reduce the frequency of the division-level review or to waive the division-level review. The workgroup wanted to add language at the Final Stage requiring the Deputy Director to justify and document any reason for waiving or reducing the frequency of the division-level review.

Board Member Schrad said she could not see any other workaround. The Department has done a good job on the availability of administrative staff.

Chairperson Woolard asked for clarification as to whether the case review must be accomplished in five business day or seven business days.

Ms. Peterson and Deputy Director Holmon could not recall how the workgroup came up with seven calendar days.[i] Chairperson Woolard supported five business days, deducing that if the group is meeting weekly, this would be a reasonable timeframe, and the group would not need to assemble an additional meeting.

Chairperson Woolard and Board Member Schrad asked about an emergency provision for an urgent situation. Ms. Peterson said that the scheduled meeting dates are not concrete, but acknowledged that it can be difficult to gather staff for a meeting on other days. Chairperson Woolard asked whether anything precludes the group from meeting before the five days due to exigent circumstances. This might be an area the Board will need to reconsider if something goes awry and the meeting must be

held sooner. Board Member Schrad suggested that there must be a regulation in place somewhere that addresses all exigent circumstances. If a situation develops, Board Member Schrad believes the Department can handle it expeditiously, but if it concerns regulatory issues, the Board may need to address.

Juvenile Correctional Center Definition and Boot Camps

Current Requirement	Change at Proposed Stage	Change at Final Stage
JCC means: • Public/private facility • Operated by/under contract with DJJ • Provides 24-hour per day care to residents under direct care of DJJ.	-Excluded facilities operating "alternative direct care programs" from JCC definition.	*(Pg. 78)* - Removes alternative direct care program exclusion from definition. *(Pg. 80)* - Adds Applicability section (§15). • Chapter applies exclusively to state-and privately operated JCCs. • Chapter does not apply to: (i) facilities operating alternative direct care programs; (ii) boot camps. *(Pgs. 129-131)* - Boot camp provisions (§§ 1230-1270) repealed and moved to new Chapter 73.

The second area of discussion was the scope of the regulatory chapter. This chapter applies specifically to juvenile correctional centers. The current regulation defines "juvenile correctional center" as a public or private facility operated by or under contract with the Department to provide 24-hour care to residents under the direct care of the Department. At the Proposed Stage, the Department wanted to ensure its alternative direct care programs are not under the jurisdiction of these regulations. The Department contracts with a number of juvenile detention centers and residential treatment centers to house residents committed to the Department. This allows the Department to place residents closer to their home communities and often in smaller settings. Alternative direct care programs are operated by juvenile detention centers and residential treatment centers and have a different physical plant and personnel structure from juvenile correctional centers. These types of facilities should not be subject to the juvenile correctional center regulations, and at the Proposed Stage, the Department excluded them from the juvenile correctional centers definition. However, the workgroup has identified a potential unintended consequence of that language. The Department's authority to place residents in these facilities stems from a broad interpretation of the term juvenile correctional center. The workgroup was concerned that excluding alternative direct care programs from the "juvenile correctional center" definition might undermine the Department's authority to continue to place residents in these programs. The workgroup is proposing at the Final Stage to remove language that excludes alternative direct care programs from the definition of juvenile correctional center and to add a new applicability

section, which specifically sets out the types of entities to which this chapter applies. Page 80 of the Board packet adds an applicability section and indicates that the chapter applies exclusively to state and privately operated juvenile correctional centers. There are no privately operated juvenile correctional centers currently, and none are expected in the future. Under the proposed amendments, the chapter does not apply to facilities that operate alternative direct care programs.

Five separate sections in this chapter address juvenile boot camps. Since 2003, the Department has had the authority to place residents in juvenile boot camp programs. No juvenile boot camp programs currently operate in the Commonwealth; however, there is a statutory requirement that the Board continue to have regulations in place to address juvenile boot camps. The Department's Community Treatment Model differs philosophically from the juvenile boot camp model, which is based on military training and provides sanctions of physical activity. The workgroup recommended removing the boot camps provision and placing them in a separate chapter.

Grievances

Current Requirement	Change at Proposed Stage	Change at Final Stage
-Superintendent/designee shall ensure compliance with DJJs grievance procedure. -Grievance procedure shall provide for • Immediate review of emergency grievances; • Resolution of emergency grievance no later than 8 hours after initial review. -No definition for "emergency grievance."	No substantive changes	*(Pg. 83)* - Replaces "emergency grievance" with "grievances that pose an immediate risk of harm to a resident." -Sets deadline for addressing, correcting, or referring non-emergency grievances to external organizations at 30 business days after receipt of grievance.

The existing regulation directs the Superintendent of the juvenile correctional center or his designee to ensure that the facility complies with the grievance procedure. Under the regulation, the grievance procedure shall require immediate review of emergency grievances and a resolution within eight hours of such review. The regulation does not define the term emergency grievance, but it is commonly understood to mean grievances that pose an immediate risk of harm to a resident, such as a medical emergency or an allegation of abuse or assault. The workgroup did not recommend changes at the Proposed Stage, but the disAbility Law Center of Virginia recommended the Department set a time frame for addressing grievances that do not rise to the level of an emergency. Based on data from FY 2019, the workgroup concluded that non-emergency grievances likely may take 30 business days to

address. There are instances when the grievance must be referred outside the facility to external agency units. Once the grievance leaves the juvenile correctional center, the staff does not have any control over how quickly the grievance is addressed. The recommendation of the workgroup is to add language providing that once the grievance is referred outside the facility, it is considered resolved for purposes of this regulatory requirement.

Monitoring Mechanical Restraints

Current Requirement	Board-approved JDC changes	Change at Final Stage
-Written procedure shall provide that when a resident is mechanically restrained, staff shall: • Provide for his reasonable comfort and ensure access to water, meals, and toilet; • Make direct, personal checks on the resident at least every 15 minutes.	-Clarifies that the 15-minute checks must be face-to-face. -Requires staff to also attempt to engage verbally with the resident during each check. -Requires a health-trained staff to monitor the resident for signs of circulation and injuries during each periodic check. -Requires staff to allow residents restrained for two or more hours to exercise limbs for at least 10 minutes every two hours.	*(Pg. 124-25)* - Allows any staff to monitor the resident for signs of circulation and injuries during each periodic check. • Medical staff must conduct a formal medical check at least every two hours. -Exempts staff from requirements when transporting mechanically restrained residents off premises.

In May 2019, the Board heard proposed amendments to the Regulation Governing Juvenile Detention Centers (JDCs) regarding mechanical restraints. Because the JDC regulation was moving through the regulatory process, the Board agreed that the Department would incorporate whatever changes the Board adopted into the juvenile correctional center (JCC) regulation once the regulation completed the process. Most of the proposed amendments to the JDC regulation are being retained; therefore, it is not necessary to discuss all of the changes the Board already approved. Ms. Peterson explained that there were some areas of distinction from the JDC regulations that prompted the workgroup to recommend a few additional changes.

Specifically, the current regulatory provision provides that if a resident is mechanically restrained, staff shall provide for his reasonable comfort and ensure he has the opportunity for meals, water, and toilet. Staff also must make direct personal checks on the resident at least once every 15 minutes. The Board approved several changes to that language during the JDC regulation presentation, such as requiring the 15-minute checks be face to face and requiring staff, while conducting such checks, to attempt to engage verbally with the resident. The committee understood that mechanically-restrained residents could experience trauma, and staff should engage the resident to ensure that he is okay.

Mechanical Restraint Chair

Current Requirement	Board-approved JDC changes	Change at Final Stage
-Written procedures shall govern the use of mechanical restraints and shall specify: • The conditions in which mechanical restraints, including the restraint chair, shall be used.	-Require direct care staff to notify the health authority immediately after placing a resident in the chair to: (i) assess resident's health condition; (ii) check for contraindications; and (iii) advise whether resident should be moved to a unit for emergency involuntary treatment.	*(Pg. 125)* - Requires the health authority or designee to ensure that the medical and mental health assessment occurs before placement in chair. • Must notify the health authority or designee immediately upon placement. • Health authority must ensure that mental health clinician conducts a subsequent assessment to determine whether to transfer resident.

The approved amendments required health-trained staff to monitor the resident for signs of circulation and injury during each periodic check. This provision was problematic because the Department does not have health-trained staff. Therefore, rather than requiring health-trained staff to conduct these period checks, the proposal amends this provision to allow any staff including, direct care staff, to conduct the checks, and have the Department's actual medical staff conduct a more formalized check at least once every two hours. This is consistent with best practices.

In addition, the approved JDC amendments direct staff to allow residents restrained for two or more hours to exercise their limbs for at least ten minutes every two hours. This could be problematic if the resident is being transported by vehicle. If the resident needs to exercise his limbs while in the vehicle, the vehicle would need to stop, and the resident would be unrestrained, which could be concerning. The workgroup recommended adding an exclusion to address transportation.

Chairperson Woolard asked if staff are trained to understand the signs of circulation and injury. Ms. Peterson responded that the existing regulation requires any staff member who is authorized to use mechanical restraints be trained in that area. This requirement would continue.

Chairperson Woolard expressed concern about extending this monitoring authorization to any staff and was hopeful that the training for mechanical restraints would include what circulation and signs of injury problems might look like.

Board Member Schrad asked if the regulation requires basic medical training. Ms. Peterson responded that Section 160 requires direct care staff to receive first aid and CPR training unless they are currently certified.

Chairperson Woolard stated that checking the resident for signs of circulation and injuries that might develop while restrained seems more specific than first aid and commented that she would feel more comfortable with requiring such staff receive training beyond first aid.

Ms. Peterson replied that in Section 1190, Subsection A, #2, the language could be amended to require that during each check, a trained staff member shall monitor the resident for signs of circulation and injury.

Chairperson Woolard recommended that the board use the language referring to mechanical restraint training and suggested that, in the future, the Board determine what mechanical restraint training includes and whether it includes checking for signs of injury and circulation problems. Chairperson Woolard noted her concerns with situations in which the resident is transported for longer than two hours and asked how other agencies or medical care facilities deal with this issue. She indicated that if it is best practice to exercise the limbs at least ten minutes every two hours, Chairperson Woolard worries about the transport issue, but acknowledges there is no easy response.

Board Member Schrad said that law enforcement does not have the resources to do anything that would rise to this level and was not sure whether the ADA had regulations regarding civil commitment transportation.

Chairperson Woolard asked for a possible inquiry as a point of information in the future. Other jurisdictions that transport youth for long periods must deal with these types of issues. Ms. Peterson agreed to conduct additional research.

Currently, the regulation points to written procedure as governing the conditions under which mechanical restraints may be used. The workgroup wanted to ensure that the JDC regulation included a process for ensuring that if a resident is placed in the restraint chair, there are no contraindications for placement. Therefore, the workgroup recommended including a requirement for direct care staff to notify the health authority immediately after placing the resident in the restraint chair to assess the resident's health condition, check for contraindications, and advise whether the resident should be moved to a unit for emergency voluntary treatment. After the proposed JDC amendments began moving through the process, the workgroup discovered that the Department's health authority is not equipped to conduct that kind of assessment. The workgroup recommended instead requiring the health authority be responsible for ensuring that this assessment take place with a medical or mental health provider.

Language was also added regarding the timing for placing the resident in the restraint chair. The recommendation of the workgroup for the JDC proposal was that the resident would have to undergo a mental health or medical assessment immediately upon being placed in the restraint chair. The workgroup recommended changing the language to make the initial mental health and medical assessment occur before the resident is placed in the restraint chair. Once the resident is placed in the chair, the health authority must ensure a subsequent assessment is conducted to determine whether the resident should be moved to a unit for emergency treatment.

Ms. Peterson stated that these provisions are more restrictive than what the Department initially proposed for the JDCs.

Chairperson Woolard wanted clarification that Bon Air's health authority is not a medical professional. Ms. Peterson answered based on conversations with the Department's health service unit, Bon Air's health authority is not appropriately equipped to conduct these types of assessments.

Restraint Use on Pregnant Juveniles

Current Requirement	Change at proposed stage	Change at Final Stage
-Not addressed	-Not addressed.	*(Pg. 128)* - Bans the use of physical and mechanical restraints, protective devices, or the restraint chair on known pregnant residents during labor, delivery or post-partum recovery. • Exception: Resident presents immediate threat of hurting self, staff, or others. -Bans the use of abdominal, leg and ankle, behind-the-back wrist, and four-point restraints on known pregnant residents. • Exception: Resident presents immediate threat of hurting self, staff, or others or presents risk of escape that cannot be reasonably minimized.

To ensure the Department is in compliance with the Juvenile Justice Delinquency Prevention Act, specifically with the 2018 reauthorization, the workgroup added language that bans the use of certain mechanical and physical restraints and the use of protective equipment on certain pregnant woman. The prohibition on the use of physical and mechanical restraints, protective devices, or the restraint chair on known pregnant women applies only when they are in labor, in delivery, or in post-partum recovery. Because pregnant residents might still be assaultive, there is an exception in the federal

legislation and the proposal that allows restraints to be used if the resident presents an immediate threat of hurting herself, staff, or others. In addition, the proposal places a prohibition on the use of abdominal, leg, ankle, behind the back, and four point restraint on known pregnant residents, but allows for an exception if the resident presents an immediate threat of hurting herself, staff, or others or presents a risk of escape that cannot be reasonably minimized. This language closely tracks the federal language, and the workgroup wanted to ensure that the JCC is complying with the provisions of federal legislation.

Chairperson Woolard asked Ms. Peterson if there are any comments she wanted to make on the moderate or minor changes.

Ms. Peterson reminded the Board that the workgroup had recommended delaying implementation of the room confinement provisions at the Proposed Stage such that the provisions would take effect on the January 1 that falls at least nine months after the regulation takes effect. Although the language in the text at the proposed stage does not clearly establish that timeframe, the disAbility Law Center of Virginia suggested that the room confinement provision be implemented without delay. Ms. Peterson indicated that the Department has accomplished a great deal with reducing room confinement and believes that a delayed implementation date is no longer needed. Therefore, the workgroup recommends removing the delayed implementation date so that the confinement provisions will take effect on the same date as the regulation.

Chairperson Woolard wanted clarification on the section regarding telephone calls to families and asked why the department does not need a written procedure permitting phone calls based on security needs and scheduled activities. Chairperson Woolard believes a written procedure provides clarity to youth and families about how things should happen.

Ms. Peterson replied that the workgroup removed that language due to the incorporation by reference issue. The Department may not require compliance with the written procedure. Section 570 instructs staff to allow residents to call their immediate family members and natural supports, and the facility wants staff to have some flexibility due to security needs.

Chairperson Woolard asked if there was a policy or document that youth or families can access to learn more about phone calls or family engagement. Ms. Peterson responded that there is a provision in the current regulation that requires the visitation procedures be provided to the parent or legal guardian after the resident is admitted to the facility.

Chairperson Woolard was concerned and asked if the family and youth would continue to have a means of understanding the expectations about the nature of the contact, frequency of the contact, etc. Would there still be a regularity that youth and family can depend on in terms of the policy, and

obviously an understanding of the exceptions in the event of a security issue. Chairperson Woolard explained that she preferred language in the regulation noting that there are policies about communication with family, even if they cannot be referenced specifically.

Ms. Peterson replied that specific language is not in the regulation. In order to address the written procedures issue, Ms. Peterson suggested adding a Subsection C, directing the Department to have written procedures in place that establish the requirements for telephone calls.

Chairperson Woolard agreed, noting her support of language that specifies that the Department will ensure family engagement, including calls or contact for family and youth.

Ms. Peterson reiterated that the Department provides copies of the visitation procedure to parents or legal guardians in the current regulations, and asked Deputy Director Holmon to comment on whether contacts other than visitation are addressed in the visitation procedure. Deputy Director Holmon responded that this issue is addressed in the Resident Handbook for the Community Treatment Model, and the parent and family receive a copy along with the visitation procedure. The visitation procedure is also posted online and made available to parents and natural supports.

Chairperson Woolard asked about using similar language for family engagement. Ms. Peterson noted that actual text regarding family engagement is located in Section 765, on page 107 of the Board packet.

Chairperson Woolard noted the summary on page 73 referring to Section 765, which indicates that the proposal relaxes the duties of facility staff to plan events and activities that include family members, and asked what relaxing the requirement means.

Ms. Peterson answered that the language as proposed ensures the periodic arrangement of events and activities, but that some were concerned that even with this fairly broad language, the Department would be obligated to arrange events at specified times or to arrange a specified number of events. The workgroup was trying to make the language more broad, and was concerned that the use of the term "periodic" could suggest frequency. The workgroup did not want to obligate facility staff to those types of events in the regulation.

Chairperson Woolard expressed her belief that periodic events and activities with family members are essential to the health of the youth. She believed that the term "periodic" is pretty broad and does suggest more than one event, but having something in the regulation on family engagement elevates it a bit more than procedure in terms of indicating the Department's philosophy.

Board Member Schrad stated her concern with creating an obligation that the Department may not have adequate funding to support. This particular regulation addresses flexibility in terms of being

able to accommodate family engagement. The primary purpose of this regulation is to ensure the Department plans a certain number of activities a year.

Chairperson Woolard acknowledged Board Member Schrad's concern and indicated that she was comfortable with the proposal, noting that the Department puts an effort into family engagement, and she is encouraged, supportive, and appreciative of the work.

Chairperson Woolard asked whether the Board's suggested edits would affect the motion provided. Ms. Peterson replied that the proposed motion before the Board is broad enough to encompass any additional changes the Board recommended.

On motion duly made by Jennifer Woolard and seconded by Dana Schrad, the Board of Juvenile Justice approved the proposed amendments to the Regulation Governing Juvenile Correctional Centers (6VAC35-71), the proposed addition of a new chapter, Regulation Governing Juvenile Boot Camps (6VAC35-73), and any additional amendments presented and adopted at the June 24, 2020 meeting for advancement to the Final Stage of the Standard Regulatory Process. Mr. Frazier – Yea; Ms. Schrad – Yea; Mr. Underwood – Yea; Mr. Vilchez – Yea; and Ms. Woolard - Yea.

DJJ RESPONSE TO COVID-19
Valerie Boykin, Director, Department

Director Boykin thanked the Board for attending the virtual meeting during this challenging time and informed that the Board of her attempts to provide updates periodically on the agency's response to COVID-19. The Director thanked the Board for its interest and support.

Director Boykin provided a brief update on COVID-19. Before the pandemic hit Virginia, the Department began to develop agency-wide plans. Each of the operational divisions had a phased approach using the Department's old pandemic flu plan as a template. The Department periodically addressed plans as the pandemic moved fast and guidance changed. The CDC and the Virginia Department of Health (VDH) were frequently providing updates that changed the Department's protocols regularly.

The first case of COVID-19 was identified in Virginia on March 7, and the Governor declared a state of emergency on March 12. Department staff quickly moved to keep up with pandemic activities.

- Deputy Director for Community Programs Linda McWilliams arranged for court service units to continue operations.
- Deputy Director for Residential Services Joyce Holmon and her team ensured the safety of staff and residents in direct care.

- Deputy Director for Administration and Finance Jamie Patten moved into fast mode with major purchases. The Human Resources (HR) Office adjusted to the state offering paid emergency leave and other major personnel issues.
- Interim Superintendent Dr. Melinda Boone and the Education team worked on an education plan when schools closed. The Education team moved schools onto the units. The Department's IT team worked to set up computers and get them online so the youth could continue their education.

Bon Air suspended visitation on March 13, one-day after the declaration of emergency. Bon Air began screening staff in the facility daily and screening youth at least every 72 hours.

Director Boykin convened a COVID-19 Response Team that met daily at 8:30 a.m. This included the deputy directors, HR director, risk manager, and public information officer. The team met every day as long as the Governor had daily press conferences. Since that time, the team has met twice per week to provide divisional updates and adjust plans as needed.

Bon Air reported two positive non-direct care (non-security based) staff the first week of April. That same week, the VDH notified the Department that Bon Air's first youth tested positive. The decision was made to set up a medical quarantine at Bon Air based on VDH guidance. The Bon Air leadership team thought it best to isolate youth in their rooms on the unit. This was not an easy decision, but the team needed time to determine next steps. The VDH recommended taking youth's temperatures twice a day. Reports indicated many individuals in the community were asymptomatic. While the CDC assigned a fever at 104 degrees, VDH suggested Bon Air test every youth with an elevated temperature of at least 99 degrees. It was through those aggressive efforts that Bon Air determined in a two-week period that 26 youth tested positive.

This was a scary and challenging time. To this date, we have not been able to trace how the virus entered the facility. Bon Air was able to isolate the outbreak to only four units and during the course of the next two or three weeks, Bon Air only had three additional youth test positive. The local health department indicated only four youth in Bon Air actually showed any symptoms. Bon Air's Dr. Moon best described it as either a bad cold or flu-like symptoms.

The Department is fortunate to have caught this early, and grateful to the local health department for the additional guidance. Youth are very resilient. Bon Air was able to open a second medical unit, and each time a youth was identified they were moved to medical isolation for a period of time or until they did not display symptoms for a certain number of days. Typically, most youth were considered recovered in seven to eight days. Youth in quarantine would stay about fourteen days, unless they became ill, which was not the case for the majority of the Bon Air population.

The Community Programs team worked with the courts to manage the population. The Supreme Court of Virginia issued about six orders delaying or changing court operations. Department staff was flexible and worked in those environments to ensure Department mandates to the court were met. The Community Programs team continued seeing young people and addressing their needs. In addition, they worked with service providers to ensure the needs of the families and youth were met. The team also developed creative ways to serve the 3,500 youth on probation or other types of supervision in the community.

Communication became a critical component for operations. Director Boykin tried to provide timely updates to the Board and to the public. The Department issued press releases when staff and youth were first diagnosed. The Department delayed releasing press updates for a period of time to determine who to inform and what information to provide. The Department always knew its first priority was to the youth, employees, and family of the youth. Department issued a press release that Bon Air had 25 positives, and unfortunately was quoted in many newspapers as the worst outbreak site in the country; however, there were only four states reporting any data at that time. The Department thought it was overreaching and overextending by sharing critical youth information.

The Department provided information to parents and began a COVID-19 page on its website posting pertinent information. The Director's first letter to parents went out on March 16, and she has issued six or seven letters to parents since the pandemic hit. Additional information has been shared across the Department to keep staff updated as protocols changed. Information is critical during this time. The Department issued additional press releases, but the media has not shared that Bon Air has been COVID-19 free for seven weeks. No new youth tested positive since the first part of May. The VDH cautions that the virus is not gone and is still widely spreading in the community. The Department is cautiously optimistic about its efforts. Deputy Director Holmon's staff showed up daily and worked through unusual circumstances.

During this time, the Community Programs staff worked with court stakeholders, and over 200 youth were released from secure detention centers over a two-week period. As of May 31, the Department released 90 youth from direct care supervision; 39 of those youth were from Bon Air and 51 from alternative placements. The Department has continued in June to release young people as appropriate. Deputy Director Holmon, the Residential Services team, and Community Programs staff reviewed the case of every indeterminately committed youth and determined if it was appropriate to release them to the community. The team looked at many factors, including the length of stay, completion of treatment, whether treatment could be finished in the community, the availability of wrap-around services for youth and their families upon release, the youth's health and that of his family, and other programs to which the youth could be sent. The Department made decisions based on the best interest of the child and family.

The current numbers at Bon Air are the lowest population the Department has had, at 159 youth with a total of 257 youth across alternative placements. Some of this data are based on the courts not being operational for three months, and we anticipate that the numbers will increase when the courts open and catch up. Director Boykin is tremendously proud of the hard work of staff across the agency who continue to deliver quality services to young people under unusual circumstances.

Chairperson Woolard said that this is an unprecedented time that challenged the agency, the youth, and their families. The conversations at the meeting are just an inkling of the pressures, and the dedication of staff doing their best under challenging circumstances is admirable. Leaving aside the court closure, the numbers at Bon Air are amazing and tremendous. The team went above and beyond to release a large number of youth back to the community. In case this pandemic reoccurs, the diligence of the Department will result in lessons learned and best practices that can be shared with other states.

Director Boykin said the team looked at every indeterminately committed youth and a number of serious offenders committed by the court and worked closely with attorneys and prosecutors. Although the Department may not have control over their release dates, the Department may make recommendations as appropriate on hearing dates. Not all courts are operational, so it may not be possible in some situations. Director Boykin thanked Legislative and Policy Manager Mike Favale and his team for their help in this effort.

Director Boykin thanked Chief Deputy Director Angela Valentine for helping with communications and answering inquiries. The Department received many questions from well-intentioned advocacy organizations, who demanded many answers that took a long time to coordinate.

Board Member Schrad said she is impressed with how things were handled and was curious to hear if the Department will make any long-term changes in protocol based on new best practices learned from this experience. This will probably be true for law enforcement agencies.

Board Member Frazier concurred, and stated his appreciation for the Department's communication, the way youth were handled, and the allowances made for staff. He thanked the Department for keeping everyone as safe as possible.

DIRECTOR'S COMMENTS AND BOARD COMMENTS

The current social justice movements allowed the Department to revisit issues around equity and social justice. The Director's Message on the website is asking us to come together and think about what can be done to renew conversations. These will be difficult and courageous conversations that can impact Department issues around equity and fairness in the system.

In the midst of a pandemic, the Yvonne B. Miller High School will celebrate a summer graduation. Dr. Boone, the Department's Interim Superintendent, has reported six graduates. Yvonne B. Miller held a winter graduation earlier this year. Some young people needed to finish course work over the summer to graduate later this year. Dr. Boone and Deputy Director Holmon are allowing a small number of parents to participate in the graduation ceremony. This is the first time the facility will open to a small number of visitors. Deputy Director Holmon and her team are working on a plan to reopen the facility for visitation, but it must be done safely. Bon Air has allowed additional phone calls for young people. The team has tried to keep the communication open with some staff using their iPhones to help with video visitation. The Department values family engagement and continues to work on keeping the youth as connected as possible.

The state is in a hiring freeze, and the Department is working with the Secretary's Office to fill critical positions.

Chairperson Woolard announced this would be her last Board meeting, although her term is not completed. Chairperson Woolard is a psychology professor and researcher in the juvenile justice area. To prevent conflicts of interest when she joined the Board, all research had to stop in Virginia connected to juvenile justice and the Department. During the pandemic, she felt the call to get back into family engagement research given the circumstances that many families experienced and decided to step down and move towards a role of promoting research on family engagement. She hopes the research will benefit the Department, the families, and the youth. Chairperson Woolard thanked Board Member Frazier for stepping in as chair, and is confident the Board will continue its tremendous work. Chairperson Woolard thanked Director Boykin and her staff for their hard work and for supporting the Board as it strives to serve youth and families.

Director Boykin read a resolution prepared for Chairperson Woolard.

NEXT MEETING DATE
September 16, 2020, at 9:30 a.m.

ADJOURNMENT
The meeting was adjourned at 12:53 p.m.

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[1] After the June 24 Board meeting, Ms. Peterson received clarification that the workgroup's proposal to require the case level review no later than seven business days after the referral was intentional. On those occasions where an emergency facility level review must be held earlier than the scheduled date, there may not be sufficient time to cover the issue at a subsequent, agency-level review meeting if it occurs that same day or the next day. In those very rare instances, the issue would need to be addressed at the following division-level meeting. Seven business days allows for sufficient time in those scenarios.

DEPARTMENT CERTIFICATION ACTIONS

August 5, 2020

SUMMARY

Certified the Crater Juvenile Detention Center until May 8, 2023.

Extended the current certification of Crossroads Community Youth Home to January 2021, with a status report on the findings of non-compliance in the December 4, 2019 audit.

Certified the Summit Transitional Living Program until April 29, 2022, with a full compliance audit.

Certified the Westhaven Boys' Home until July 9, 2023.

Certify Certified the 12th District Court Service Unit until May 18, 2023, with a status report in August 2021 by the Regional Program Manager regarding the area of noncompliance.

Certified the 30th District Court Service Unit until June 17, 2023, with a letter of congratulations for 100% compliance.

CERTIFICATION AUDIT REPORT
TO THE
DEPARTMENT OF JUVENILE JUSTICE

PROGRAM AUDITED:
Crater Juvenile Detention Center
6102 County Drive
Disputanta, VA 23842
(804) 862-0644
Jack M. Scott, Executive Director
JScott@cyc.state.va.us

AUDIT DATES:
December 3, 2019

CERTIFICATION ANALYST:
Learna R. Harris

CURRENT TERM OF CERTIFICATION:
May 9, 2017-May 8, 2020

REGULATIONS AUDITED:
6VAC35-101 Regulation Governing Juvenile Secure Detention Centers

PREVIOUS AUDIT FINDINGS December 12, 2016:
100% Compliance Rating

CURRENT AUDIT FINDINGS – December 3, 2019:
99.6% Compliance Rating
Number of deficiencies: One
6VAC35-101-1060 (H) Medication

DEPARTMENT CERTIFICATION ACTION 8/5/2020: Certified the Crater Juvenile Detention Center until May 8, 2023.
Pursuant to 6VAC35-20-100C.2, if the certification audit finds the program or facility in less than 100% compliance with all regulatory requirements and a subsequent status report, completed prior to the certification action, finds 100% compliance on all regulatory requirements, the director or designee shall certify the facility for a specific period of time, up to three years.

TEAM MEMBERS:
Learna Harris, Team Leader
Shelia Palmer, Central Office
Mark Lewis, Central Office
John Adams, Central Office
Clarice Booker, Central Office
Shamika Massenburg, Henrico JDC

POPULATION SERVED:

The Crater Juvenile Detention Center is a secure custody facility operated by the Crater Youth Care Commission. The Crater Juvenile Detention Home provides services for the cities of Petersburg, Hopewell, and Emporia and the counties of Prince George, Sussex, Surry and Dinwiddie. The facility serves a pre-dispositional population of 22 male and female residents'

ages eight through 17. The facility is also approved to serve juveniles through the age of 19 in the Re-entry Program.

PROGRAMS AND SERVICES PROVIDED:

In addition to all mandated services, Crater Juvenile Detention Center provides the following:

- Educational services are available Monday-Friday, from 8:30 am to 3:00 pm, with four (4) teachers assigned to the educational program, five and a half hours daily.
- Recreation, both indoor and outdoor, is an integral part of the daily schedule.
- Large muscle group activities are offered twice daily.
- Special guest/visitors and speakers are an active part of the program. They include bible study groups, and presentations from the community.
- Crisis counseling is also available as needed through the District 19 Community Services Board. These services include intensive one to one counseling, substance abuse counseling, and family counseling. A mental health clinician is assigned to the facility in addition to a contractual psychiatrist.
- Parents and guardians visit youth on Thursdays from 7:30 pm to 8:30 pm and Sundays from 12:30 pm to 1:30 pm. Special visitations are on an as needed basis IAW our Visitation Policy.
- The Department of Juvenile Justices' Re-Entry Program as needed.

CORRECTIVE ACTION PLAN
TO THE
DEPARTMENT OF JUVENILE JUSTICE

FACILITY/PROGRAM:	Crater Juvenile Detention Center
SUBMITTED BY:	Jack M. Scott, Executive Director
CERTIFICATION AUDIT DATES:	December 3, 2019
CERTIFICATION ANALYST:	Learna R. Harris

Under Planned Corrective Action indicate; 1) The cause of the identified area of non-compliance. 2) The effect on the program. 3) Action that has been taken/will be taken to correct the standard cited. 4) Action that will be taken to ensure that the problem does not recur.

6VAC35-101-1060 (H). Medication. CRITICAL

H. In the event of a medication incident or an adverse drug reaction, first aid shall be administered if indicated. Staff shall promptly contact a poison control center, pharmacist, nurse, or physician and shall take actions as directed. If the situation is not addressed in standing orders, the attending physician shall be notified as soon as possible and the actions taken by staff shall be documented. A medication incident shall mean an error made in administering a medication to a resident including the following: (i) a resident is given incorrect medication; (ii) medication is administered to the incorrect resident; (iii) an incorrect dosage is administered; (iv) medication is administered at a wrong time or not at

all; and (v) the medication is administered through an improper method. A medication error does not include a resident's refusal of appropriately offered medication

Audit Finding:
One of one applicable medication incident reviewed there was no documentation that the prescribing physician was notified.

Program Response

Cause:
A medication error occurred where a medication that was prescribed once daily and dispensed as a morning medication was received again at bedtime medication pass. It was reported to the nurse upon the discovery of the incident. It was a medication that would not cause an adverse reaction or overdose. When reported to the nurse, the prescribing doctor was not made aware, nor was the facilities covering doctor within 24 hours of the incident occurring. Human Error.

Effect on the Program:
Although no serious event occurred due to the omission of notifying the physician, not reporting failed the requirement of Policies and Procedures in place to prevent a serious event.

Planned Corrective Action:
Increase staff training sessions and individual training session to decrease or eliminate medication errors. A call will be placed to the prescribing physician for all future medication error incidents, if unable to contact the prescribing physician, our contracted facility physician will be contacted.

Completion date:
December 16, 2019

Person responsible:
Facility director, facility nurse.

Current Status on June 11, 2020: Compliant
One of one applicable medication incident reviewed had documentation that the prescribing physician was notified.

CERTIFICATION AUDIT REPORT
TO THE
DEPARTMENT OF JUVENILE JUSTICE

PROGRAM AUDITED:
Crossroads Community Youth Home
5684 Mooretown Road
Williamsburg, VA 23188
757-890-4140
Patrick Hines, Program Manager III
Currently: Amy Crotty
Amy.Crotty@yorkcounty.gov

AUDIT DATES:
December 3-4, 2019

CERTIFICATION ANALYST:
Shelia L. Palmer

CURRENT TERM OF CERTIFICATION:
May 9, 2017–May 8, 2020

REGULATIONS AUDITED:
6VAC35-41 Regulation Governing Juvenile Group Homes

PREVIOUS AUDIT FINDINGS – May 10, 2017:
100% Compliance Rating

CURRENT AUDIT FINDINGS – December 4, 2019:
92.36%
6VAC35-41-110 (A). Grievance procedure.
6VAC35-41-165 (A). Employee tuberculosis screening and follow-up
6VAC35-41-165 (B). Employee tuberculosis screening and follow-up
6VAC35-41-170. Physical examination
6VAC35-41-190 (A). Required initial orientation.
6VAC35-41-190 (B). Required initial orientation
6VAC35-41-200 (A). Required initial training
6VAC35-41-200 (B). Required initial training.
6VAC35-41-200 (D). Required initial training.
6VAC35-41-210 (B). Required retraining.
6VAC35-41-210 (C). Required retraining.
6VAC35-41-210 (E). Required retraining.
6VAC35-41-210 (H). Required retraining.
6VAC35-41-310 (B). Personnel records.
6VAC35-41-350 (C). Buildings and inspections.
6VAC35-41-490 (I). Emergency and evacuation procedures. (CRITICAL)
6VAC35-41-1200. Health screening at admission. (CRITICAL)
6VAC35-41-1210 (A). Tuberculosis screening. (CRITICAL)
6VAC35-41-1250 (A). Residents' health records. (CRITICAL)
6VAC35-41-1280 (H). Medication. (CRITICAL)
6VAC35-41-1280 (J). Medication. (CRITICAL)

DEPARTMENT CERTIFICATION ACTION 8/5/2020: Extended the current certification of Crossroads Community Youth Home to January 2021, with a status report on the findings of non-compliance in the December 4, 2019 audit.
Pursuant to 6VAC35-20-100 (4.a)
4. If the certification audit finds the program or facility in less than 100% compliance with all critical regulatory requirements or less than 90% on all noncritical regulatory requirements or both, and a subsequent status report, completed prior to the certification action, finds less than 100% compliance on all critical regulatory requirements or less than 90% compliance on all noncritical regulatory requirements or both, the program or facility shall be subject to the following actions:
a. If there is an acceptable corrective action plan and no conditions or practices exist in the program or facility that pose an immediate and substantial threat to the health, welfare, or safety of the residents, the program's or facility's certification shall be continued for a specified period of time up to one year with a status report completed for review prior to the extension of the certification period.

TEAM MEMBERS:
Shelia L. Palmer, Team Leader
Clarice Booker, DJJ Central Office
Deborah Hayes, DJJ Central Office
Mark Lewis, DJJ Central Office
Learna Harris, DJJ Central Office
John Adams, DJJ Central Office
Leslie Hull, Central Office
Romilda Smith, Central Office
Thomasine Norfleet, Virginia Beach Crisis

POPULATION SERVED:

Crossroads Community Youth Home is a community-based group home for at-risk adolescent males and females between the ages of 14 and 17. It has a capacity of 16 residents. The facility is operated by Colonial Group Home Commission and serves the 9th Judicial District residents and families from that jurisdiction.

PROGRAMS AND SERVICES PROVIDED:

The program emphasizes personal accountability, competency development, and positive functioning in the community. In order to achieve the objectives stated above, the program includes building life skills competencies, rehabilitating socially unacceptable behavior, enabling insight into problematic behavior, reinforcing appropriate limits and boundaries, facilitating positive life choices, and promoting appropriate self-confidence.

In addition to all mandated services. Crossroads Community Youth Home provides the following at the facility:

- Education
- Social Skills
- Decision Making
- Anger Management
- Baby Think It Over

- Law Related Education
- Active Daily Living Skills
- Study Hall and Tutoring

Crossroads Community Youth Home interacts with the community in obtaining such services as:

- Professional counseling services through Colonial Behavioral Health
- York County Juvenile Psychological Services and Substance Abuse Programs
- Education through York County Public Schools

CORRECTIVE ACTION PLAN
TO THE
DEPARTMENT OF JUVENILE JUSTICE

FACILITY/PROGRAM: **Crossroads Community Youth Home**

SUBMITTED BY: **Patrick Hines, Program Manager III**

CERTIFICATION AUDIT DATES: **December 4-5, 2019**

CERTIFICATION ANALYST: **Shelia L. Palmer**

Under Planned Corrective Action indicate; 1) The cause of the identified area of non-compliance. 2) The effect on the program. 3) Action that has been taken/will be taken to correct the regulation cited. 4) Action that will be taken to ensure that the problem does not recur.

6VAC35-41-110 (A). Grievance procedure.
A. Written procedure shall provide that residents are oriented to and have continuing access to a grievance procedure that provides for:
1. Resident participation in the grievance process with assistance from staff upon request;
2. Investigation of the grievance by an objective employee who is not the subject of the grievance;
3. Documented, timely responses to all grievances with the reasons for the decision;
4. At least one level of appeal;
5. Administrative review of grievances;
6. Protection from retaliation or threat of retaliation for filing a grievance; and
7. Hearing of an emergency grievance within eight hours.

Audit Finding: Nine of 10 grievances reviewed did not have documentation of an administrative review.

Program Response

Cause:
As per policy, all grievances require an administrative review. In nine of ten grievances reviewed, there was no documentation that an administrative review had been completed.

Effect on Program:
It is every resident's right to be treated fairly and equitably. Staff are required to implement all policies and procedures equally to all residents. In order to ensure due process, administrative reviews must be completed for each grievance filed by a resident.

Planned Corrective Action:
The current Grievance Form does not provide the format to document that an administrative review was completed. A new form has been developed (Form CCYH-110) with information required to ensure the necessary follow-up. Procedure will follow that once the resident completes the grievance, the Program Manager will forward the grievance to an assigned investigating staff

member. If the resident requests an appeal, the form will be forwarded to the Case Manager/designee for a decision. Final decision will be completed by the Program Manager.

Completion Date:
The new form will be used immediately.

Person Responsible:
Program Manager, Patrick Hines, will provide the final decision and ensure the resident understands and signs the Grievance Form. The Division Manager will review all completed grievances monthly.

Current Status on June 25, 2020: Compliant
Five of five grievances reviewed documented an administrative review.

6VAC35-41-165 (A). Employee tuberculosis screening and follow-up.

A. On or before the employee's start date at the facility each employee shall submit evidence of freedom from tuberculosis in a communicable form that is no older than 30 days. The documentation shall indicate the screening results as to whether there is an absence of tuberculosis in a communicable form.

Audit Finding: Four of seven new employee files reviewed did not have documentation of a tuberculosis screening on or before the employee's start date.

Program Response

Cause:
In four of seven files, there was no documentation that an initial evaluation of freedom from tuberculosis in a communicable form was completed. There was no administrative follow-up to determine whether or not the tuberculosis screening had been completed on or before the employee's start date.

Effect on Program:
This could have potentially led to the employees in question being positive for tuberculosis and transmitting the disease to co-workers and the residents on site. Although there appeared to be no direct impact on any of the resident's or other staff's health, the potential still existed.

Planned Corrective Action:
Employee Personnel Files will include a checklist detailing specific requirements that must be completed before and after new employee hires. For potential employees, after review of the reference checks, the Program Manager will contact the employees to complete background checks, as well as provide the forms necessary for completion of the tuberculosis screening and the physical examination. All paperwork must be completed prior to the official date of employment.

Completion Date:

All current new employees who have not completed a tuberculosis screening will be scheduled to complete one immediately. For potential employees, the forms will be provided immediately after reference checks are completed.

Person Responsible:
Program Manager, Patrick Hines, shall ensure that each potential employee has the initial tuberculosis screening for completion. Administrative staff will file the completed paperwork in the employee's personnel file. The Division Manager will review new employee files monthly.

Current Status on June 25, 2020: Compliant
Three of three new employee files reviewed had documentation of a tuberculosis screening on or before the employee's start date

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6VAC35-41-165 (B). Employee tuberculosis screening and follow-up.
B. Each employee shall submit evidence of an annual evaluation of freedom from tuberculosis in a communicable form.

Audit Finding: Four of five employee files did not have documentation of an annual tuberculosis screening for the year 2018.

Two of five employee files did not have documentation of an annual tuberculosis screening for the year 2019.

Program Response

Cause:
In four of five employees for the year 2018 and two of five employees for the year 2019, there was no documentation that an annual evaluation of freedom from tuberculosis in a communicable form was completed. There was no administrative follow-up reviewing the date when the prior year tuberculosis test was administered.

Effect on Program:
This could have potentially led to the employees in question being positive for tuberculosis and transmitting the disease to co-workers and the residents on site. Although there was no direct impact on any of the resident's or other staff's health, the potential still existed.

Planned Corrective Action:
Employee personnel files will include a checklist detailing specific requirements that must be completed after new employee hire, as well as a separate checklist for annual employee updates. Required annual tuberculosis testing will be included on the annual checklist. At the time of hire, the Program Manager will emphasize the required process for obtaining annual tuberculosis screening and follow-up. Once proper documentation detailing results of the tuberculosis test is received, a copy will be placed in the employee's file.

Completion Date:

All current employees who have not completed a tuberculosis screening within the past year will be scheduled to complete one immediately. Annual tuberculosis screening and follow-up will be effective immediately,

Person Responsible:
Program Manager, Patrick Hines, or designee, shall ensure that each employee has the initial tuberculosis screening. Administrative staff will review the employee personnel checklist regularly to ensure timely annual tuberculosis screening follow-up in accordance with this standard. The Division Manager will review current employee files quarterly.

Current Status on June 25, 2020: Compliant
Three of three employee files reviewed had documentation of an annual tuberculosis screening for the year 2020.

6VAC35-41-170. Physical examination.
When the qualifications for a position require a given set of physical abilities, all persons selected for such positions shall be examined by a physician at the time of employment to ensure that they have the level of medical health or physical ability required to perform assigned duties. Persons hired into positions that require a given set of physical abilities may be reexamined annually in accordance with written procedures.

Audit Finding: Four of seven new employee files reviewed did not have documentation of a physical examination.

Program Response

Cause:
In four of seven new employee files, there was no documentation that a physical examination was completed to ensure that they have the level of medical health or physical ability required to perform the assigned duties. There was no administrative follow-up reviewing the personnel files to determine whether or not a physical examination had been completed at the time of employment.

Effect on Program:
This could have potentially led to the employees in question being unable to complete the required set of physical abilities as documented in their job description. Although there appeared to be no concerns or issues directly impacting their job performance, the potential still existed.

Planned Corrective Action:
Employee Personnel Files will include a checklist detailing specific requirements that must be completed before and after new employee hires. For potential employees, after review of the reference checks, the Program Manager will contact the employees to complete background checks, as well as provide the forms necessary for completion of the tuberculosis screening and the physical examination. All paperwork must be completed prior to the official date of employment.

Completion Date:
All current new employees who have not completed the physical examination form will be scheduled to complete one within 30 days. For potential employees, the forms will be provided immediately after the reference checks are completed.

Person Responsible:
Program Manager, Patrick Hines, shall ensure that each potential employee has the initial physical examination form for completion. Administrative staff will file the completed paperwork in the employee's personnel file and review the employee personnel checklist regularly to ensure timely physical examinations are completed in accordance with this standard. The Division Manager will review all new employee files quarterly.

Current Status on June 25, 2020: Compliant
Three of three new employee files reviewed had documentation of a physical examination.

6VAC35-41-190 (A). Required initial orientation.
A. Before the expiration of the employee's seventh workday at the facility, each employee shall be provided with a basic orientation on the following:
1. The facility;
2. The population served;
3. The basic objectives of the program;
4. The facility's organizational structure;
5. Security, population control, emergency preparedness, and evacuation procedures in accordance with 6VAC35-41-490 (emergency and evacuation procedures);
6. The practices of confidentiality;
7. The residents' rights; and
8. The basic requirements of and competencies necessary to perform in the position.

Audit Finding: Three of seven employee files did not have documentation that the required initial orientation was conducted before the expiration of the employee's seventh workday at the facility.

Program Response

Cause:
For three of the seven employee's files in question, there was no documentation that the required initial orientation training was conducted within seven (7) workdays showing that the employee received proper orientation to the facility or to the population served. There was no administrative follow-up conducted to verify the information.

Effect on Program:
The date on the initial training documents is very important in terms of the employee learning the correct elements of the program from the start of employment in order to meet the needs of the residents on site.

Planned Corrective Action:

Employee personnel files will include a checklist detailing initial training requirements to be completed after new employee hire. In order to ensure compliance with initial training, all new employees will receive a "New Employee Orientation" handbook which includes a signature page detailing the requirements of the program. All new employees will meet one-on-one with the Program Manager, or designee, for basic orientation within 7 days of employee's start date regarding the following:

- The Facility
- The Population Served
- The basic objectives of the program
- The facility's organizational structure
- Security, population, emergency preparedness
- The practice of confidentiality
- The resident's files

Once the orientation is complete, the new employee will sign the signature page for inclusion in the employee's file.

Completion Date:
Effective immediately

Person Responsible:
Program Manager, Patrick Hines, or designee, shall ensure that each employee has completed and signed/dated the basic orientation form. Administrative staff will place the document in the employee's personnel files, with a copy provided to the employee. The Division Manager will review all new employee files quarterly.

Current Status on June 25, 2020: Compliant
Three of three employee files had documentation of the required initial orientation was conducted before the expiration of the employee's seventh workday at the facility.

6VAC35-41-190 (B). Required initial orientation.
B. Prior to working with residents while not under the direct supervision of staff who have completed all applicable orientations and training, each direct care staff shall receive a basic orientation on the following:
1. The facility's program philosophy and services;
2. The facility's behavior management program;
3. The facility's behavior intervention procedures and techniques, including the use of least restrictive interventions and physical restraint;

Audit Finding: Three of seven new employee files reviewed did not have documentation of the required initial orientation being conducted prior to working with residents while not under the direct supervision of staff.

Program Response

Cause:

In three of seven new employee's files, there was no documentation that the required initial orientation training was conducted prior to working with residents while not under the direct supervision of staff. There was no signed documentation showing that the employee received proper orientation and training for direct care on the program philosophy and services, behavior management program, and intervention procedures and techniques. There was no administrative follow-up conducted to verify the information.

Effect on Program:
The date on the initial training documents is very important in terms of the employee learning the correct elements of the program from the start of employment in order to meet the needs of the residents on site.

Planned Corrective Action:
Employee Personnel Files will include a checklist detailing initial training requirements to be completed after new employee hire. In order to ensure compliance with initial training, all new employees will receive a "New Employee Orientation" handbook, which includes a signature page detailing the requirements of the program. All new employees will meet one-on-one with the Program Manager, or designee, for basic orientation prior to working alone with residents regarding the following:

- The facility's program philosophy and services
- The facility's behavior management program
- The facility's behavior intervention procedures and techniques, including the use of least restrictive interventions and physical restraint

Once the orientation is complete, the new employee will sign the signature page for inclusion in the employee's file.

Completion Date:
Effective immediately

Person Responsible:
Program Manager, Patrick Hines, or designee, shall ensure that each employee has completed and signed/dated the required initial orientation form. Administrative staff will place the document in the employee's personnel files, with a copy provided to the employee. The Division Manager will review all new employee files quarterly.

Current Status on June 25, 2020: Compliant
Three of three new employee files reviewed had documentation of the required initial orientation being conducted prior to working with residents while not under the direct supervision of staff.

6VAC35-41-200 (A). Required initial training.
A. Each full-time and part-time employee and relief staff shall complete initial, comprehensive training that is specific to the individual's occupational class, is based on the needs of the population served, and ensures that the individual has the competencies to perform in the position.

1. Direct care staff shall receive at least 40 hours of training, inclusive of all training required by this section, in their first year of employment.
2. Contractors shall receive training required to perform their position responsibilities in a juvenile residential facility.

Audit Finding: Three of seven new employee files reviewed did not have documentation of direct care staff receiving at least 40 hours of training.

Program Response

Cause:
In three of seven new employee's files, there was no documentation that the required initial training had been completed and that direct care staff had received at least 40 hours of training based on the needs of the population. There was no administrative follow-up to verify completeness of the initial training files.

Effect on Program:
The date on the initial training documents is very important in terms of the employee learning the correct elements of the program from the start, in order to meet the needs of the residents in the program and ensure that the employee has the competencies to perform the job duties. Therefore, the initial required training needs to be conducted within 30 days and 40 hours of training completed within their first year of employment.

Planned Corrective Action:
Employee personnel files will include a checklist detailing initial training requirements to be completed after new employee hire. Required annual training will be on a separate checklist. In order to ensure compliance, all new employees will be provided a Training Log detailing 40 hours of required training, certifications, and/or renewals that will occur within 30 days of hire, as well as throughout the year.

Once the initial training is completed, each employee will sign a signature page for inclusion in the employee's file.

Completion Date:
Effective immediately

Person Responsible:
Program Manager, Patrick Hines, or designee, shall ensure that each employee has completed and signed/dated the initial orientation form, to include the required initial training within 30 days. Administrative staff will place the document in the employee's personnel files and will ensure that Training Logs are created for new employees and placed in the Training Log Binder. The Division Manager will review all new employee files and training logs quarterly.

Current Status on June 25, 2020: Not determined
Three of three new employee files reviewed have not completed their first year of employment with Crossroads Youth Group Home.

6VAC35-41-200 (B). Required initial training.
B. Within 30 days following the employee's start date at the facility or before the employee is responsible for the direct supervision of a resident, all direct care staff and staff who provide direct supervision of the residents while delivering services, with the exception of workers employed by contract to provide behavioral health or health care services, shall complete training in the following areas:
1. Emergency preparedness and response;
2. First aid and cardiopulmonary resuscitation, unless the individual is currently certified, with certification required as applicable to their duties;
3. The facility's behavior management program;
4. The residents' rules of conduct and the rationale for the rules;
5. The facility's behavior intervention procedures, with physical and mechanical restraint training required as applicable to their duties;
6. Child abuse and neglect;
7. Mandatory reporting;
8. Maintaining appropriate professional relationships;
9. Interaction among staff and residents;
10. Suicide prevention;
11. Residents' rights, including, but not limited to, the prohibited actions provided for in 6VAC35-41-560 (prohibited actions);
12. Standard precautions; and
13. Procedures applicable to the employees' position and consistent with their work profiles.

Audit Finding: Within 30 days following the employee's start date at the facility or before the employee is responsible for the direct supervision of a resident:

Two of seven new employee files reviewed did not have documentation of emergency preparedness and response training.

Three of seven new employee files reviewed did not have documentation of the facility's behavior management program, the facility's rules of conduct and rationale for the rules, child abuse and neglect, mandatory reporting, maintaining appropriate professional relationships, interaction among staff and residents, suicide prevention, resident's rights, the prohibited actions, standard precautions and procedures applicable to the employees' position and consistent with their work profiles.

Four of seven new employee files reviewed did not have documentation of training in first aid and cardiopulmonary resuscitation and behavior intervention procedures with physical and mechanical restraint training.

Program Response

Cause:

In two of seven new employee's files, there was no documentation that the required initial training, to include emergency preparedness and response training, was conducted within 30 days following the employee's start date.

In three of seven new employee's files, there was no documentation that the required initial training, to include facility's behavior management program, the facility's rules of conduct and rationale for the rules, child abuse and neglect, mandatory reporting, maintaining appropriate professional relationships, interaction among staff and residents, suicide prevention, resident's rights, the prohibited actions, standard precautions and procedures applicable to the employees' position and consistent with their work profiles, was conducted within 30 days following the employee's start date.

In four of seven new employee's files, there was no documentation that the required initial training, to include first aid and cardiopulmonary resuscitation and behavior intervention procedures with physical and mechanical restraint training, was conducted within 30 days following the employee's start date.

There was no administrative follow-up to verify completeness of the initial training files.

Effect on Program:
The date on the initial training documents is very important in terms of the employee learning the correct elements of the program from the start, in order to meet the needs of the residents in the program. Therefore, the required initial training needs to be conducted within 30 days.

Planned Corrective Action:
Employee personnel files will include a checklist detailing initial training requirements to be completed after new employee hire. Required annual training will be on a separate checklist. In order to ensure compliance, all new employees will be provided a Training Log detailing 40 hours of required training, certifications, and/or renewals that will occur within 30 days of hire, as well as throughout the year. Training areas include, but are not limited, to the following:

1. Emergency Preparedness and Response
2. CPR/ First Aid/AED Training
3. Facility's Behavior Management Program
4. Residents Behavior Rules of Conduct and Rationale for Rules
5. Facilities Behavior Intervention Procedures with Physical and Mechanical Restraint Training (Handle with Care)
6. Child Abuse and Neglect
7. Mandatory Reporting
8. Maintaining Appropriate Professional Relationships
9. Interaction Among Staff and Residents
10. Suicide Prevention
11. Resident Rights Including, but not limited to, the prohibitive action
12. Standard Precautions
13. Procedures Applicable to Employees Position and Consistent with Work Profiles

Once the initial training is completed, each employee will sign a signature page for inclusion in the employee's file.

Completion Date:
Effective immediately

Person Responsible:
Program Manager, Patrick Hines, or designee, shall ensure that each employee has completed and signed/dated the initial orientation form, to include the required initial training within 30 days. Administrative staff will place the document in the employee's personnel files and will ensure that Training Logs are created for new employees and placed in the Training Log Binder. The Division Manager will review all new employee files and training logs quarterly.

Current Status on June 25, 2020: Compliant
Within 30 days following the employee's start date at the facility or before the employee is responsible for the direct supervision of a resident:

Three of three new employee files reviewed had documentation of emergency preparedness and response training.

Three of three new employee files reviewed had documentation of the facility's training in behavior management program, the facility's rules of conduct and rationale for the rules, child abuse and neglect, mandatory reporting, maintaining appropriate professional relationships, interaction among staff and residents, suicide prevention, resident's rights, the prohibited actions, standard precautions and procedures applicable to the employees' position and consistent with their work profiles.

Current Status on June 25, 2020: Not Determined
First aid and cardiopulmonary resuscitation, behavior intervention procedures with physical and mechanical restraint training was postponed for March 2020 due to the coronavirus. This training will occur after July 1, 2020.

First aid and cardiopulmonary resuscitation is scheduled for July 29, 2020.
Behavior intervention procedures with physical and mechanical restraint training (Handle with Care) is scheduled for July 29, 2020 and August 1, 2020.

6VAC35-41-200 (D). Required initial training.
D. Training shall be required by and provided as appropriate to the individual's job duties and in accordance with the provider's training plan.

Audit Finding: Three of seven new employee files reviewed did not have documentation of the required initial training appropriate to the individual's job duties and in accordance with the provider's training plan.

Program Response

Cause:
In three of seven new employee's files, there was no documentation that the required initial training had been completed appropriate to the employee's job duties and in accordance with the Crossroads training plan. There was no administrative follow-up to verify completeness of the initial training files.

Effect on Program:
The date on the initial training documents is very important in terms of the employee learning the correct elements of the program from the start, in order to meet the needs of the residents in the program and ensure that the employee has the competencies to perform in the position. Therefore, all initial required training needs to be conducted in accordance with the Crossroads training plan.

Planned Corrective Action:
Employee personnel files will include a checklist detailing initial training requirements to be completed after new employee hire. Required annual training will be on a separate checklist. In order to ensure compliance, all new employees will be provided a Training Log detailing all the required training, certifications, and/or renewals that will occur in order to meet the required job duties year. The Training Log will be kept in a separate Training Log binder.

Completion Date:
Effective immediately

Person Responsible:
Program Manager, Patrick Hines, or designee, shall ensure that each employee has completed and signed/dated the initial orientation form, to include the required initial training within 30 days. Administrative staff will place the document in the employee's personnel files and will ensure that Training Logs are created for new employees and placed in the Training Log Binder. The Division Manager will review all new employee files and training logs quarterly.

Current Status on June 25, 2020: Compliant
Three of three new employee files reviewed had documentation of the required initial training appropriate to the individual's job duties and in accordance with the provider's training plan

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6VAC35-41-210 (B). Required retraining.
B. All staff shall complete an annual training refresher on the facility's emergency preparedness and response plan and procedures.

Audit Finding: There was no documentation of annual emergency preparedness and response plan refresher training in two of four employee files for the year 2017 and two of five employees files for 2018.

Program Response

Cause:
In two of four employee files in 2017 and two of five employee's files in 2018, there was no documentation that the required refresher training for emergency preparedness and response plan and procedures was completed. There was no administrative follow-up to verify completeness of the retraining files.

Effect on Program:

All employees are required to be up-to-date on all certifications, including emergency preparedness and response plan and procedures, in the event of an emergency. Fortunately, there are no documented cases of situations or negative outcomes regarding the health and welfare of the program's youth, staff, or facility.

Planned Corrective Action:
Employee personnel files will include a Staff Annual Retraining checklist (Form CCYH-210), which includes emergency preparedness and response plan and procedures, suicide prevention, child abuse and neglect, mandatory reporting, residents' rights, including prohibited actions, standard precautions, behavior intervention procedures, and medication management. A Training Log detailing all required training, certifications, and/or renewals to meet the required job duties will be kept in a separate Training Log binder. The Program Manager will schedule monthly training opportunities. In addition, annually all staff will be provided a specific timeframe for completion of any online training requirements, to include follow-up testing. Copies of certificates and/or training sign-in sheets will be filed with the employee's Training Log.

Completion Date:
Effective immediately

Person Responsible:
Program Manager, Patrick Hines, or designee, in collaboration with the Administrative Assistant, will ensure the training records are kept up-to-date for each employee. The Division Manager will review employee training logs quarterly.

Current Status on June 25, 2020: Compliant
There was documentation of annual emergency preparedness and response plan refresher training in three of three employee files for the year 2020.

6VAC35-41-210 (C). Required retraining.
C. All direct care staff and staff who provide direct supervision of the residents while delivering services, with the exception of workers who are employed by contract to provide behavioral health or health care services, shall complete at least 40 hours of training annually that shall include training in the following areas:
1. Suicide prevention;
2. Child abuse and neglect;
3. Mandatory reporting;
4. Residents' rights, including, but not limited to, the prohibited actions provided for in 6VAC35-41-560 (prohibited actions);
5. Standard precautions; and
6. Behavior intervention procedures.

Audit Finding: There was no documentation of suicide prevention, mandatory reporting, resident rights, standard precautions and emergency response in two of four employee files for the year 2017.

There was no documentation of child abuse and neglect in three of four employee files for the year 2017.

There was no documentation of 40 hours of training for the year 2017 in two of four employee files, for the year 2018 in three of five employee files and the year 2019 in five of five employee files.

In two of five employee files, there was no documentation of training in suicide prevention, child abuse and neglect, mandatory reporting, resident rights, and standard precautions for the year 2018.

Program Response

Cause:
In two of four employee files in 2017, there was no documentation that the required training for suicide prevention, mandatory reporting, resident's rights, standard precautions, or emergency preparedness and response was completed.

In three of four employee files in 2017, there was no documentation that child abuse and neglect training was completed.

In two of four employee files in 2017, three of five employee files in 2018, or five of five employee files in 2019, there was no documentation that the required 40 hours of training was completed.

In two of five employee files in 2018, there was no documentation that the required training for suicide prevention, child abuse and neglect, mandatory reporting, resident's rights, and standard precautions was completed.

There was no administrative follow-up to verify completeness of the required retraining files.

Effect on Program:
All employees are required to be up-to-date on all retraining, certifications, and/or renewals in order to meet the required job duties. Fortunately, there are no documented cases of situations or negative outcomes regarding the health and welfare of the program's youth, staff, or facility.

Planned Corrective Action:
Employee personnel files will include a Staff Annual Retraining checklist (Form CCYH-210), which includes emergency preparedness and response plan and procedures, suicide prevention, child abuse and neglect, mandatory reporting, residents' rights, including prohibited actions, standard precautions, behavior intervention procedures, and medication management. A Training Log detailing all required training, certifications, and/or renewals to meet the required job duties will be kept in a separate Training Log binder. The Program Manager will schedule monthly training opportunities. In addition, annually all staff will be provided a specific timeframe for completion of any online training requirements, to include follow-up testing. Copies of certificates and/or training sign-in sheets will be filed with the employee's Training Log.

Completion Date:
Effective immediately

Person Responsible:
Program Manager, Patrick Hines, or designee, in collaboration with the Administrative Assistant, will ensure the training records are kept up-to-date for each employee. The Division Manager will review employee training logs quarterly.

Current Status on June 25, 2020: Compliant
There was documentation of suicide prevention, child abuse and neglect, mandatory reporting, resident rights, standard precaution and emergency response in three of three employee files for the year 2020.

Current Status on June 25, 2020: Not determined
Crossroads Youth Group Home trains on the fiscal year. Their fiscal year begins July 1, 2019 – June 30, 2020.

6VAC35-41-210 (E). Required retraining.
E. Employees who administer medication shall complete annual refresher training on the administration of medication.

Audit Finding: There was no documentation in two of five employee files for the year 2018 and three of five employee files for the year 2019 of an annual medication refresher training on the administration of medication

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Program Response

Cause:
In two of five employee files in 2018 and three of five employees in 2019, there was no documentation that the required annual medication refresher training on the administration of medication was completed. There was no administrative follow-up to verify completeness of the retraining files.

Effect on Program:
All employees are required to be up-to-date on all required training, certifications, and/or renewals in order to meet the required job duties. This is especially important in regards to medication management. Fortunately, there are no documented cases of situations or negative outcomes regarding the health and welfare of the program's youths.

Planned Corrective Action:
Employee personnel files will include a Staff Annual Retraining checklist (Form CCYH-210), which includes emergency preparedness and response plan and procedures, suicide prevention, child abuse and neglect, mandatory reporting, residents' rights, including prohibited actions, standard precautions, behavior intervention procedures, and medication management. A Training Log detailing all required training, certifications, and/or renewals to meet the required job duties will be kept in a separate Training Log binder. The Program Manager will schedule annual medication management training for all staff. Training will include follow-up testing prior to certification.

Completion Date:

Effective immediately

Person Responsible:
Program Manager, Patrick Hines, or designee, in collaboration with the Administrative Assistant, will ensure the training records are kept up-to-date for each employee. The Division Manager will review employee training logs quarterly.

Current Status on June 25, 2020: Not Determined
Crossroads Youth Group Home 32-hour Administration of Medication training for their 10 employee (three new employees and seven seasoned employees) was postponed March 2020 due to the coronavirus.

The 32-hour Administration of Medication training is scheduled for July 1, 2020 for new and seasoned staff and again on July 18, 2020 for the remaining staff with Health Care Solutions, Inc.

6VAC35-41-210 (H). Required retraining.
H. Staff who have not timely completed required retraining shall not be allowed to have direct care responsibilities pending completion of the retraining requirements.

Audit Finding: In two of four new employee files reviewed, there was no documentation that they received the required initial training pertaining to regulation 6VAC-35-41-200 (B).

Program Response

Cause:
In two of four new employee files, there was no documentation of the required initial training pertaining to regulation 6VAC-35-41-200(B). There was no administrative follow-up to verify completeness of the initial training files.

Effect on Program:
The date on the initial training documents is very important in terms of the employee learning the correct elements of the program from the start, in order to meet the needs of the residents in the program and be able to provide direct care responsibilities. Therefore, the required training needs to be conducted within 30 days of date of hire.

Planned Corrective Action:
Employee personnel files will include a checklist detailing initial training requirements to be completed after new employee hire. Required Annual Retraining will be on a separate checklist. In order to ensure compliance, all new employees will be provided a Training Log detailing 40 hours of required training, certifications, and/or renewals that will occur within 30 days of hire, as well as during the year. Training areas include, but are not limited, to the following:

1. Emergency Preparedness and Response
2. CPR/ First Aid/AED Training
3. Facility's Behavior Management Program

4. Residents Behavior Rules of Conduct and Rationale for Rules
5. Facilities Behavior Intervention Procedures with Physical and Mechanical Restraint Training (Handle with Care)
6. Child Abuse and Neglect
7. Mandatory Reporting
8. Maintaining Appropriate Professional Relationships
9. Interaction Among Staff and Residents
10. Suicide Prevention
11. Resident Rights Including, but not limited to, the prohibitive action
12. Standard Precautions
13. Procedures Applicable to Employees Position and Consistent with Work Profiles

Once the initial training is completed, each employee will sign a signature page for inclusion in the employee's file.

Completion Date:
Effective immediately

Person Responsible:
Program Manager, Patrick Hines, or designee, shall ensure that each employee has received a copy of the required initial training, and has completed initial training requirements within 30 days of hire. All new employees will sign/date the signature page and administrative staff will place the signed document in the personnel files. The Division Manager will review new employee files quarterly.

Current Status on June 25, 2020: Compliant
There was documentation in three of three new employee files reviewed receiving the required initial training pertaining to regulation 6VAC-35-41- 200 (B).

6VAC35-41-310 (B). Personnel records.
B. The records of each employee shall include:
1. A completed employment application form or other written material providing the individual's name, address, phone number, and social security number or other unique identifier;
2. Educational background and employment history;
3. Documentation of required reference check;
4. Annual performance evaluations;
5. Date of employment for each position held and date of separation;
6. Documentation of compliance with requirements of Virginia law regarding child protective services and criminal history background investigations;
7. Documentation of the verification of any educational requirements and of professional certification or licensure if required by the position;
8. Documentation of all training required by this chapter and any other training received by individual staff; and
9. A current job description.

Audit Finding: There was no documentation of an annual performance evaluation in five of five employees for the year 2018 and 2019. Either there was no evaluation in the file or the evaluation did not have the employee's signature.

Program Response

Cause:
In five of five employees in 2018 and 2019, there was no documentation of an annual performance evaluation in the employee file, or the evaluation did not have the employee's signature. There was no administrative follow-up conducted to verify evaluations requiring updates.

Effect on Program:
Loss of continuity in annual evaluation reports leaves the potential for improper staff performance, as issues can be addressed at that time. Fortunately, there are no documented cases of negative outcomes for the health and welfare of the program's youths, staff or facility.

Planned Corrective Action:
All current evaluations will be reviewed and any employees requiring an up-to-date evaluation will be completed immediately. Evaluations will also be used to ensure staff are up-to-date on all training requirements. Employee records shall be reviewed on a monthly basis to ensure compliance with evaluation requirements.

Completion Date:
Effective immediately

Person Responsible:
Program Manager, Patrick Hines, or designee, will review current evaluations and complete new employee evaluations as necessary. Administrative staff will review employee files for up-to-date training and evaluations monthly. Division Manager will review employee files quarterly

Current Status on June 25, 2020: Compliant
There was documentation of an annual performance evaluation in three of three employee's files for the year 2020 with the employee's signature.

6VAC35-41-350 (C). Buildings and inspections.
C. The facility shall maintain a current copy of its annual inspection and approval, in accordance with state and local inspection laws, regulations, and ordinances, of the following:
1. General sanitation;
2. Sewage disposal system;
3. Water supply;
4. Food service operations; and
5. Swimming pools, if applicable.

Audit Finding: There is no documentation of an annual sanitation inspection for the year 2019. An annual sanitation inspection should have been completed by March 15, 2019.

Program Response

Cause:
For 2019, there was no documentation on file of an annual sanitation inspection. There was no administrative follow-up conducted to verify required annual inspections.

Effect on Program:
Loss of continuity in annual inspections leaves the potential for hazardous conditions for residents, staff, and guests at the facility. Fortunately, there are no documented cases of negative outcomes for the health and welfare of the program's youths, staff or facilities.

Planned Corrective Action:
When it was determined that there was no documentation of a sanitation inspection completed in 2019, a new sanitation inspection was completed on December 4, 2019 by Mr. John Adams. Annual sanitation inspections will be completed twice a year, in Spring and Fall. Calendar reminders will be set to ensure proper inspection follow-up occurs.

Completion Date:
Effective immediately

Person Responsible:
Program Manager, Patrick Hines, along with Administrative staff, will review the inspection logs every 6 months to ensure all inspections, including general sanitation, sewage disposal system, water supply, and food service operations, are completed and up-to-date. The Division Manager will review all required inspections twice a year.

Current Status on June 25, 2020: Compliant
There was documentation of an annual sanitation inspection completed on December 4, 2019. An annual sanitation inspection should be completed before or on December 4, 2020.

6VAC35-41-490 (I). Emergency and evacuation procedures. (CRITICAL)
1. At least one evacuation drill (the simulation of the facility's emergency procedures) shall be conducted each month in each building occupied by residents. During any three consecutive calendar months, at least one evacuation drill shall be conducted during each shift.

Audit Finding: There was no documentation of a fire drill being conducted on the first shift 12pm-8am for December 2018, January 2019 and February 2019.

Program Response

Cause:

There was no documentation on file of a fire drill being conducted during first shift 12pm-8am for December 2018, January 2019, and February 2019. There was no administrative follow-up conducted to verify at least one fire drill was conducted during each shift monthly.

Effect on Program:
Loss of continuity in monthly fire drills conducted during each shift leaves the potential for a serious emergency situation for residents and staff at the facility. Regularity of the drills will ensure that everyone is prepared in case of a real emergency. Fortunately, there are no documented cases of negative outcomes for the health and welfare of the program's youths, staff or facility.

Planned Corrective Action:
Previously, specific dates were scheduled each month for the different shifts to complete fire drills. A new protocol has been established that fire drills will be completed every Monday by a different shift. Additional fire drills will continue to be conducted immediately after a new resident has arrived at Crossroads.

Completion Date:
Effective immediately

Person Responsible:
Program Manager, Patrick Hines, along with Administrative staff, will review the fire drill logs weekly to ensure proper completion. The Division Manager will review fire drill logs monthly for completion.

Current Status on June 25, 2020: Compliant
There was documentation of a fire drill being conducted on the first shift 12pm-8am for January 2020, February 2020, March 2020 and April 2020.

6VAC35-41-1200. Health screening at admission. (CRITICAL)
The facility shall require that:
1. To prevent newly arrived residents who pose a health or safety threat to themselves or others from being admitted to the general population, all residents shall immediately upon admission undergo a preliminary health screening consisting of a structured interview and observation by health care personnel or health-trained staff. As necessary to maintain confidentiality, all or a portion of the interview shall be conducted with the resident without the presence of the parent or guardian.
2. Residents admitted to the facility who pose a health or safety threat to themselves or others shall not be admitted to the facility's general population but provision shall be made for them to receive comparable services.
3. Immediate health care is provided to residents who need it.

Audit Finding: One of fifteen medical records reviewed did not have documentation of a preliminary health screening upon admission.

Program Response

Cause:
In one of fifteen medical records reviewed, there was no documentation of a preliminary health screening completed upon admission. There was no case management follow-up conducted to verify all the required documentations were completed.

Effect on Program:
In order to prevent newly arrived residents who post a health or safety threat to themselves or others from being admitted to the general population, all residents must complete a preliminary health screening. If the resident poses a health or safety threat, they should not be admitted to the general population until the proper services are provided. Fortunately, there are no documented cases of negative outcomes for the health and welfare of the program's youths, staff or facility.

Planned Corrective Action:
During a new resident intake, all the proper documentation, including screening tools, must be completed prior to the resident joining the general population. If the resident poses a health or safety threat, they will be placed in quarantine/isolation until the proper services are provided. In order to ensure compliance, all admission paperwork will be reviewed by the Casework Specialist, or designee, for completion within 24 hours of a youth's admission to the facility. Screening forms will also be reviewed by both the Residential Operations Supervisor, as well as the Program Manager within 72 hours of the resident's arrival. Any incomplete paperwork will be completed immediately. The Division Manager will review new intake case file within one week of resident admission.

Completion Date:
Effective Immediately.

Person Responsible:
Casework Specialist, or designee, will review admission paperwork within 24 hours (or next business day) of admission. Residential Operations Supervisor and Program Manager, Patrick Hines, will review screening forms and admissions paperwork within 72 hours. The Division Manager will review all new intake case files within one week of admission.

Current Status on June 25, 2020: Compliant
Three of three medical records reviewed had documentation of a preliminary health screening upon admission.

6VAC35-41-1210 (A). Tuberculosis screening. (CRITICAL)

A. Within seven days of placement each resident shall have had a screening assessment for tuberculosis. The screening assessment can be no older than 30 days.

Audit Finding: Two of fifteen medical files reviewed the tuberculosis screening was older than 30 days.

Program Response

Cause:
In two of fifteen medical files reviewed, documentation of a previous tuberculosis screening assessment was shown to be more than 30 days old. The primary cause was there was no case management follow-up conducted to verify all the required documentations were completed.

Effect on Program:
The date on any tuberculosis screening is very important in terms of the resident's need for immediate medical attention or follow-up care. This situation could have had a severe adverse impact upon the youth's health, other residents, and the staff well-being as it relates to contagious diseases.

Planned Corrective Action:
In order to ensure compliance, all intake documentation, including the Tuberculosis Screening Form, will be reviewed by the Casework Specialist, or designee, for completion within 24 hours (or next business day) of a youth's admission to the facility. Screening forms will also be reviewed by the Residential Operations Supervisor and the Program Manager within 72 hours of the resident's arrival. Any resident requiring a tuberculosis skin test will have the test administered within 5 days of placement. The test will be read within 48-72 hours. Final results will be placed in resident's "red" medical folder and personal binder.

Completion Date:
Effective Immediately

Person Responsible:
Casework Specialist, or designee, will review admission paperwork within 24 hours (or next business day) of admission. Residential Operations Supervisor and Program Manager will review screening forms and admissions paperwork within 72 hours. Division Manager will review all new intake case files within one week of admission.

Current Status on June 25, 2020: Compliant
Three of three medical files reviewed had documentation that the tuberculosis screening was completed within seven days of placement.

6VAC35-41-1250 (A). Residents' health records. (CRITICAL)
A. Each resident's health record shall include written documentation of (i) the initial physical examination, (ii) an annual physical examination by or under the direction of a licensed physician including any recommendation for follow-up care, and (iii) documentation of the provision of follow-up medical care recommended by the physician or as indicated by the needs of the resident.

Audit Finding: Two of two applicable medical files reviewed did not have documentation of a follow-up medical care as recommended by the doctor.

Program Response

Cause:

In two of two medical files reviewed, there was no documentation of follow-up medical care as recommended by the doctor. There was no case management follow-up conducted to verify all the required documentations were completed.

Effect on Program:
During the physical examination, follow-up medical care by a provider is very important in terms of the resident's need for immediate medical attention or additional care. This situation could have had a severe adverse impact upon the youth's health, other residents, and the staff well-being as it relates to the resident's needs.

Planned Corrective Action:
In order to ensure compliance, all physical examination forms will be reviewed by the Casework Specialist, or designee, for any required follow-up care within 24 hours (or next business day) of a youth's admission to the facility. All forms will also be reviewed by the Residential Operations Supervisor and the Program Manager within 72 hours of the resident's arrival. Any resident requiring follow-up care that has not been documented will be addressed immediately. Follow-up results will be placed in resident's "red" medical folder and personal binder.

Completion Date:
Effective Immediately

Person Responsible:
Casework Specialist, or designee, will review admission paperwork within 24 hours (or next business day) of admission. Residential Operations Supervisor and Program Manager will review all forms, including physical examination forms, and admissions paperwork within 72 hours. Division Manager will review all new intake case files within one week of admission.

Current Status on June 25, 2020: Compliant
Three of three medical files reviewed documented a follow-up medical care as recommended by the doctor.

6VAC35-41-1280 (H). Medication. (CRITICAL)
H. In the event of a medication incident or an adverse drug reaction, first aid shall be administered if indicated. Staff shall promptly contact a poison control center, pharmacist, nurse, or physician and shall take actions as directed. If the situation is not addressed in standing orders, the attending physician shall be notified as soon as possible and the actions taken by staff shall be documented. A medical incident shall mean an error made in administering a medication to a resident including the following: (i) a resident is given incorrect medication; (ii) medication is administered to an incorrect resident; (iii) an incorrect dosage is administered; (iv) medication is administered at a wrong time or not at all; and (v) the medication is administered through an improper method. A medication error does not include a resident's refusal of appropriately offered medication.

Audit Finding: One of two applicable medication incidents reviewed did not document the action taken by staff.

Program Response

Cause:
In one of two applicable medical incidents reviewed, there was no documentation that staff took corrective actions by contacting the prescribing physician, pharmacy, or Poison Control Center as specified, or providing the necessary information in the medication incident report. There was no case management follow-up conducted to verify all the necessary actions had been completed.

Effect on Program:
For any medication error or incident, the corrective actions are very important in ensuring that the resident's need for possible immediate medical attention or follow-up care is addressed. This situation could have had a severe adverse impact upon the youth's health, other residents, and the staff well-being as it relates to the resident's needs. Fortunately, there were no adverse health effects for the resident in this case.

Planned Corrective Action:
When medication errors or incidents occur, the Program Manager is contacted immediately. In an effort to increase performance and staff accountability, medication audits will be completed weekly, to include the review of all medication error forms. The "Medication Error and/or Drug Reaction Report Form" (Form CCYH-1280(H)(J)) has been revised to ensure that staff MUST document ALL actions taken as noted. All staff will receive additional training / retraining on proper administration of medication and documenting all actions taken at the next scheduled Medication Management Training in Spring of 2020.

Completion Date:
Effective immediately.

Person Responsible:
Weekly audits for medication forms to be completed by staff trained in Medication Management. Casework Specialist, or designee, will review Medication Error forms by next business day. Program Manager will review all forms within 72 hours. Division Manager will review all medication forms quarterly.

Current Status on June 25, 2020: Non-Compliant
One of one applicable medication incidents reviewed did not have documentation of the action taken by staff to notify the attending physician.

6VAC35-41-1280 (J). Medication. (CRITICAL)
J. Medication refusals shall be documented including action taken by staff. The facility shall follow procedures for managing such refusals that shall address:
1. Manner by which medication refusals are documented, and
2. Physician follow-up, as appropriate.

Audit Finding: Two of two applicable medication refusal reviewed had no documentation of the physician follow up.

Two of two applicable medication refusal reviewed was not documented on the form in accordance with procedures.

Program Response

Cause:
In two of two applicable medication refusals reviewed, there was no documentation of the physician follow-up form or that staff took corrective actions by contacting the prescribing physician, pharmacy, or Poison Control Center as specified, or providing the necessary information in the Medication Refusal Form. There was no case management follow-up conducted to verify all the necessary actions had been completed.

Effect on Program:
For any medication refusal, the actions taken are very important in ensuring that the resident's need for possible immediate medical attention or follow-up care is addressed. This situation could have had a severe adverse impact upon the youth's health, other residents, and the staff well-being as it relates to the resident's needs. Fortunately, there were no adverse health effects for the resident in this case.

Planned Corrective Action:
When medication refusals occur, the Program Manager is contacted immediately. Staff will be required to complete two forms – "Medication Error and/or Drug Reaction Report Form" (Form CCYH-1280(H)(J)) and "Crossroads Resident Medication Refusal Form" (Form CCYH-1280(J)). Both forms require reporting of all actions taken, to include contacting the physician. The Case Specialist, or Designee, will review both forms within 24 hours (or the next business day) to ensure that all follow-up actions have occurred. Medication audits will be completed weekly, to include the review of all medication refusal forms. Staff will receive additional training/retraining on proper documentation of medication refusals at the next scheduled Medication Management Training in Spring of 2020.

Completion Date:
Effective immediately.

Person Responsible:
Weekly audits to be completed by staff trained in Medication Management. Casework Specialist, or designee, will review both medication refusal forms by next business day. Program Manager will review all forms within 72 hours. Division Manager will review all medication forms monthly.

Current Status on June 25, 2020: Non-Compliant
One of one applicable medication refusal reviewed there was no documentation of the physician follow up.

Current Status on June 25, 2020: Compliant
One of one applicable medication refusal reviewed was documented on the form in accordance with procedures.

Compliance Monitoring Visit
Residential Programs

Program:	The Summit Transitional Living Program
Date of Visit:	May 21, 2020
Type of Visit:	Announced Monitoring Visit
Administrator:	Heather Ross
Monitoring Staff:	Learna Harris

The Summit Transitional Living Program audit was conducted on April 30, 2019, with the following findings:

6VAC35-41-180 (A). Employee and volunteer background checks. CRITICAL

6VAC35-41-1280 (F). Medication

6VAC35-41-1280 (H). Medication. CRITICAL

6VAC35-41-1280 (J). Medication. CRITICAL

6VAC35-41-1280 (M). Medication. CRITICAL

Department Certification Action was taken on July 30, 2019 and the current certification status of Summit Transitional Living Program was continued until December 8, 2019, with a monitoring report from the Certification Unit. Although compliance was noted in all areas during the December monitoring report a further continuance was made until June 8, 2020, with another monitoring report.

A monitoring visit was conducted at the Summit Transitional Living Program on May 21, 2020 by Learna Harris. The visit included the following:

- reviewing three resident case and medical files
- reviewing log book entries
- reviewing one new employee file and three seasoned employee training records
- reviewing a fire inspection reports and the fire drill logbook
- reviewing four Serious Incident Reports
- reviewing regulations missed during the previous audit

The facility was found in compliance with the following regulations:

6VAC35-41-180 (A). Employee and volunteer background checks. CRITICAL

6VAC35-41-1280 (F). Medication

6VAC35-41-1280 (H). Medication. CRITICAL

6VAC35-41-1280 (J). Medication. CRITICAL

6VAC35-41-1280 (M). Medication. CRITICAL

Audit Team Observations

Due to the Coronavirus this audit was conducted virtually. At the time of the visit there were seven residents onsite and all doing well. Ms. Rose stated that the program is doing well, she has gone to great lengths to ensure all procedures are followed and that all new staff and existing staff are compliant with all training. Ms. Rose also incorporated guidelines that ensure that medical procedures are covered accurately to include a check and balance system. The work of her and her staff is quite impressive.

RECOMMENDED DEPARTMENT CERTIFICATION ACTION – Certify the Summit Transitional Living Program until April 29, 2022, with a full compliance audit.

Pursuant to 6VAC35-20-100C.2, if the certification audit finds the program or facility in less than 100% compliance with all regulatory requirements and a subsequent status report, completed prior to the certification action, finds 100% compliance on all regulatory requirements, the director or designee shall certify the facility for a specific period of time, up to three years.

CERTIFICATION AUDIT REPORT
TO THE
DEPARTMENT OF JUVENILE JUSTICE

PROGRAM AUDITED:
Westhaven Boys' Home
3515 Race Street
Portsmouth, VA 23707
(757) 397-5371
Carlos Hooker, Director
chooker@tyscommission.org

AUDIT DATES:
February 10-11, 2020

CERTIFICATION ANALYST:
Mark Ivey Lewis

CURRENT TERM OF CERTIFICATION:
July 10, 2017 – July 9, 2020

REGULATIONS AUDITED:
6VAC35-41 Regulation Governing Juvenile Group Homes and Halfway Houses

PREVIOUS AUDIT FINDINGS – February 6-7, 2017
6VAC35-41-50 (A). Age of residents
6VAC35-41-210 (C). Required retraining
6VAC35-41-460 (A). Maintenance of the buildings and grounds
6VAC35-41-1250 (C). Residents' health records
6VAC35-41-1280 (E). Medication. CRITICAL

CURRENT AUDIT FINDINGS – February 10-11, 2020
98.59% Compliance Rating
6VAC35-41-90 (D). Serious incident reports.
6VAC35-41-110 (A). Grievance procedure.
6VAC35-41-1210 (A). Tuberculosis screening. CRITICAL
6VAC35-41-1280 (H). Medication. CRITICAL
No repeated deficiencies from previous audit

DEPARTMENT CERTIFICATION ACTION 8/5/2020: Certified the Westhaven Boys' Home until July 9, 2023.
Pursuant to 6VAC35-20-100C.2, if the certification audit finds the program or facility in less than 100% compliance with all regulatory requirements and a subsequent status report, completed prior to the certification action, finds 100% compliance on all regulatory requirements, the director or designee shall certify the facility for a specific period of time, up to three years.

TEAM MEMBERS:
Mark Ivey Lewis, Central Office
Clarice Booker, Central Office
John Adams, Central Office
Deborah Hayes, Central Office
Learna Lee, Central Office
Nikesha Roberts, Central Office
Jackie Nixon, Chesapeake Juvenile Services

Angela Rice, Norfolk Juvenile Detention Center

POPULATION SERVED:

Westhaven Boys' Home is a 12-bed residential facility that serves pre-dispositional and post-dispositional males age 12 to 17 years of age who are referred by the Juvenile Court and/or Social Services. The program is sponsored by the Tidewater Youth Services Commission and serves the cities of Portsmouth, Chesapeake, Virginia Beach, Suffolk, Franklin, and Isle of Wight County.

The facility is a two-story brick building. Sleeping quarters are located upstairs. The Kitchen, dining area, TV lounge, recreation room, administration offices and laundry facilities are located downstairs. There are two bathrooms consisting of a sink, toilet and shower upstairs and two bathrooms consisting of a sink and toilet downstairs.

PROGRAMS AND SERVICES PROVIDED:

Westhaven Boys' Home is a community-based program where the residents live, attend school and work in the community just as they would if they were living at home. Westhaven Boys' Home provides a structured environment where immediate feedback and counseling is provided to encourage growth in the areas of social skills and positive behavior. A point sheet is utilized and is broken down in a time frame that corresponds to WBH's daily schedule. This provides the resident the opportunity to turn his behavior around without it effecting his entire day. Residents earning 90 out of a hundred daily points, earn extra privileges such as playing video games and having extra phone privileges. The primary focus of the program is to provide a safe and secure setting for youth awaiting a court hearing and to help them learn to control and accept responsibility for their behavior. The program is also designed to provide supervision and individualized treatment that addresses the individual needs of each resident.

Westhaven Boys' Home's educational component is provided by the Portsmouth Public Schools. Most of the youth attend the local middle or high schools and are transported by staff. Any resident who has been suspended from school is required to do assigned homework and community projects.

The facility has a strong recreational program that includes educational, cultural, recreational and therapeutic components. Activities can range from going to the museum to taking first aid and CPR classes to going canoeing and bike riding.

Upon completion of the Westhaven Boys' Home program, the residents are prepared for reunification with family or placed in a less restrictive setting such as a foster home or independent living program.

SERVICES PROVIDED:

- Direct:
    - Case Management
    - Individual Counseling
    - Family Counseling
    - Education

- Community/Volunteer Service
- Independent Living Skills
- Aggression Replacement Training (ART)
- Skill Streaming
- Anger Control Training
- Moral Reasoning Training
- Community Group
- After School Enrichment Program
- Independent Living Skills
- Book Club
- Community/Volunteer Services

- Community
  - Therapeutic Recreation and Summer Program
  - Recreation Centers
  - Museums
  - Local festivals
  - Cultural and Educational growth
  - Medical Services

CORRECTIVE ACTION PLAN
TO THE
DEPARTMENT OF JUVENILE JUSTICE

FACILITY/PROGRAM: **Westhaven Boys Home**

SUBMITTED BY: **Carlos Hooker, Director**

CERTIFICATION AUDIT DATES: **February 10-11, 2020**

CERTIFICATION ANALYST: **Mark Ivey Lewis**

Under Planned Corrective Action indicate; 1) The cause of the identified area of non-compliance. 2) The effect on the program. 3) Action that has been taken/will be taken to correct the standard cited. 4) Action that will be taken to ensure that the problem does not recur.

6VAC35-41-90 (D). Serious incident reports.
D. The facility shall (i) prepare and maintain a written report of the events listed in subsections A and B of this section and (ii) submit a copy of the written report to the director or designee. The report shall contain the following information:

1. The date and time the incident occurred;
2. A brief description of the incident;
3. The action taken as a result of the incident;
4. The name of the person who completed the report;
5. The name or identifying information of the person who made the report to the placing agency and to either the parent or legal guardian, as appropriate and applicable; and

6. The name of or identifying information provided by the person to whom the report was made, including any law enforcement or child protective service personnel.

Audit Finding:
Five of five serious incident reports reviewed did not have documentation of the name or identifying information of the person who made the report to the placing agency and to the parent.

Program Response

Cause:
It had been the practice for the Director or Assistant Director to complete and the submit the form. The Director or Assistant Director had been present or notified in all instances however because the Director or Assistant Director had completed the form he/she were remiss in indicating how they were notified. Notifications of how the Director or Assistant Director were notified were documented in the logbook or on the internal agency incident form however it was not on the DJJ SIR form. In some instances, this is because the Administrator was present during the incident which did result in notification.

Effect on Program:
Due to the lack of documentation, it could make it appear that the Director or Designee were not notified of the incident.

Planned Corrective Action:
The Director or Designee will document on the SIR form the time and date that he/she were contacted by the WBH staff and if the Director or Designee is present for the incident the SIR will indicate "present during incident".

Completion Date:
February 12, 2020

Person Responsible:
Carlos Hooker, Director

Current Status on May 21, 2020: Compliant
Seven of seven incident reports reviewed had documentation of the name or identifying information of the person who made the report to the placing agency and to the parent.

6VAC35-41-110 (A). Grievance procedure.
A. Written procedure shall provide that residents are oriented to and have continuing access to a grievance procedure that provides for:

1. Resident participation in the grievance process with assistance from staff upon request;

2. Investigation of the grievance by an objective employee who is not the subject of the grievance;

3. Documented, timely responses to all grievances with the reasons for the decision;
4. At least one level of appeal;
5. Administrative review of grievances;
6. Protection from retaliation or threat of retaliation for filing a grievance; and
7. Hearing of an emergency grievance within eight hours.

Audit Finding:
Four of five grievances reviewed did not document the reasons for the decisions stated on the grievance.

Program Response

Cause:
The grievance forms that were reviewed, lack the necessary documentation to explain why a particular decision was rendered. The Assistant Director neglected to complete this section of the form.

Effect on Program:
It would appear that after a decision has been rendered by the Director or Assistant Director, there is no documentation on the grievance form as to why a particular decision was rendered. All parties that are involved in the grievance process should be aware of why a particular decision was rendered and there should be documentation to explain why.

Planned Corrective Action:
The Director will double check every grievance form to make sure that we are in compliance with this standard.

Completion Date:
February 12, 2020

Person Responsible:
Carlos Hooker, Director

Current Status on May 25, 2020: Compliant
One of one grievances reviewed documented the reason for the decisions stated on the grievance.

6VAC35-41-1210 (A). Tuberculosis screening. CRITICAL
A. Within seven days of placement each resident shall have had a screening assessment for tuberculosis. The screening assessment can be no older than 30 days.

Audit Finding:
One resident, who was placed at the facility on 6/12/17, did not have a screening assessment for tuberculosis until 6/25/17, 13 days after placement.

Program Response

Cause:
Due to a lack of communication between the Director, Assistant Director and secretary, a resident was not screened in a timely manner to receive his assessment before the 7th day of placement.

Effect on Program:
When residents are not screened for tuberculosis by a medical professional before their 7th day in the program, we potentially may not catch early on a communicable disease.

Planned Corrective Action:
The Director, Assistant Director and secretary will review all new intakes within 48 hours to see if they need to be screened by a medical professional for tuberculosis. If the resident has been in detention for less than 30 days, then WBH will secure the necessary documents to show that they have been screened already. If they are not coming from a secured facility or have not been screened, then WBH will transport the resident to the nearest medical facility for a tuberculosis assessment or test. This incident transpired in 2017. Since this time, WBH has been proactive with minimizing missed tuberculosis screenings.

Completion Date:
February 12, 2020

Person Responsible:
Carlos Hooker, Director

Current Status on May 25, 2020: Compliant
Two of two residents, who were placed at the facility between 2/16/2020 and 5/15/2020, had a screening assessment for tuberculosis within the proper regulation time frame.

6VAC35-41-1280 (H). Medication. CRITICAL
H. In the event of a medication incident or an adverse drug reaction, first aid shall be administered if indicated. Staff shall promptly contact a poison control center, pharmacist, nurse, or physician and shall take actions as directed. If the situation is not addressed in standing orders, the attending physician shall be notified as soon as possible and the actions taken by staff shall be documented. A medical incident shall mean an error made in administering a medication to a resident including the following: (i) a resident is given incorrect medication; (ii) medication is administered to an incorrect resident; (iii) an incorrect dosage is administered; (iv) medication is administered at a wrong time or not at all; and (v) the medication is administered through an improper method. A medication error does not include a resident's refusal of appropriately offered medication.

Audit Finding:
One of three applicable medical files reviewed did not have a completed medication incident report. A medication incident occurred when a medication called Trileptal 600mg was not administered as prescribed on 3/22/17 due to the resident being off campus on a medical appointment.

Program Response

Cause:
While this resident was on a doctor's appointment, he missed his scheduled medication. There was documentation on his Medication Administration Report (MAR) as to why he missed his medication, but a medication incident report was not completed.

Effect on Program:
There needs to be proper documentation whenever there is a medication incident or a resident does not take their scheduled medication. The documentation will also show that the parent/guardian, referring worker and doctor were also notified of this inicident/error. This incident transpired in 2017. Since that time, WBH has been proactive with completing medication incident reports for any medication incidents including missed medications.

Planned Corrective Action:
WBH will complete medication incident reports whenever there are any medication incidents including missed medications due to residents being out in the community at the time a medication is to be administered.

Completion Date:
February 12, 2020

Person Responsible:
Carlos Hooker, Director

Current Status on May 25, 2020: Compliant
Two applicable medical files reviewed had a completed medication incident report for an incident which occurred on 5/11-12/2020 for one resident and for an incident which took place on 3/5/2020 for another resident.

CERTIFICATION AUDIT REPORT
TO THE
DEPARTMENT OF JUVENILE JUSTICE

PROGRAM AUDITED:
12th District Court Service Unit (Chesterfield)
7000 Lucy Corr Boulevard
Chesterfield, VA. 23832
(804) 748-1372
James Nankervis, Director
james.nankervis@djj.virginia.gov

AUDIT DATES:
December 9, 2019

CERTIFICATION ANALYST:
Clarice T. Booker

CURRENT TERM OF CERTIFICATION:
May 19, 2017 - May 18, 2020

REGULATIONS AUDITED:
6VAC35-150 Regulations for Nonresidential Services Available to Juvenile and Domestic Relations District Courts

PREVIOUS AUDIT FINDINGS - February 16, 2017:
96% Compliance Rating
6VAC35-150-336 (A) Social histories
6VAC35-150-420 Contacts during juvenile's commitment

CURRENT AUDIT FINDINGS – December 9, 2019
96% Compliance Rating
Number of deficiencies: Two
6VAC35-150-336 (A) Social histories
6VAC35-150-420 Contacts during juvenile's commitment

DEPARTMENT CERTIFICATION ACTION 8/5/2020: Certify Certified the 12th District Court Service Unit until May 18, 2023, with a status report in August 2021 by the Regional Program Manager regarding the area of noncompliance.
Pursuant to 6VAC35-20-100C.2, if the certification audit finds the program or facility in less than 100% compliance with all regulatory requirements and a subsequent status report, completed prior to the certification action, finds 100% compliance on all regulatory requirements, the director or designee shall certify the facility for a specific period of time, up to three years.

TEAM MEMBERS:
Clarice Booker, Team Leader
Priscilla Boggs, 3rd District Court Service Unit (Portsmouth)
Gina Burton, 1st District Court Service Unit (Chesapeake)
Vanessa Grooms, 13th District Court Service Unit (Richmond)
Learna Harris, Central Office
Deborah Hayes, Central Office
Tracy King, 23-A District Court Service Unit (Roanoke)
Mark Lewis, Central Office

POPULATION SERVED:

The 12th District Court Service Unit serves Chesterfield County and the city of Colonial Heights.

PROGRAMS AND SERVICES PROVIDED:

The 12th District Court Service Unit provides mandated services including:

- Intake
- Probation supervision
- Direct care and parole supervision
- Investigative reports

The Unit interacts with the community in obtaining such services as:

- Mental health support, including substance abuse services, evaluations and general counseling;
- Access to CSA funds for services and possible placement of youth;
- Chesterfield Adolescent Reporting Center: youth on supervision are referred there as a sanction for probation or parole violations.

CORRECTIVE ACTION PLAN
TO THE
DEPARTMENT OF JUVENILE JUSTICE

FACILITY/PROGRAM:	**12th District Court Service Unit (Chesterfield)**
SUBMITTED BY:	**James P. Nankervis, Court Service Unit Director**
CERTIFICATION AUDIT DATES:	**December 9, 2019**
CERTIFICATION ANALYST:	**Clarice T. Booker**

Under Planned Corrective Action indicate; 1) The cause of the identified area of non-compliance. 2) The effect on the program. 3) Action that has been taken/will be taken to correct the standard cited. 4) Action that will be taken to ensure that the problem does not recur.

6VAC35-150-336 (A) Social histories

A social history shall be prepared in accordance with approved procedures (i) when ordered by the court, (ii) for each juvenile placed on probation supervision with the unit, (iii) for each juvenile committed to the Department, (iv) for each juvenile placed in a postdispositional detention program for more than 30 days pursuant to § 16.1-284.1 of the Code of Virginia, or (v) upon written request from another unit when accompanied by a court order. Social history reports shall include the following information:

1. **Identifying and demographic information on the juvenile;**
2. **Current offense and prior court involvement;**
3. **Social, medical, psychological, and educational information about the juvenile;**
4. **Information about the family; and**
5. **Dispositional recommendations, if permitted by the court.**

Audit Finding:

The social history reports did not address or provide information on other states in six out of ten social history reports reviewed.

Program Response

Cause:
The youth and family are asked if there is court involvement/charges in other jurisdiction, meaning any federal, state or local jurisdiction.

Effect on Program:
There was no effect on the CSU providing accurate reports. The Commonwealth Attorneys, defense attorneys and judges understood that "jurisdiction" means "all geographical areas," outside of Virginia "with the power and authority to administer justice."

Planned Corrective Action:
We will replace the word "jurisdiction" with the word "state."

Completion Date:
January 1, 2020, in coordination with the implementation of the new social history format.

Person Responsible:
All CSU staff who prepare social histories and the supervisory staff who review the reports.

Current Status on June 28, 2020: Compliant
Ten social history reports were reviewed and eight of the 10 were compliant.

6VAC35-150-420 Contacts during juvenile's commitment
During the period of a juvenile's commitment, a designated staff person shall make contact with the committed juvenile, the juvenile's parents, guardians, or other custodians, and the treatment staff at the juvenile's direct care placement as required by approved procedures. The procedures shall specify when contact must be face-to-face contact and when contacts may be made by video conferencing or by telephone.

Audit Finding:
The case staffing was not conducted every 30 days in six out of nine applicable case records reviewed in accordance with approved procedures. There was no documentation that the probation officer co-chaired the re-entry meeting with the JCC counselor in four out of six applicable case records reviewed in accordance with approved procedures,

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Program Response

Cause:
Parole/direct care cases were being mixed in with the high-risk probation cases that are reviewed monthly. This caused the parole/direct care cases to fall outside of the 30 day policy.

The re-entry meetings are being held per standards and all required elements of the meetings are met with the exception of the statement that the probation officer was a "co-chair" along with the JCC counselor.

Effect on Program:
Even though the direct care staffings were held monthly versus every 30 days, case management or the delivery of services remained unaffected. The re-entry meetings were held and the probation officers assigned were all present. There was no impact on the delivery of services.

Planned Corrective Action:
All direct-care case staffings will be held within the 30-day timeframe. The probation officer will be identified as the "co-chair" along with the JCC counselor in BADGE for the re-entry meetings.
Completion Date:
January 1, 2020

Person Responsible:
Probation staff whom supervise parole direct care cases and their supervisors.

Current Status on June 28, 2020: Non-compliant
The case staffing was not conducted every 30 days in accordance with approved procedures in six out of nine applicable case records reviewed.

Current Status on June 28, 2020: Not determinable
Nine cases were reviewed. There was no applicable case to determine compliance on re-entry meetings.

CERTIFICATION AUDIT REPORT
TO THE
DEPARTMENT OF JUVENILE JUSTICE

PROGRAM AUDITED:
30th District Court Service Unit
190 Beech St., Suite 203
Gate City, VA 24251
(276) 386-9561
Mark E. Thompson, Director
mark.thompson@djj.virginia.gov

AUDIT DATES:
January 28-29, 2020

CERTIFICATION ANALYST:
Clarice T. Booker

CURRENT TERM OF CERTIFICATION:
June 18, 2017–June 17, 2020

REGULATIONS AUDITED:
6VAC35-150 Regulations for Nonresidential Services Available to Juvenile and Domestic Relations District Courts

PREVIOUS AUDIT FINDINGS – March 15, 2017:
98.4% Compliance Rating
Number of deficiencies: One
6VAC35-150-336 (A) Social histories

CURRENT AUDIT FINDINGS – January 29, 2020:
100% Compliance Rating

DEPARTMENT CERTIFICATION ACTION 8/5/2020: Certify the 30th District Court Service Unit until June 17, 2023, with a letter of congratulations for 100% compliance.
Pursuant to 6VAC35-20-100C.1, if the certification audit finds the program or facility in 100% compliance with all regulatory requirements, the director or designee shall certify the facility for three years.

TEAM MEMBERS:
Clarice T. Booker, Team Leader
Darcy Janson, 28th District Court Service Unit (Abingdon)
Mark Lewis, Central Office

POPULATION SERVED:
The 30th District Court Service Unit serves the City of Norton and the counties of Lee, Scott and Wise.

PROGRAMS AND SERVICES PROVIDED:
The 30th District Court Service Unit provides mandated services including:

- Intake
- Probation supervision
- Direct care and parole supervision
- Investigative reports

The Unit interacts with the community in obtaining such services as:

- Juvenile Drug Court
- Outreach Detention/Electronic Monitoring
- Community Service
- Intensive Supervision
- Mental Health services, including:
  - Assessments
  - Individual and family counseling
  - Group counseling
  - Relapse prevention counseling
  - Educational group/brief motivational intervention
  - Crisis intervention
  - Substance abuse evaluations and treatment
  - SASSI Assessments
  - Trauma assessments

Post Office Box 1110
Richmond, VA 23218-1110
804.588.3903

COMMONWEALTH *of* VIRGINIA

Board of Juvenile Justice

BOARD OFFICERS

§ 5.01. Officers Elected from the Board.

The Officers of the Board elected from its membership shall be the Chairperson, Vice- chairperson and Secretary, who shall each be elected by the Board at its first regular meeting of the fiscal year. Officers shall serve for a term of one year and shall be eligible for re-election.

§ 5.02. Chairperson.

The Chairperson shall be the presiding officer of the Board at its meetings. Upon request of the Board, the Chairperson shall act as its spokesperson or representative and shall perform such additional duties as may be imposed on that position by an Act of the General Assembly or by direction of the Board. The Chairperson shall be an ex-officio member of all Committees of the Board.

§ 5.03. Vice-chairperson.

In the absence of the Chairperson at any meeting or in the event of disability or of a vacancy in the office, all the powers and duties of the Chairperson shall be vested in the Vice-chairperson. The Vice-chairperson shall also perform such other duties as may be imposed by the Board or the Chairperson.

§ 5.04. Secretary.

The Secretary shall (1) review and recommend improvements to Board meeting procedures and other relevant Board business so as to facilitate the administrative efficiency of the Board; (2) ensure the development of appropriate resolutions, etc., which are needed by the Board from time to time; (3) serve as the Board's parliamentarian; (4) work closely with the Department staff who are assigned to provide administrative assistance to the Board to review and sign minutes and policy documents, etc.; and (5) to ensure that unique or non-routine materials and equipment are available for the Board to carry out its functions. In the event that both the Chairperson and Vice-chairperson are absent at any meeting, the Secretary shall preside over the meeting.

STATE BOARD OF JUVENILE JUSTICE

BY-LAWS

Revised November 13, 2019

Article 1.

§ 1.01. Establishment and Composition.
The State Board of Juvenile Justice (the "Board") is established by § 66-4 of the Code of Virginia. The Board consists of nine members appointed by the Governor and confirmed by the General Assembly if in session and, if not, at its next succeeding session. Two of the nine members shall be experienced educators.

Article 2.

§ 2.01. Term of Office.
In accordance with § 66-5 of the Code of Virginia, the term of office of Board members shall be for four years, except that appointments to fill vacancies shall be for the remainder of the unexpired terms. No person shall be eligible to serve more than two successive four-year terms, except that a person appointed to fill a vacancy may be eligible for two additional, successive four-year terms after the term of the vacancy for which the person was appointed has expired.

§ 2.02. Orientation.
In accordance with § 2.2-3702 of the Code of Virginia, within two weeks of their appointment or re-appointment, members of the Board shall (i) be furnished by the Board's administrator or legal counsel with a copy of the Virginia Freedom of Information Act (§ 2.2-3700 et seq.), and (ii) read and become familiar with the provisions of that Act.

§ 2.03. Meetings.
Section 66-8 of the Code of Virginia requires that the Board meet at least four times each calendar year. The Board shall meet as follows:

(a) Regular Meetings - Meet once during each calendar quarter at such times and places as it deems appropriate.

(b) Special Meetings - Special meetings of the Board may be called by the Chairperson or, if the Chairperson is absent or disabled, by the Vice chairperson or by any four members of the Board at such dates, times and places as may be specified in the call for the meeting.

§ 2.04. Notice.
At least five days' notice in writing shall be given to a Board member of the date, time, and place of all meetings. In accordance with § 2.2-3707 of the Code of Virginia, notice including the time, date and place of each meeting shall be furnished to any citizen of the Commonwealth who requests such information. Notices for meetings shall state whether or not public comment will be received at the meeting, and, if so, the approximate points during the meeting public comment will be received. Any requests to be notified of Board meetings on a continual basis shall be made at least once a year, in writing and shall include the requester's name, address, zip code, daytime telephone number, email address (if available) and organization, if applicable. Notice to any citizen of the Commonwealth who requests such information, reasonable under the circumstance, of special or emergency meetings shall be given contemporaneously with the notice provided Board members.

§ 2.05. Board Materials.
With the exception of any materials that are exempt from public disclosure pursuant to § 2.2-3705 of the Code of Virginia, at least one copy of all agenda packets and materials furnished to Board members for a meeting shall be made available for inspection by the public at the same time such documents are furnished to the members of the Board.

§ 2.06. Cancellation or Rescheduling of Meetings.
The Chairperson may, with the concurrence of a majority of the Board, cancel or postpone a meeting. The Director of the Department of Juvenile Justice (the "Director") shall ensure that proper and immediate public notice is given. In an emergency, the Chairperson is authorized to cancel, significantly alter, or postpone the meeting time.

§ 2.07. Quorum.
In accordance with § 66-9 of the Code of Virginia, a majority of the current membership of the Board shall constitute a quorum for all purposes.

§ 2.08. Attendance.
Participation is essential to the fulfillment of the function of membership. The absence of any member impedes the business of the Board and deprives the Department of Juvenile Justice (the "Department") of the overall policy direction this Board is responsible for providing. Should any member miss three consecutive regular meetings, or a total of five or more regular meetings during a calendar year, the Chairperson, following consultation with the member, is authorized to advise the appropriate Executive Branch official(s). In accordance with § 66-5 of the Code of Virginia, members of the Board may be suspended or removed by the Governor at his pleasure.

§ 2.09. Conduct of Business
The Board actively encourages and welcomes public participation in all its public deliberations. All meetings of the Board, including meetings and work sessions during which no votes are cast or any decisions made, shall be public meetings, and shall be conducted in accordance with § 2.2-3707 of the Code of Virginia. Votes shall not be

taken by written or secret ballot in an open meeting, and minutes shall be recorded at all public meetings. All meetings shall be conducted in accordance with the principles of procedures prescribed in Roberts' Rules of Order.

Article 3. Powers and Duties.

§ 3.01. General Powers and Duties.
Section 66-10 of the Code of Virginia gives the Board the following general powers and duties:

a) To establish and monitor policies for programs and facilities for which the Department is responsible by law;
b) To ensure the development of a long-range youth services policy;
c) To monitor the activities of the Department and its effectiveness in implementing the policies of the Board;
d) To advise the Governor and Director on matters relating to youth services;
e) To promulgate such regulations as may be necessary to carry out the provisions of Title 66 of the Code of Virginia and other laws of the Commonwealth;
f) To ensure the development of programs to educate citizens and elicit public support for the activities of the Department;
g) To establish length-of-stay guidelines for juveniles indeterminately committed to the Department and to make such guidelines available for public comment;
h) To adopt all necessary regulations for the management and operation of the schools in the Department, provided that any such regulations do not conflict with regulations relating to security of the institutions in which the juveniles are committed; and
i) To establish compulsory minimum entry-level, in-service, and advanced training standards, as well as the time required for completion of such training, for persons employed as juvenile correctional officers employed at a juvenile correctional facility as defined in § 66-25.3. For juvenile correctional officers who may have contact with pregnant residents, such standards shall include training on the general care of pregnant women, the impact of restraints on pregnant residents and fetuses, the impact of being placed in restrictive housing or solitary confinement on pregnant residents, and the impact of body cavity searches on pregnant residents.

§ 3.02. Additional Specific Powers and Duties.
Various sections of the Code of Virginia give the Board additional specific powers and duties, both mandatory and discretionary. Such sections of the Code of Virginia include, but are not limited to, the following:

a) Section 2.2-4007.02 of the Code of Virginia requires the Board to promulgate regulations for public participation in the formation and development of regulations.

b) Section 16.1-223 of the Code of Virginia requires the Board to promulgate regulations governing the security and confidentiality of data in the Virginia Juvenile Justice Information System.
c) Section 16.1-233 of the Code of Virginia requires the Board to establish minimum standards for court service unit staff and related supportive personnel and to promulgate regulations pertaining to their appointment and functions to the end that uniform services, insofar as is practical, will be available to juvenile and domestic relations district courts throughout the Commonwealth.
d) Section 16.1-284.1 of the Code of Virginia requires the standards established by the Board for secure juvenile detention centers to require separate services for the rehabilitation of juveniles placed in post-dispositional dentition programs for greater than 30 calendar days.
e) Section 16.1-293.1 of the Code of Virginia requires the Board to promulgate regulations for the planning and provision of mental health, substance abuse, or other therapeutic treatment services for persons returning to the community following commitment to a juvenile correctional center or post-dispositional detention program.
f) Section 16.1-309.3 of the Code of Virginia authorizes the Board to approve local plans for the development, implementation, and operation of a community-based system of services under the Virginia Juvenile Community Crime Control Act (Article 12.1 of Title 16.1 of the Code of Virginia). This section also requires the Board to solicit written comments on the plan from the judge or judges of the juvenile and domestic relations court, the director of the court service unit, and if applicable, the director of programs established under the Delinquency Preventions and Youth Development Act (Chapter 3 of Title 66 of the Code of Virginia).
g) Section 16.1-309.5 of the Code of Virginia requires the Board to promulgate regulations to serve as guidelines in evaluating requests for reimbursement of one-half the cost of construction, enlargement, renovation, purchase, or rental of a secure juvenile detention center or other home and to ensure the geographically equitable distribution of state funds provided for such purpose.
h) Section 16.1-309.9 of the Code of Virginia requires the following:
    a. The Board to develop, promulgate, and approve standards for the development, implementation, operation, and evaluation of a range of community-based programs, services, and facilities authorized by the Virginia Juvenile Community Crime Control Act (Article 12.1 of Title 16.1 of the Code of Virginia)
    b. The Board to approve minimum standards for the construction and equipment of secure juvenile detention centers or other facilities and for the provision of food, clothing, medical attention, and supervision of juveniles to be housed in these facilities and programs.
i) Section 16.1-309.10 of the Code of Virginia authorizes the Board to visit, inspect, and regulate any secure juvenile detention center, group home, or the residential care facility for children in need of services, delinquent, or alleged delinquent that is established by a city, county, or any combination thereof.

j) Section 16.1-322.5 of the Code of Virginia requires the Board to approve those localities creating a Commission for the purpose of financing and constructing a regional detention or group home. This section also requires the Board to approve contracts for construction of such facilities.

k) Section 16.1-322.7 of the Code of Virginia requires the Board to make, adopt, and promulgate regulations governing specific aspects of the private management and operation of local or regional secure juvenile detention centers or other secure facilities.

l) Section 66-10.1 of the Code of Virginia requires the Board to promulgate regulations to effectuate the purposes of Chapter 5.1 (§32.1-162.16 et seq.) of Title 32.1 of the Code of Virginia governing any human research conducted or authorized by the Department.

~~l)~~m) Section 66-10.2 of the Code of Virginia requires the Board to promulgate regulations governing the housing of youth who are detained in a juvenile correctional facility pursuant to a contract with the federal government and not committed to such juvenile correctional facility by a court of the Commonwealth.

~~m)~~n) Section 66-13 of the Code of Virginia requires the Board to prescribe standards for the development, implementation, and operation of juvenile boot camps.

~~n)~~o) Section 66-23 authorizes the Board to promulgate regulations to govern the process by which superintendents of juvenile correctional centers consent to residents applying for driver's licenses and issue employment certificates;

~~o)~~p) Section 66-24 of the Code of Virginia requires the Board to promulgate regulations for the certification of community group homes or other residential care facilities that contract with or are rented for the care of juveniles in direct state care.

~~p)~~q) Section 66-25.1 of the Code of Virginia requires the Board to promulgate regulations governing the form and review process for any agreement with a public or private entity for the operation of a work program for juveniles committed to the Department.

~~q)~~r) Section 66-25.6 of the Code of Virginia requires the Board to promulgate regulations governing the private management and operation of juvenile correctional facilities.

~~r)~~s) Section 66-28 of the Code of Virginia requires the Board to prescribe policies governing applications for grants pursuant to the Delinquency Prevention and Youth Development Act (Chapter 3 of Title 66 of the Code of Virginia) and standards for the operation of programs developed and implemented under the grants.

Article 4. Committees.

§ 4.01.Special or Ad Hoc Committees

Special or Ad Hoc Committees may be constituted at any time by action of the Board or the Chairperson. At the time a Special Committee is created, its mission shall be specifically established by action of the Board or by the Chairperson. In creating such

Special Committees, the Chairperson shall specify the time within which the Committee is to make its report to the Board.

§ 4.04. Other Appointments.
The Chairperson may designate members of the Board from time to time to serve on various task forces, advisory councils, and other committees and to serve as liaison with Department functions and state organizations or associations.

Article 5. Officers.

§ 5.01. Officers Elected from the Board.
The Officers of the Board elected from its membership shall be the Chairperson, Vice-chairperson and Secretary, who shall each be elected by the Board at its first regular meeting of the fiscal year. Officers shall serve for a term of one year and shall be eligible for re-election.

§ 5.02. Chairperson.
The Chairperson shall be the presiding officer of the Board at its meetings. Upon request of the Board, the Chairperson shall act as its spokesperson or representative and shall perform such additional duties as may be imposed on that position by an Act of the General Assembly or by direction of the Board. The Chairperson shall be an ex-officio member of all Committees of the Board.

§ 5.03. Vice-chairperson.
In the absence of the Chairperson at any meeting or in the event of disability or of a vacancy in the office, all the powers and duties of the Chairperson shall be vested in the Vice-chairperson. The Vice-chairperson shall also perform such other duties as may be imposed by the Board or the Chairperson.

§ 5.04. Secretary.
The Secretary shall (1) review and recommend improvements to Board meeting procedures and other relevant Board business so as to facilitate the administrative efficiency of the Board; (2) ensure the development of appropriate resolutions, etc., which are needed by the Board from time to time; (3) serve as the Board's parliamentarian; (4) work closely with the Department staff who are assigned to provide administrative assistance to the Board to review and sign minutes and policy documents, etc.; and (5) to ensure that unique or non-routine materials and equipment are available for the Board to carry out its functions. In the event that both the Chairperson and Vice-chairperson are absent at any meeting, the Secretary shall preside over the meeting.

§5.05. Order of Succession in Absence of Officers
In the event that the Chairperson, Vice-chairperson, and Secretary all are absent from a meeting, the Board member in attendance with the longest tenure on the Board shall be authorized to preside over the meeting. In the event that two or more such members in

attendance have served identical terms, the Director shall be authorized to designate one of the two Board members to preside over the meeting.

Article 6. Department of Juvenile Justice.

§ 6.01. Director.
§ 66-1 of the Code of Virginia establishes the Department of Juvenile Justice under the immediate supervision of a Director who is appointed by the Governor, subject to confirmation by the General Assembly. In accordance with § 66-2 of the Code of Virginia, the Director is responsible for supervising the Department and for exercising such other powers and performing such other duties as may be provided by law or as may be required of the Director by the Governor and the Secretary of Public Safety. The Director shall implement such standards and goals of the Board as formulated for local and community programs and facilities. In accordance with § 16.1-234 of the Code of Virginia, it shall be the duty of the Department to ensure that minimum standards established by the Board for court service and other state-operated programs are adhered to.

§ 6.02. Relationship of the Board and Department.
In keeping with the powers and duties imposed upon the Board and upon the Director by law, the Board shall regularly meet with the Director in order that the responsibilities of each are carried out efficiently and cooperatively. The Board shall periodically assess its needs for administrative assistance and how well those needs are being met, and shall so advise the Director. In accordance with § 16.1-309.4 of the Code of Virginia, the Department shall submit to the Board on or before July 1 of odd-numbered years, a statewide plan for the establishment and maintenance of a range of institutional and community-based, diversion, predispositional and postdispositional services to be reasonably accessible to each court. The Department shall establish procedures to ensure (i) the superior quality and timeliness of materials submitted to the Board and (ii) that the Board is informed as early as possible of individuals attending Board meetings.

§ 6.03. Administrative Assistance.
The Department shall provide staff assistance to the Board in carrying out its administrative duties.

Article 7. Amendments and Procedural Irregularities.

§ 7.01. Annual Review.
The Board shall review the By-Laws annually to ensure compliance with any amendments that may have been made to applicable sections of the Code of Virginia.

§ 7.02. Amendments.
The By-Laws may be amended at any regular or special meeting of the Board by an affirmative vote of the majority of the Board, provided that the proposed amendment was included in the notice of the meeting.

§ 7.03. Procedural Irregularities.
Failure to observe procedural provisions of the By-Laws does not affect the validity of Board actions.

§ 7.04. Effective Date.
The foregoing By-Laws are adopted by the Board and are effective as amended, November 13, 2019.

EXECUTIVE SUMMARY

The Program Design and Planning Study presented in this report follows the March 2001 "Step-By-Step Procedures for Approval and Reimbursement for Local Facility Construction, Enlargement and Renovation", a Department of Juvenile Justice (DJJ) publication. Planning Studies for both a replacement Juvenile Detention Center, and a replacement Juvenile Shelter (the County's "non-secure" facility) are included herein. A previous Needs Assessment Report was prepared in 2018 and approved by the Board of Juvenile Justice. It proposed a need for 50-55 secure beds, which includes 8-16 beds for the Commonwealth's Community Placement Program (CPP), of which Prince William County is a part, and currently has 8 beds for males in the CPP. Because of the continued decline in the Juvenile Detention Center (JDC) population, Prince William County has determined that their facility should be designed for 48 beds, with expansion space for a future housing pod.

The Molinari Juvenile Shelter (MJS) is an existing 15 bed facility in Prince William County (PWC) providing a non-secure detention facility, which is a temporary residential option for low risk juveniles awaiting court outcomes. The shelter is considered a detention alternative. While the approved Needs Assessment focused on the Juvenile Detention Center, it also made a recommendation for PWC to consider co-locating the existing Juvenile Detention Center and the Molinari Juvenile Shelter on the same site. Currently, the two facilities are approximately sixteen miles apart. The sharing of support services such as food service, laundry, and medical staff would likely result in reduced operational costs and facilitate an improved continuum of care for youth in the County. As part of Prince William County's goals to keep their JDC population on the decline, they have determined that the MJS plays a key role, and part of the plan presented in this Study is to relocate the Molinari Juvenile Shelter adjacent to the Juvenile Detention Center and increase its capacity to 20 beds.

Program design

The 2018 Needs Assessment Report showed the JDC service area population growing, with a projected growth in the County outpacing the same population growth in the Commonwealth. However, while the general population in the County increased, overall crime incident rate decreased, as have detention admissions to the JDC. Reported crime and crime rates in Virginia have, with some few exceptions, been declining. This declining trend is consistent with crime trends in Prince William County and the cities of Manassas and Manassas Park. With projected growth in the general population in Prince William County, it is reasonable to assume that there will be a need to implement program options and detention alternatives in the County to accommodate continuing pressure on resource needs. Average Daily Populations in JDC's statewide have been declining due to a decrease in juvenile crime, an increase in the use of diversion and detention alternatives, and the introduction of structured Detention Assessment Instruments.

The research documented in the Program Design shows that Prince William County's Department of Social Services shoulders most of the detention alternatives provided by the County. Youth will receive services from the Department of Social Services by either Court Order, arrest, referral from Juvenile Court Services Intake, a Shelter Care Order, or/and Emergency Placement Order. When this occurs, the County offers a continuum of program services and alternatives to secure detention based on the need.

When secure detention is needed, the Juvenile Detention Center exists to provide a safe, secure and structured environment that offers therapeutic programming and services which promote positive change, the overall well-being of the youth, and the protection of public safety.

Planning Study

The purpose of this Planning Study is to describe the construction and cost necessary to meet specific needs identified in both the Needs Assessment and the Program Design. The study presents the County's

forward-thinking approach to plan a campus for their juvenile justice services on one site, co-locating the JDC, the MJS, and Department of Social Service's Pre-trial program. Each of these three entities is detailed separately for size, cost, and staffing.

Site

Prince William County determined that the County owned site adjacent to the existing Juvenile Detention Center is the preferred location for the new juvenile services campus.

Design Concept

The driving factors for the new JDC are the lack of educational, program, staff, and support space, and the facility's interior configuration, neither of which are in line with the Prince William County's vision to provide a therapeutic, flexible, and operationally secure and safe facility for their County.

One of the guiding and distinguishing principles that is intended to set the new JDC apart is its awareness of and sensitivity to trauma informed design. Trauma informed design acknowledges and assumes that individuals being served at this facility are more likely than not to have a history of trauma in their lives, and to provide an environment that reduce the likelihood of exacerbating trauma-related symptoms. To contribute to the success of juvenile outcomes while at the Juvenile Detention Center or the Molinari Juvenile Shelter, both facilities will be designed with attention paid details such as providing connections to nature, natural light, and views to the outdoors, providing appropriate opportunities for social engagement, and selecting color palettes that are calming.

Building Construction and Special Considerations

The exterior design proposes similar materials for the Juvenile Detention Center and the Molinari Juvenile Shelter but gives each building its own identity. The design gives the appearance of a campus with different buildings that complement each other, not one large building. The MJS will be residential in appearance, as the short-term alternative to secure detention, and its architectural detailing will be more refined, and a smaller scale. The JDC will have a more formal appearance, without being institutional. An angled, accent colored wall will cut across the site, through both buildings, tying them together. The building systems (architectural, structural, mechanical, electrical, plumbing, electronic security, and life safety) and materials will all be integrated, taking into consideration durability, life cycle cost, environmental, and aesthetic issues in order to provide best value for the capital investment.

Architectural Space Programs – Juvenile Detention Center, Molinari Juvenile Shelter, and Juvenile Services Administration

Three separate space programs were prepared. One is for the 48-bed Juvenile Detention Center, the second is for the 20-bed Molinari Juvenile Shelter, and the third is for Juvenile Services Administration and Pre-Trial staff offices. The detailed breakdown is provided in Section 3, starting on page 47 with each program's departmental and individual space program following. The total gross square footage of each space program is listed below.

Juvenile Detention Center	57,491 square feet
Molinari Juvenile Shelter	17,471 square feet
Juvenile Services Administration	2,178 square feet
Total	**77,140 square feet**

Staffing Analysis – Juvenile Detention Center and Molinari Juvenile Shelter

Juvenile Detention Center:
The staffing operation of the Prince William County Juvenile Detention Center is divided into two 12-hour shifts providing 24-hour, 7-days per week security coverage. In addition, there is a standard "business shift" for clerical, program, and administrative staff. Just as they currently operate in the existing facility, staff will continue providing juvenile supervision in the housing pods by "direct supervision" methodology. The Juvenile Detention Center staffing plan for a full 48-bed facility consists of 63 total positions. The detailed breakdown is provided on page 83.

Molinari Juvenile Shelter:
The staffing operation of the Molinari Juvenile Shelter is divided into three 8-hour shifts providing 24-hour, 7-days per week security coverage. In addition, there is a standard "business shift" for clerical, program and administrative staff. Due to the size of the facility, staff are asked to perform or lend help with a variety of roles in addition to their primary job position. The Molinari Juvenile Shelter staffing plan for a full 20-bed facility consists of 21.5 total (FTE= full time equivalent) positions. The detailed breakdown is provided on page 86.

Project Costs Juvenile Detention Center
Project Budget, Facility Operation Budget, Facility Start Up Costs, State Reimbursement

Project Budget:
The Department of Juvenile Justice's "Step by Step" methodology for estimating reimbursable cost requires the use of R.S. Means cost estimating publications to establish the cost for the LCR 002 form. Basic nationwide square foot cost is used as a basis, then "additive" items are included to account for specific, unique design considerations for the building. Finally, the "location factor" found in R.S. Means is used to qualify the square foot cost based on where the project is located in the United States. Fairfax County, Virginia is the closest match for Prince William County.

The independent cost estimating firm, Downey and Scott, LLC, who prepared a schematic design construction cost estimate for the project, is located in Northern Virginia. They collect current data from construction projects in the area, rather than using a nation-wide average. They have an eye on local labor, the local General Contractors for different construction types, and what is being charged for general conditions, profit, overhead, and other construction related costs. Their estimate for this project is based on the actual building design, size, shape, and materials, while the R.S. Means estimate is based on a basic building type, three stories tall, and a rectangular shape. When there is an absence of an independent estimate, the R.S. Means publications are a good resource to use as a guide, but in this case, Prince William County took the extra step to obtain an independent cost estimate.

Due to the differences in the two methods, the building construction cost estimates vary. The LCR002 form was prepared using both estimates, and both are found in the Appendix of this study. It is the desire of Prince William County that DJJ use the LCR 002 form based on the independent estimate, rather than the LCR 002 based on R.S. Means, because the independent estimate is believed to be more accurate for the proposed design.

The construction contingency uses 3% as recognized and allowed by DJJ. Prince William County and Moseley Architects agree that a higher construction contingency is more prudent in the current construction market environment and recommend between 5% - 10% for a total project cost estimate for a project in the schematic design phase.

	R.S. Means	Downey & Scott
TOTAL ESTIMATED PROJECT COST	$28,979,115	$34,839,096

Facility Operation Budget:

It is anticipated that the juvenile population in the JDC will remain flat in the upcoming years, therefore the same amount of food and services that are used in FY2020 will be estimated for FY2025, but the cost for the food and services are inflated at a rate of 2% per year. Economic outlooks consistently predict between 2% – 3% inflation per year for the next few years. Staffing is anticipated to increase modestly in the new building over current levels, mainly as related to the smaller housing pods, and increased therapy, classroom education, and programs that will need therapeutic and security staff coverage. Many of these positions are already filled in the existing JDC, so the salaries and benefits calculated on page 98 are based on known existing conditions. The fiscal year 2025 (FY25) Salary and Benefits Budget for the 63 total positions is calculated to be $5,434,400 with the JDC One Year Operational Budget for FY25 calculated to be $6,371,410.

Facility Start Up Costs:
Start-up costs include free standing equipment and start-up costs for staffing and operations. Free standing furnishings, fixtures, and equipment (known as FF&E) includes items placed in the building that are not built in and are not part of the General Contractors scope of work. The start-up costs for staffing and operations includes staff training, staff uniforms, moving expenses, and similar staff costs to be incurred when the new building becomes operational and the youth are moved.

State Reimbursement:
Prince William County understands that there is currently a moratorium on state reimbursement for construction of local facilities. We are seeking approval of the Planning Study from the Board of Juvenile Justice in order to be compliant with the reimbursement process. We as a locality will seek reimbursement from the General Assembly.

Reimbursement is subject to the approval by the General Assembly based on the Board of Juvenile Justice approval of the Planning Study. As allowed by DJJ's "Formula for State Reimbursement of Local Projects", this secure detention project qualifies in the following ways:

1. The JDC is a replacement of the existing facility. At this time, there is not an intended re-use of the building once it is vacated. With the documented decline in youth population, and the intentional effort to re-design the new building differently with a more therapeutic, treatment based approach, Prince William County requests that DJJ look upon this facility as "new construction", as the renovation and expansion formula in the "Step by Step" manual does not apply. The County is requesting 50% of approved cost.
2. Current applicable reimbursement for staffing and operations.
3. Free Standing equipment: up to 50% of total cost. The cap in the 1997 "Step by Step" manual is out of date, and Prince William County requests a higher cap.
4. Start-up funding: up to 1/12 (30 days) of state's share of annual staffing and operating costs.

Consideration and approval from the Board of Juvenile Justice for the Planning Study will result in making us eligible for reimbursement funds for this project which will greatly benefit the localities in helping to offset their local share.

Project Costs Molinari Juvenile Shelter
Project Budget, Facility Operation Budget, Facility Start Up Costs, State Reimbursement

Project Budget:
The Department of Juvenile Justice's "Step by Step" methodology for estimating reimbursable cost requires the use of R.S. Means cost estimating publications to establish the cost for the LCR 002 form. Basic nationwide square foot cost is used as a basis, then "additive" items are included to account for design considerations for the building. Finally, the "location factor" found in R.S. Means is used to qualify the

square foot cost based on where the project is located in the United States. Fairfax County, Virginia is the closest match for Prince William County.

The independent cost estimating firm, Downey and Scott, LLC, who prepared a schematic estimate for the project, is located in Northern Virginia. Their estimate for this project is based on the actual building design, size, shape, and materials, while the R.S. Means estimate is based on a basic building type, three stories tall, and a rectangular shape. When there is an absence of an independent estimate, the R.S. Means publications are a good resource to use as a guide, but in this case, Prince William County again took the extra step to obtain an independent cost estimate.

Due to the differences in the two methods, the building construction cost estimates vary. The LCR002 form was prepared using both estimates, and both are found in the Appendix of this study. It is the desire of Prince William County that DJJ use the LCR 002 form based on the independent estimate, rather than the LCR 002 based on R.S. Means, because the independent estimate is believed to be more accurate for the proposed design.
The construction contingency uses 3% as recognized and allowed by DJJ. Prince William County and Moseley Architects agree that a higher construction contingency is more prudent in the current construction market environment and recommend between 5% - 10% for a total project cost estimate for a project in the schematic design phase.

	R.S. Means	Downey & Scott
TOTAL ESTIMATED PROJECT COST	$9,766,012	$11,190,804

Facility Operation Budget:
The capacity of the Molinari Juvenile Shelter is increased in the new design from 16 beds to 20 beds (25%). Therefore, the amount of food and some services that are used in FY2020 will be increased by 25% for FY2025, then the cost for the food and services are inflated at a rate of 2% per year. Economic outlooks consistently predict between 2% – 3% inflation per year for the next few years.

Staffing is anticipated to increase in the new building over current levels, due to the increase in the number of beds from 16 to 20. Personnel Services are the largest piece of the facility's operational budget. Many of these positions are already filled in the existing JDC, so the salaries and benefits calculated on page 103 are based on known existing conditions. The fiscal year 2025 (FY25) Salary and Benefits Budget for the 21.5 total FTE positions is calculated to be $1,882,700 with the JDC One Year Operational Budget for FY25 calculated to be $2,124,975.

Facility Start Up Costs:
Start-up costs include free standing equipment and start-up costs for staffing and operations. Free standing furnishings, fixtures, and equipment (known as FF&E) includes items placed in the building that are not built in and are not part of the General Contractors scope of work. The start-up costs for staffing and operations includes staff training, staff uniforms, moving expenses, and similar staff costs to be incurred when the new building becomes operational and the youth are moved.

State Reimbursement:
Reimbursement is subject to approval by the General Assembly based on the Board of Juvenile Justice approval of the Planning Study. As allowed by DJJ's "Formula for State Reimbursement of Local Projects", this "less-secure" detention project qualifies in the following way:

1. The Molinari Juvenile Shelter is a replacement and bed expansion of the existing facility. At this time, there is not an intended re-use of the building once it is vacated. With the documented decline in secure detention beds, the Molinari Juvenile Shelter is a secure detention alternative, designed with an educational, therapeutic, and rehabilitative approach. Prince William County requests that DJJ look upon this facility as "new construction". The County is requesting 50% of approved cost.

Consideration and approval from the Board of Juvenile Justice for the Planning Study will result in making us eligible for reimbursement funds for this project which will greatly benefit the localities in helping to offset their local share.

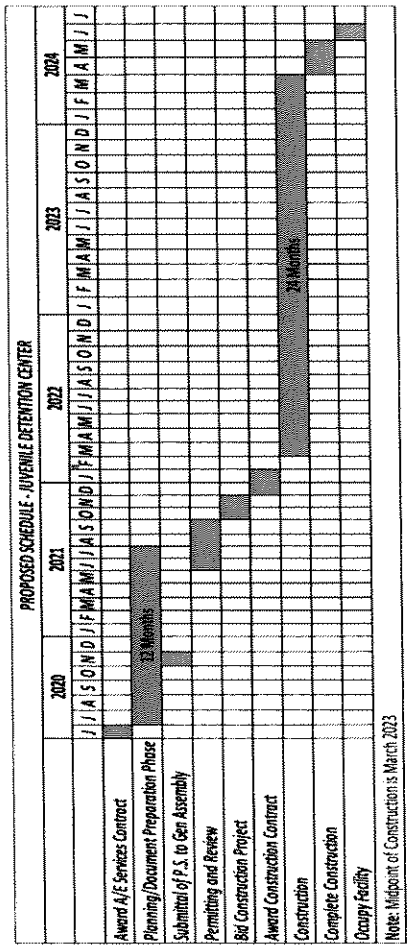
Proposed Schedule

A proposed project schedule is indicated on page 107 and replicated below for your reference. The anticipated duration from award of design services contract to final completion of construction is approximately four years. The intended construction start is early spring 2022, with a 24-month construction schedule and move-in for both facilities in Summer 2024. In order to meet this schedule, the County is requesting approval from the Board of Juvenile Justice of these Program Design and Planning reports in Summer/Fall 2020.

Concept Design Drawings

Drawings are found starting on page 108 of the Planning Study.

End of Executive Summary



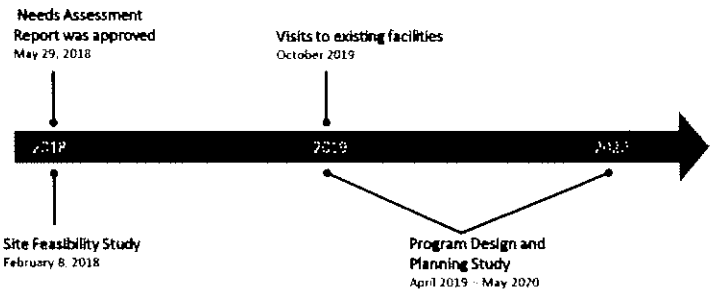
PRINCE WILLIAM COUNTY

Juvenile Services Campus Planning Study September 16, 2020

PRINCE WILLIAM COUNTY

Timeline of Project

PRINCE WILLIAM COUNTY



3

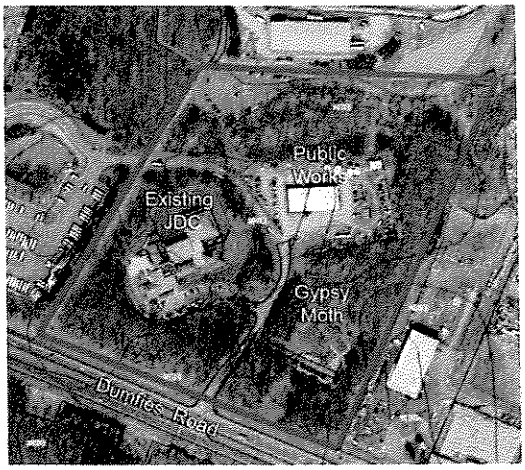
Existing Buildings

PRINCE WILLIAM COUNTY

- Constructed 1978
- Additions in 1997 and 2000

JDC Comparison	Square Footage	Number of beds
Existing Building	35,000	72 (48 used)
New Building	58,300	48

Molinari Comparison	Square Footage	Number of beds
Existing Building	7,000	15
New Building	18,000	20



Overview: Planning Study

PRINCE WILLIAM COUNTY

Main goals for this project that cannot be realized in the existing building are:

- Focus on trauma informed design and promoting mental wellness of residents and staff
- Central Control station at lobby providing secure admission to perimeter
- Space for private visits with family/ counselors / attorneys
- Space for educators, classrooms, and vocational programs
- Secure reception area for detainees/law enforcement with secure holding/interview/medical
- A secure outdoor activity area that can be easily supervised
- Staff areas for training and meetings
- Increased digital and electronic connections within the building
- Combining DJJ design/construction standards with a rehabilitative environment

Mission Statement:
It is the mission of the Prince William County Juvenile Detention Center to:
Protect the community, the staff and youth we serve;
Provide quality structured programs in a humane environment; and
Promote healthy emotional, educational, social and physical development.

5

PRINCE WILLIAM COUNTY

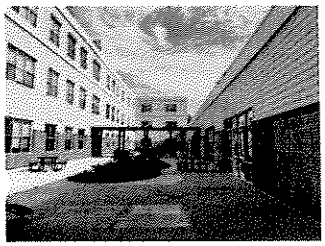
6

Trauma Informed Design

PRINCE WILLIAM COUNTY

In an effort to contribute to the success of juvenile outcomes while at the Juvenile Detention Center (JDC) or the Molinari Juvenile Shelter (MJS), both facilities will be designed with attention paid to Trauma Informed Design criteria, including the following:

- Replicate patterns of daily life
- Provide connections to nature, natural light and views to the outdoors
- Attention to acoustics
- Supervised social engagement
- Selection of colors and patterns that are visually appealing and calming
- Exposure to large format images of nature
- Suicide resistant fixtures and furnishings



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Trauma Informed Design

PRINCE WILLIAM COUNTY

8

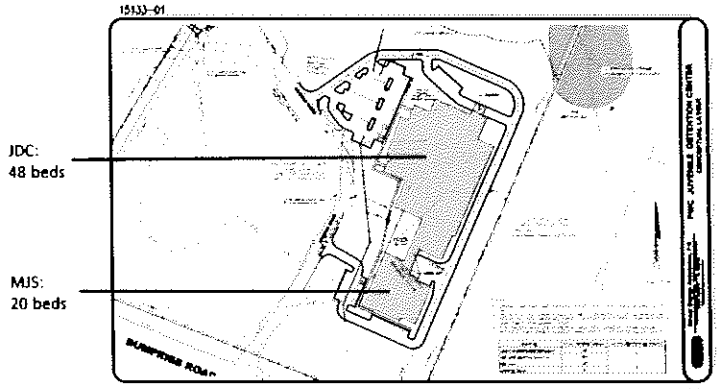
Trauma Informed Design

PRINCE WILLIAM COUNTY

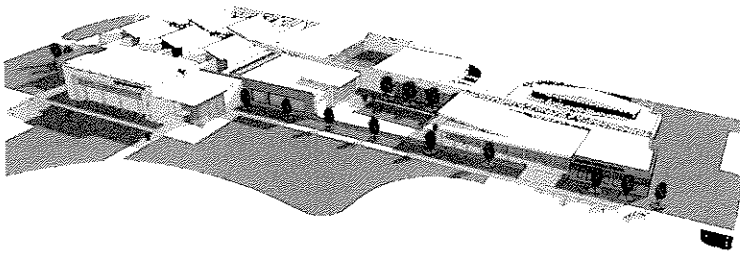
9

Proposed Site Plan

PRINCE WILLIAM COUNTY

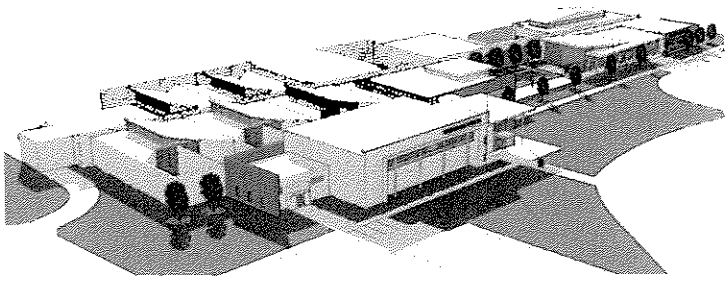


Exterior Rendering



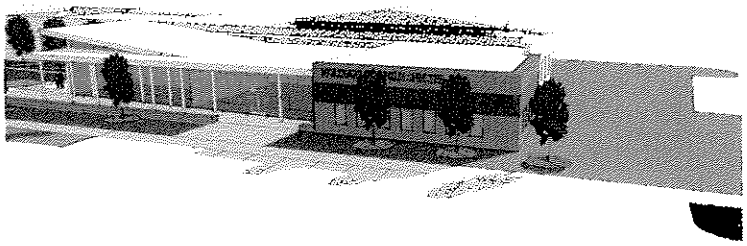
11

Exterior Rendering



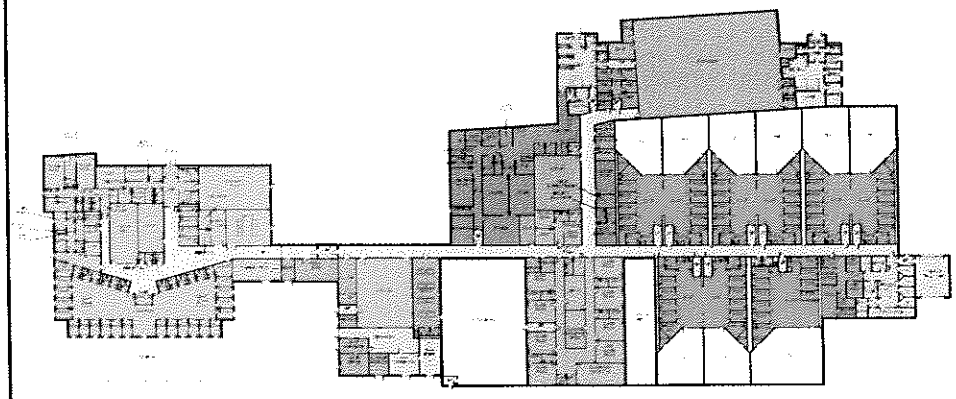
12

Exterior Rendering



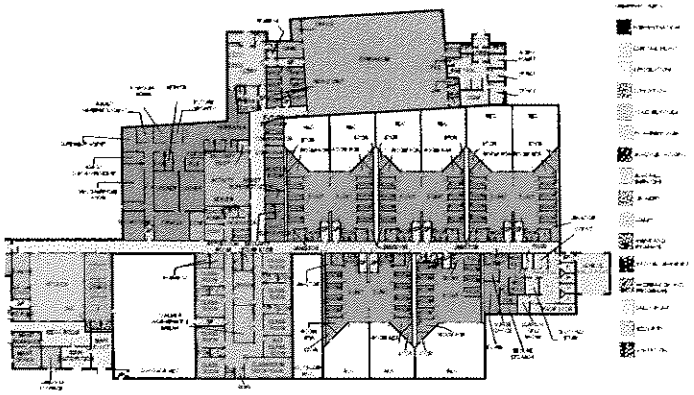
13

Overall Floor Plan



14

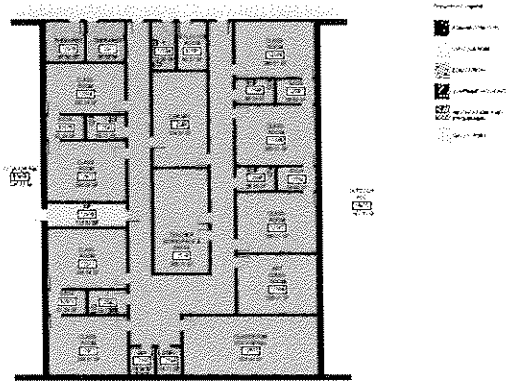
JDC



JDC Admin

JDC School

PRINCE WILLIAM COUNTY



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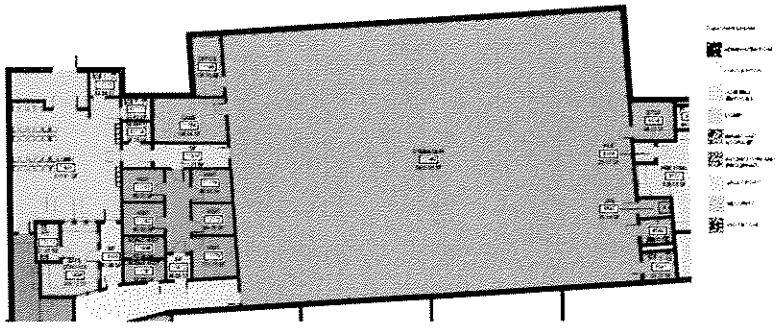
JDC Gym

PRINCE WILLIAM COUNTY



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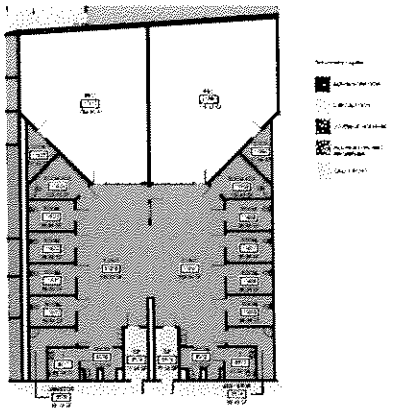
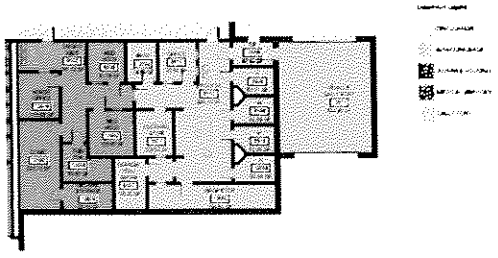
JDC Housing



19

JDC Intake/Medical



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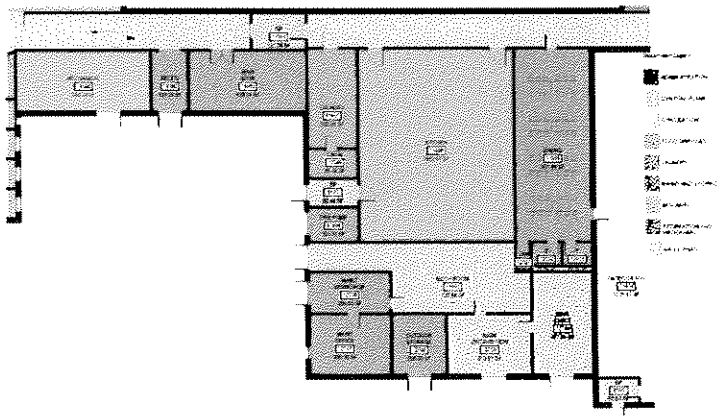
Mechanical

PRINCE WILLIAM COUNTY



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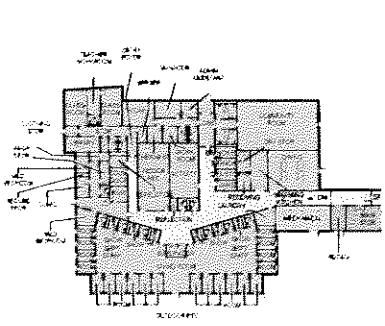
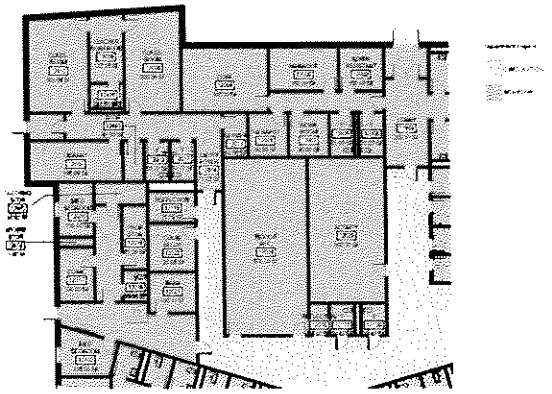
Molinari Juvenile Shelter

PRINCE WILLIAM COUNTY



Molinari Juvenile Shelter Plan



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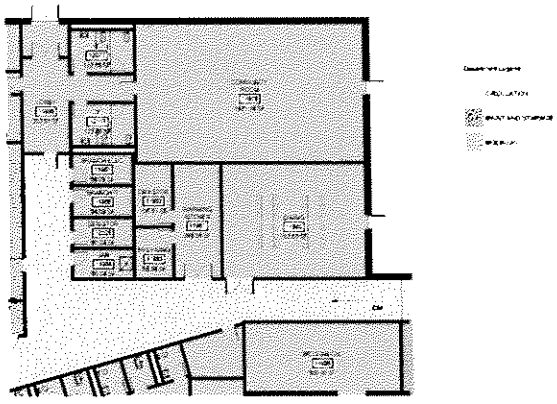
Molinari Juvenile Shelter Plan



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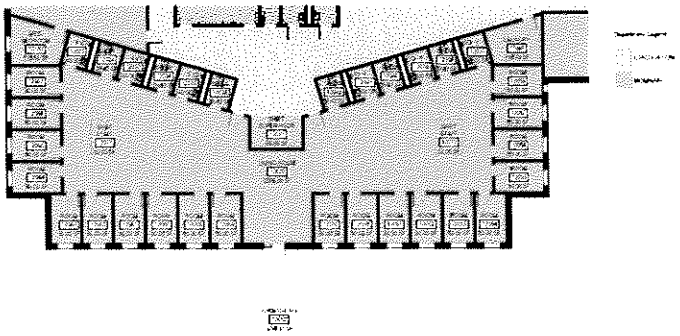
Molinari Juvenile Shelter Housing

PRINCE WILLIAM COUNTY



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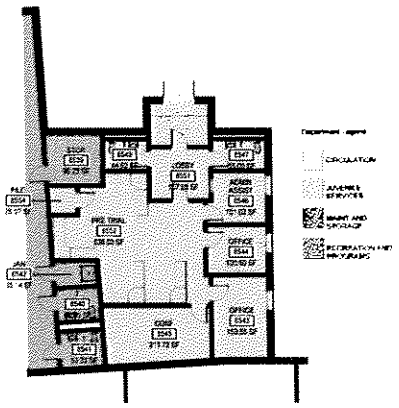
Juvenile Services

PRINCE WILLIAM COUNTY



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PRINCE WILLIAM COUNTY

JDC Cost Estimate

PRINCE WILLIAM COUNTY

JDC Project Cost	0.33 Formula R.S. Means	Downey & Scott (includes 10% design contingency)
Subtotal New Construction	$18,859,669	$23,168,055
Site and Utility Construction Cost	$3,291,742	$3,291,742
Other Costs	$4,584,933	$5,652,677
Subtotal	**$26,736,344**	**$32,112,474**
Escalation for Two Years	$2,406,271	$2,890,123
Total Estimated Project Cost	**$29,142,615**	**$35,002,596**

Molinari Cost Estimate

PRINCE WILLIAM COUNTY

Molinari Project Cost	D.J.J. Formula R.S. Means	Downey & Scott (includes 10% design contingency)
Subtotal New Construction	$6,152,320	$7,168,062
Site and Utility Construction Cost	$1,053,894	$1,053,894
Other Costs	$1,753,430	$2,044,837
Subtotal	**$8,959,644**	**$10,266,793**
Escalation for Two Years	$806,368	$924,011
Total Estimated Project Cost	**$9,766,012**	**$11,190,804**

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Total Cost Estimate

PRINCE WILLIAM COUNTY

Total Project Cost	D.J.J. Formula R.S. Means	Downey & Scott (includes 10% design contingency)
JDC total project cost	$29,142,615	$35,002,596
Molinari total project cost	$9,766,012	$11,190,804
Total Estimated Project Cost	$38,908,627	$46,193,400

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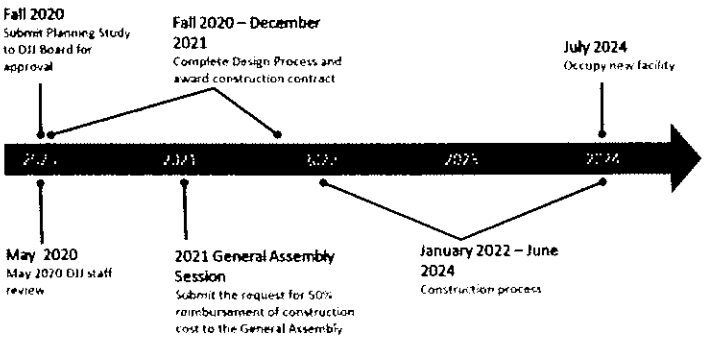
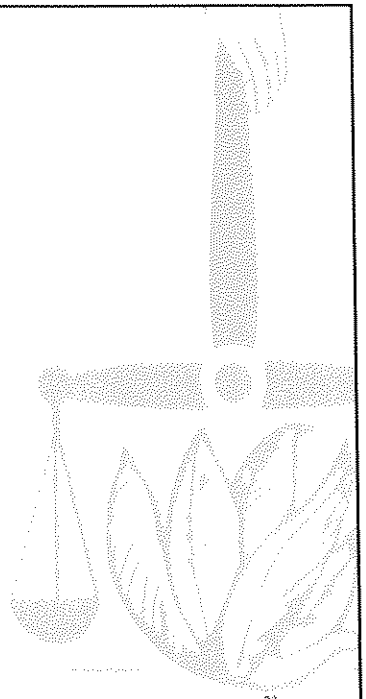
PRINCE WILLIAM COUNTY

Schedule: Next Steps

PRINCE WILLIAM COUNTY



Questions?



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Virginia Juvenile Community Crime Control Act (VJCCCA) Plans for the City of Richmond and the City of Lynchburg

The following localities (2) have submitted revised VJCCCA Plans for FY 2021 and FY 2022 with balanced budgets for both years. These plans have been reviewed by staff and are recommended for approval by the Board for the first year (FY 2021 through June 20 2021) of the 2019-2020 biennium.

- **RICHMOND**: In June, Richmond's VJCCCA plan was approved for the FY 2021 / FY 2022 biennium. Since that time, however, the locality has convened their stakeholders and determined the need to make significant modifications to their plan. The modifications include discontinuation of the Family Ties program, creation of an Evening Reporting Center, and reallocation of funding across program areas.

- **LYNCHBURG**: Lynchburg is currently operating under a VJCCCA plan that expires on September 30, 2020. At the June meeting, the Board continued Lynchburg's FY 2020 plan for one additional quarter to give the locality additional time to convene its stakeholders and develop a collaboratively developed plan. Following a downward trend in referrals for DJJ youth, the locality has reduced the amount budgeted in support of their publically operated group home / shelter care facility. Group home funds have been reallocated and will support new community based programming.

Virginia Juvenile Community Crime Control Act Plans for the York County Commission

The following programs have submitted requests to reduce their Maintenance of Effort (MOE) to match the state allocation beginning in FY 2021. The budget section of the plan has been revised, reviewed by state VJCCCA staff, and is recommended for approval by the Board for FY2021 and FY2022.

Three localities of the York County Combined Plan

1. Gloucester County
2. James City County
3. Poquoson (York) County

	Current MOE	Proposed Reduced MOE
Gloucester County	$57,125	$44,727
James City County	$144,572	$91,512
Poquoson	$22,659	$10,295
	$224,356	$146,534

COMMONWEALTH OF VIRGINIA

Department of Juvenile Justice

Valerie P. Boykin
Director

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Richmond, VA 23218
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TO: State Board of Juvenile Justice

FROM: Virginia Department of Juvenile Justice

SUBJECT: Request Authorization to Submit a Variance for and a Proposed Amendment to 6VAC35-150-335 (Diversion) of the Regulation for Nonresidential Services

DATE September 16, 2020

I. SUMMARY OF ACTION REQUESTED

The Department of Juvenile Justice (the department) respectfully requests the State Board of Juvenile Justice (board) to authorize, through the fast-track regulatory process, amendments to the Regulation for Nonresidential Services, specifically the diversion provision set out in 6VAC35-150-335. This provision currently addresses an intake officer's statutory authority to informally address (divert) a juvenile's alleged truancy by allowing such juvenile to satisfy a truancy plan and deferring the filing of a petition with the juvenile and domestic relations court for a 90-day period while the juvenile completes the plan. Subsection A of 6VAC35-150-335 currently provides:

> A. When an intake officer proceeds with diversion in accordance with subsection B of § 16.1-260 of the Code of Virginia, such supervision shall not exceed 120 days. **For a juvenile alleged to be a truant pursuant to a complaint filed in accordance with § 22.1-258 of the *Code of Virginia*, such supervision shall be limited to 90 days.**

The proposed amendment would strike the regulatory language above that limits the diversion period for truancy offenses to 90 days in order to reflect changes enacted by the 2020 General Assembly session. Striking this regulatory language will effectively extend the maximum period for completing a truancy diversion from 90 days to 120 days.

In addition to this proposed amendment, the department respectfully requests that the board approve a variance to 6VAC35-150-335 in order to allow intake officers in court service units to extend truancy diversion periods to 120 days in accordance with the new law. This variance would remain in effect until the proposed regulatory amendment completes the regulatory process and the regulation takes effect, or for three years, whichever occurs first.

The variance, if approved, and the proposed amendment, once effective, would apply to the 32 state-operated and two locally operated court service units in the Commonwealth of Virginia.

II. BACKGROUND

Section 16.1-260 of the *Code of Virginia* sets out the statutory rules intake officers must follow when diverting eligible juvenile offenses. Currently, the statute allows an intake officer to delay the filing of a petition for a complaint alleging a child is in need of services, supervision, or delinquent, provided: 1) the alleged offense is not a violent juvenile felony; and 2) the juvenile has not had a previous felony offense diverted or has not been adjudicated delinquent for a previous felony offense. In these cases, the intake officer must develop a plan for the juvenile, which may include restitution, community service, treatment, and other alternatives that the juvenile must accomplish within a specified timeframe. Because this statutory provision is silent as to the duration of the diversion period (i.e., the length of time the juvenile has to complete the diversion plan), the department's regulations place a 120-day cap on these diversionary periods, as set out in 6VAC35-150-335.

Section 16.1-260 also allows intake officers to divert offenses for juveniles alleged to be truant. The intake officer may defer filing the petition with the court through diversion if: 1) the juvenile has not had more than two truancy offenses diverted or has not been adjudicated delinquent for truancy on more than two occasions, and 2) the immediately previous diversion or adjudication occurred at least three calendar years prior to the current complaint. Until July 1, 2020, unlike diversions for other eligible juvenile offenses, the *Code of Virginia* set a maximum 90-day time limit for completing the truancy diversion. Whether tackling the 90-day diversion plan for truancies or the 120-day plan for other eligible offenses, if a juvenile failed to complete the diversion plan successfully within those specified time limits, the intake officer was required to file the petition.

During the 2020 legislative session, the department lobbied for legislation that would remove the statutory 90-day cap for completing the truancy diversion plan. In its testimony before the applicable legislative committees, the department indicated that removing this language would allow DJJ to align its truancy diversion cap with the 120-day regulatory cap already in place for other diversions. The General Assembly voted unanimously in support of striking the 90-day limitation, effective July 1, 2020.

Because the statute is now silent regarding the time limit for completing any eligible diversion, truancy or otherwise, and because 6VAC35-150-335 sets the maximum time limit for truancy diversion plans at 90 days, the court service units remain subject to the 90-day cap on truancy diversion plans until the regulation is amended.

III. PROPOSED REGULATORY AMENDMENT

Language

To carry out the intent of the legislation, the department respectfully requests the board to approve an amendment to subsection A of 6VAC35-150-335 to strike the 90-day cap on truancy diversions as follows:

> A. When an intake officer proceeds with diversion in accordance with subsection B of § 16.1-260 of the Code of Virginia, such supervision shall not exceed 120 days. ~~For a juvenile alleged to be a truant pursuant to a complaint filed in accordance with § 22.1-258 of the *Code of Virginia*, such supervision shall be limited to 90 days.~~

Rationale of Submission through Fast-Track Process

Although the department is seeking a variance (discussed in Part IV below) that would allow court service units to extend the diversion period for truancies immediately, the department would like to ensure that this regulatory provision is updated as soon as practicable. Few mechanisms are available to expedite this regulatory change. While § 2.2-4006 of the *Code of Virginia* exempts from the Administrative Process Act agency actions necessary to conform to changes in Virginia statutory law, this exemption is available only where no agency discretion is involved. In the case of truancy diversions, because the General Assembly has stricken the mandated statutory timeframe for completing such diversion plans, the department now has the discretion to increase or decrease the required timeframes for truancy diversion plans as it sees fit.

Section 2.2-4012.1 of the *Code of Virginia* allows for an expedited regulatory process for submitting proposed regulations anticipated to be noncontroversial. The "fast-track process" allows state agencies to bypass the initial stage of the standard regulatory process and compresses the timeframes for executive level review of the regulatory package. If a member of the applicable standing committee of the Senate or House of Delegates, a member of the Joint Commission on Administrative Rules (JCAR), or ten or more members of the public raise objections to the proposed amendment, the package is continued using the standard, three-stage, regulatory process.

Because the proposed amendment to the regulation reflects the statutory change approved unanimously in both Houses of the General Assembly, and because the proposed change will conform truancy diversion periods with diversion periods for more serious offenses, the proposed amendment is not expected to be controversial. The fast-track process appears to be the quickest and most efficient means of amending the regulation. The table below illustrates this point.

Standard Regulatory Process			**Fast-Track Regulatory Process**	
NOIRA				
DPB	14 day deadline		OAG	No deadline
Secretary (if applicable)	14 day deadline		DPB determination	10 day deadline
Publication	30 day comment period		DPB standard review	30 day deadline
Proposed Stage			Secretary	14 day deadline
OAG	No deadline		Governor	No deadline
DPB (and impact analysis)	45 day deadline		Publication	30 day public comment period
Secretary	14 day deadline		Adoption period	15 day final adoption period
Governor	No deadline			
Publication	60 day comment period			
Final Stage				
OAG (if applicable)	No deadline			
DPB	14 day deadline			
Secretary	14 day deadline			
Governor	No deadline			
Publication	30 day final adoption period			

IV. PROPOSED VARIANCE

Justification

Pursuant to 6VAC35-150-40, a program administrator may request a variance to a regulatory requirement if the administrator is unable to comply with a section or subsection of the Regulations for Nonresidential Services. According to 6VAC35-20-92, variances are available only for noncritical regulatory requirements; may be issued at the board's discretion, provided the program administrator has met the requirements of this section; and, once approved, must be clear as to their scope and duration.

The proposed variance requested here would make the same amendments to the regulatory language as is proposed in Part III above. Under the variance, truancy diversion plans would need to be completed within the same 120-day timeframe as all other eligible diversion plans.

The department believes this request meets the regulatory requirements for a variance as set out in 6VAC35-150-40 and 6VAC35-20-92. The Deputy Director of Community Services has submitted a request for the variance on behalf of all juvenile court service units operating in the state of Virginia. Because the regulatory requirements are contained in the Regulations for Nonresidential Services, there are no critical regulatory requirements that would disqualify these provisions from the variance process. Furthermore, the department believes that court service units are unable to comply successfully with the regulatory provision that currently sets the maximum timeframe for completing such truancy diversion plans at 90 days. According to data maintained by the department, of the 23,932 intake complaints for which court service units assigned a diversion plan between Fiscal Year 2017 and Fiscal Year 2019, 2,872 were truancy diversion plans. Of those truancy diversions, only 66.7% were completed successfully, compared to the successful rate of 84.7% for all other diverted complaints. This indicates that the lower success rate for truancy diversions might be attributable to the shorter diversion period. The department believes that 90 days is not a sufficient amount of time to develop a truancy plan and to ensure the resident's successful completion of such plan, and the data seems to support this concern.

Proposed Scope

The department requests that the board grant the variance for a three-year period or until 6VAC35-150-335 is amended, whichever occurs first.

V. CONCLUSION

Based on the information provided in this memorandum, the department believes that adopting the proposed regulatory amendments and corresponding variance will enable court service units to increase the success rates for truancy diversions. The proposed amendments are consistent with the stated intent for the unanimously approved legislative change, and absent such regulatory amendment, the department will be unable to carry out this objective effectively.

Valerie P. Boykin
Director

Linda McWilliams
Deputy Director

COMMONWEALTH OF VIRGINIA

Department of Juvenile Justice

Division of Community Programs

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August 26, 2020

VIA ELECTRONIC MAIL

Dear Chairman Frazier:

On behalf of the Division of Community Programs of the Department of Juvenile Justice, I write respectfully requesting that the Board of Juvenile Justice (board) approve a variance to the regulatory requirement in 6VAC35-150-335 pertaining to diversions for juvenile truancy offenses. This regulatory section currently provides, in part:

> When an intake officer proceeds with diversion in accordance with subsection B of § 16.1-260 of the Code of Virginia, such supervision shall not exceed 120 days. For a juvenile alleged to be a truant pursuant to a complaint filed in accordance with § 22.1-258 of the Code of Virginia, such supervision shall be limited to 90 days.

As the regulatory language indicates, when a youth is alleged to be truant, an intake officer is authorized to divert the truancy offense for a maximum period of 90 days. This allows the juvenile to complete programs and treatment with the goal of addressing and ultimately correcting the truant behavior. If the juvenile fails to complete the diversion plan within the 90-day timeframe, the intake officer is required to file the truancy petition with the juvenile and domestic relations court. This regulatory requirement is derived from statutory language that, until July 1, 2020, was contained in § 16.1-260 of the *Code of Virginia*. Unlike truancy, other offenses eligible for diversion had, and continue to have, no statutory cap for completion. Section 335 of the regulations, however, places a 120-day cap on other offenses eligible for diversion.

During the 2020 Virginia General Assembly Session, the General Assembly voted unanimously in support of a bill that removed the 90-day cap on truancy diversions. Pursuant to this new legislation (2020 Acts of Assembly, Chapter 753), intake officers should have the authority to extend the deadline for completing truancy diversions beyond 90 days. However, because the regulatory language capping the period for truancy diversions at 90 days remains in place, court service unit intake officers remain subject to this cap for truancy diversions. To address and correct this restriction, the Division of Community Programs requests a variance, striking the regulatory language that imposes a 90-day cap on truancy diversions, as provided below:

> When an intake officer proceeds with diversion in accordance with subsection B of § 16.1-260 of the Code of Virginia, such supervision shall not exceed 120 days. ~~For a juvenile alleged to be a truant pursuant to a complaint filed in accordance with § 22.1-258 of the Code of Virginia, such supervision shall be limited to 90 days.~~

Pursuant to 6VAC35-20-92, a variance request must be submitted in writing and must include: 1) the noncritical regulatory requirement for which a variance is requested; 2) the justification for the request; 3) any actions taken to come into compliance; 4) the person responsible for such action; 5) the date at which time compliance is expected; and 6) the specific time period requested for the variance. The Division of Community Programs believes this variance is justified because the existing regulatory language containing the 90-day cap prevents court service units from ensuring successful completion of truancy diversions. According to data maintained by the department, of the 23,932 intake complaints assigned a diversion plan between Fiscal Years 2017 and 2019, 2,872 were truancy diversion plans. Of those truancy diversions, only 66.7% were completed successfully, compared to 84.7% for all other diverted complaints. This indicates that the lower success rate for truancy diversions could be attributable to the shorter diversion periods. While the 32 state-operated and two locally operated court service units have complied with the statutory and corresponding regulatory timeframes since their inception, this compliance was at the expense of those juveniles who, given the hurdles presented

and the short timeframe for fulfilling the obligations under the diversion plan, were unable complete the diversion plan successfully.

I understand that the agency is working to amend the regulatory language through the process outlined in the Administrative Process Act in § 2.2-4000 et.seq. The Division of Community Programs requests that the board approve the variance for a period of three years or until the proposed amendment to 6VAC35-150-335 completes the regulatory process, whichever occurs first.

By copy of this email, I am requesting that the Director of the Department of Juvenile Justice approve a waiver to the regulatory requirement pursuant to her authority in 6VAC35-20-93, that would exempt the 34 court service units in the Commonwealth from the 90-day cap on truancy diversions until the board takes up this issue at its September 16 meeting.

Thank you for your consideration of this matter.

Sincerely,

Linda McWilliams

Linda McWilliams
Deputy Director of Community Programs

Cc: Valerie Boykin
Director, Department of Juvenile Justice

Valerie P. Boykin
Director

COMMONWEALTH OF VIRGINIA

Department of Juvenile Justice

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August 28, 2020

Linda McWilliams
Deputy Director of Community Programs
Virginia Department of Juvenile Justice
PO Box 1110
Richmond, Virginia 23218

VIA ELECTRONIC MAIL

Dear Ms. McWilliams:

This letter responds to your request for a waiver to the regulatory requirement in subsection A of 6VAC35-150-335, related to truancy diversion plans. Under this regulatory provision, court service units may informally address or "divert" a truancy charge, provided the juvenile alleged to be truant completes the diversion plan within 90 days. The regulation sets the cap on diversion plans for other eligible offenses at 120 days. On behalf of the 32 state-operated and two locally operated court service units in the Commonwealth of Virginia, you are requesting that I grant a waiver removing the 90-day cap on truancy diversions. You seek this waiver pursuant to my authority under 6VAC35-20-93. I understand that you have submitted a variance request to the Board of Juvenile Justice for consideration at its September 16 meeting.

The basis for your request involves legislation enacted during the 2020 General Assembly Session. Prior to this legislative change, § 16.1-260 of the *Code of Virginia* authorized intake officers in court service units to defer filing a truancy petition with the juvenile and domestic relations court for a maximum period of 90 days to allow the affected juvenile to complete a truancy diversion plan. As you point out in your request, there was and continues to be no similar statutory cap on diversion periods for other eligible offenses. Effective July 1, 2020 pursuant to legislation enacted by the General Assembly (2020 Acts of Assembly, Chapter 753), the 90-day limitation has been removed. Despite this legislative change, the 90-day truancy diversion limitation remains a requirement in the regulation; therefore, intake officers continue to be subject to this 90-day limitation for truancy diversions.

Pursuant to 6VAC35-20-93, the Director of the Department of Juvenile Justice has the authority to issue a waiver to a noncritical regulatory requirement, provided: (i) the requirement is not mandated by statute or by federal or state regulations other than those issued by the board; (ii) noncompliance with the regulatory requirement will not result in a threat to the health,

welfare, or safety of residents, the community, or staff: (iii) enforcement of the regulatory requirement will create an undue hardship; (iv) juveniles care or services would not be adversely affected; and (v) there are emergency conditions or circumstances that make compliance with the regulatory requirement impossible or impractical. Based on my review of this request, it appears that the 34 state- and locally operated court service units are presented with such circumstances. The *Code of Virginia* no longer caps truancy diversion periods at 90 days, and I doubt the General Assembly would have approved this statutory change if it expected the change to threaten the health, welfare, or safety of affected youth. Indeed, the department expects this change to benefit youth alleged to be truant, as well as the general community. According to data maintained by the department, juveniles successfully completed diversion plans for other eligible offenses with a maximum 120-day diversion period far more frequently than for truancy, which suggests that these lower success rates for truancy diversions could be attributable to the shorter diversion periods. If so, continued adherence to the 90-day regulatory requirement for truancies will continue to pose an unwarranted hardship on court service units struggling to ensure the resident's successful completion of the plan within this shorter timeframe. The 90-day cap acts as an unwarranted barrier to successful completion of truancy diversions, and granting this waiver to extend the truancy diversion period to 120 days will allow additional time to develop the plan and arrange services so the juvenile can successfully meet the plan's requirements. I believe these changes will result in a reduction in truancy across the Commonwealth.

I find that your request meets the regulatory criteria for issuance of a waiver, and I grant your request accordingly. The waiver will expire when the board makes a determination on your variance request at the September 16, 2020 meeting.

Sincerely,

Valerie P Boykin

Valerie P. Boykin

cc: Tyren Frazier, Acting Chairman
Board of Juvenile Justice

COMMONWEALTH OF VIRGINIA

Department of Juvenile Justice

Valerie P. Boykin
Director

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TO: State Board of Juvenile Justice

FROM: Virginia Department of Juvenile Justice

SUBJECT: Request Authorization to Initiate NOIRA for Regulation to Address Detained Youth under Federal Custody

DATE September 16, 2020

I. SUMMARY OF ACTION REQUESTED

The Department of Juvenile Justice (the department) respectfully requests that the State Board of Juvenile Justice (board) authorize the initiation of a Notice of Intended Regulatory Action (NOIRA) to commence the first stage of the standard regulatory process for the regulatory action mandated by 2020 legislation (2020 Acts of Assembly, Chapter 599, SB 20). This legislation relates to youth housed in juvenile correctional facilities and under federal government custody. The department has convened an interagency committee consisting of representatives from the Department of Juvenile Justice, the Department of Behavioral Health and Developmental Services, the Office of Refugee Resettlement, and various juvenile detention facilities to develop these provisions.

II. BACKGROUND

During the 2020 Virginia General Assembly Session, Senator Adam Ebbin introduced legislation directing the Board of Juvenile Justice to promulgate regulations to address youth detained in a juvenile correctional facility pursuant to a contract with the federal government. The intent of the legislation, which took effect on July 1, 2020, was to ensure that immigrant minors placed in state-licensed juvenile secure facilities have additional regulatory protections in place and that staff provide a heightened level of care for this vulnerable group of residents.

The statute applies specifically to contractual arrangements between "juvenile correctional facilities" and the federal government. The department is aware of two types of agreements that may fall under this statutory mandate. First, juvenile correctional facilities may have contracts to house youth under legal custody of the Office of Refugee Resettlement (ORR). ORR is a division of the federal Department of Homeland Security responsible for placing unaccompanied immigrant minors apprehended in the United States without legal authorization. Pursuant to federal law, ORR must place such unaccompanied youth in the least restrictive setting that is in the youth's best interest. While this generally involves placement in nonsecure facilities such as shelter care, foster care, group homes, staff secure facilities, residential treatment centers, or other special needs care facilities,

unaccompanied minors deemed a danger to themselves or others or charged with or convicted of a criminal offense must be placed in secure settings. Currently, the Shenandoah Valley Juvenile Center, a state-licensed, locally operated secure juvenile detention center in Staunton Virginia, is the only secure facility in the country that has a cooperative agreement with ORR to house unaccompanied minors.

Second, Immigration and Customs Enforcement (ICE) may contract with state-licensed juvenile facilities for the temporary placement of accompanied minors and, occasionally, accompanied minors in exigent circumstances when transportation to ORR is delayed. The youth may be confined in such facilities for a 72-hour period or in some cases, for up to 30 days. Currently, ICE has contractual arrangements in place with nine facilities across the United States and is seeking to expand this number. ICE has no current contracts with any juvenile facilities in the Commonwealth of Virginia.

Senator Ebbin's legislation directs the Board of Juvenile Justice to establish regulations that will apply to juvenile correctional facilities that contract with the federal government in either of the two scenarios described above. Section 66-25.3 of the *Code of Virginia* defines "juvenile correctional facility" as "any institution operated by or under the authority of the Department" (of Juvenile Justice). This term is commonly understood to include state-operated juvenile correctional centers that house and supervise youth who are committed to the Department of Juvenile Justice by a juvenile or circuit court pursuant to §16.1-278.7 of the *Code of Virginia*. While the department has never entered into a contractual arrangement to house such youth in its juvenile correctional centers, the committee believes that in order to comply with the express statutory language, the proposed regulation must apply to juvenile correctional centers that enter into such contractual arrangements in the future.

Far less frequently, the *Code* uses the term "juvenile correctional facility" to refer to locally or regionally operated secure juvenile detention centers. These facilities detain youth charged with a delinquency offense while they await adjudication or dispositional hearings. Many juvenile detention centers in Virginia also operate postdispositional programs for youth who have been adjudicated delinquent for certain eligible offenses and detained for up to six months by court order pursuant to *Code of Virginia* § 16.1-284.1. During his testimony before various committees of the General Assembly, Senator Ebbin indicated that SB 20 was intended to apply, at a minimum, to the Shenandoah Valley Juvenile Center, the secure detention facility that currently has a contractual arrangement with ORR. Consistent with this expressed intent, the committee believes that the regulation must apply to this juvenile detention center, as well as any other detention centers that execute agreements for similar programs with the ORR or ICE in the future.

III. MANDATORY CONTENT OF THE REGULATION

The legislation sets forth a number of topics that must be addressed in the new regulation. These topics include:

- Standards (i) governing the use of physical force, mechanical restraints, and spit guards, and (ii) avoiding the use of isolation;
- Staff training requirements regarding cognitive behavioral interventions, trauma-informed care, cultural background implications, de-escalation techniques, and physical and mechanical restraints;
- Requirements for an appropriate number of bilingual staff and culturally relevant programs;
- Methods to ensure that such detained youth understand their rights and responsibilities;
- Standards to ensure the provision of necessary physical and mental health care;

- A requirement that any contract in which a juvenile correctional facility agrees to house youth under federal custody must provide DJJ staff with the same access to such youth that DJJ has for all other youth in juvenile correctional facilities, and
- Standards for recordkeeping, including extended recordkeeping requirements for records and video footage related to reported incidents.

For several years, proposed amendments to existing regulatory provisions governing juvenile correctional centers and secure juvenile detention centers have been underway. The board has approved proposed amendments to both sets of regulations that impose additional restrictions on the use of restraints, protective devices, and isolation. A regulatory amendment also recently took effect that requires such contracts to give the department's staff access to the case files of residents in these programs so that the department can ensure these facilities are complying with state regulatory provisions regarding life, health, and safety of residents.

In addition to the proposed amendments that are underway, existing regulatory provisions address a few of the topics identified in Senator Ebbin's legislation. The committee, therefore, intends to focus primarily on those topics that are not expressly addressed either in current regulations or in the proposed amendments currently in process. These issues include the following:

- *Standards avoiding the use of isolation.* As part of this review, the committee will need to establish a definition for isolation and clarify whether isolation is limited to room confinement as a disciplinary sanction or whether it extends to all forms of room confinement.
- *Staff training requirements regarding cognitive behavioral interventions, trauma-informed care, cultural background implications, and de-escalation techniques.* The committee intends to specify in this regulatory provision the staff who will be subject to the various types of training, how frequently the training must be provided, and whether training is a prerequisite to working in the various facilities or working directly with residents.
- *Requirements for an appropriate number of bilingual staff and culturally relevant programs.* The regulation will need to specify the number of bilingual staff necessary for such programs and may need to delineate those positions that require this skill. The regulation should also contain detailed requirements regarding culturally relevant programming.
- *Standards for extended recordkeeping requirements for records and video footage related to reported incidents.* The regulation should address which reportable incidents should be subject to extended recordkeeping requirements and what those extended requirements entail.

In addition to the topics addressed above, the workgroup also will consider whether the existing and proposed regulatory provisions governing juvenile detention centers and juvenile correctional centers and addressing the remaining topics in Senator Ebbin's legislation will protect the life, health, and safety of these vulnerable residents. These topics include: (i) use of force, (ii) the methods employed to ensure youth understand their rights and responsibilities, (iii) the provision of physical and mental health care, (iv) the department's access to case records and to residents for audit purposes, and (v) other standards for recordkeeping.

III. PROCESS FOR SUBMISSION OF REGULATORY ACTION AND NEXT STEPS

The committee recommends submitting this regulatory action through the thee-part standard regulatory process. The NOIRA is the first stage of this process and alerts the public of an agency or board's intent to take certain action on a regulation. If the board approves the department's request to initiate this NOIRA action, the

department will complete and submit the necessary filing to the Virginia Regulatory Town Hall. This will launch review of the proposal by the Department of Planning and Budget, the Secretary of Public Safety and Homeland Security, and the Governor's office. Once the requisite reviews are completed at the state Executive Branch level, the action will undergo a 30-day public comment period, after which time, the department will provide the board with proposed text for amendments to the regulation. If the board approves the proposed text, this will initiate the second stage ("the proposed stage") of the regulatory process.

V. CONCLUSION

While the committee has yet to establish the specific provisions of the regulation, the department believes the approach and information outlined in this memorandum provide a sound framework for the development of the regulation. The department respectfully requests approval of this approach and authorization to submit the necessary paperwork to initiate the first stage of the standard regulatory process.

DEPARTMENT OF JUVENILE JUSTICE
REGULATORY UPDATE

September 16, 2020

CURRENT ACTIONS:

6VAC35-170 Minimum Standards for Research Involving Human Subjects or Records of the Department of Juvenile Justice

Stage: (Fast-Track Process)

Status: This chapter was last amended effective December 1, 2016. This regulatory action seeks minor amendments to the process for requesting and approving requests for data and human research proposals. The fast-track action has been reviewed by the Office of the Attorney General (OAG), the Department of Planning and Budget (DPB), the Secretary of Public Safety and Homeland Security (SPSHS), and is currently under review by the Governor's office.

Next step: Once the Governor's office completes its review, the Department will notify the appropriate House and Senate committees, as well as the Joint Committee on Administrative Rulemaking. The fast-track action will be published in the *Virginia Register of Regulations*, followed by a 30-day public comment period. Fifteen days after the public comment period closes, the regulation will become effective unless: 1) the regulation is withdrawn; 2) a later effective date is specified by the agency; or 3) an objection is made by an applicable member of the applicable House and Senate committees, the Joint Commission on Administrative Rules, or 10 or more general public members.

6VAC35-41 Regulation Governing Juvenile Group Homes and Halfway Houses

Stage: Proposed (Standard Regulatory Process)

Status: This regulation became effective on January 1, 2014. This action involves a comprehensive review of the regulatory requirements. The Notice of Intended Regulatory Action (NOIRA) was published in the *Virginia Register* on October 31, 2016. At the NOIRA stage, no public comments were submitted. Now in the Proposed Stage, the action has been approved by the OAG, DPB, and the SPSHS. Currently, the action is undergoing review in the Governor's office.

Next step: Once the Governor's office completes its review, the action will be published in the *Virginia Register of Regulations* and followed by a 60-day public comment period.

6VAC35-71 Regulation Governing Juvenile Correctional Centers

Stage: Proposed (Standard Regulatory Process).

Status: This regulation became effective on January 1, 2014. This action involves a comprehensive review of the regulatory requirements. The NOIRA was published in the *Virginia Register* on October 3, 2016. At the NOIRA stage, no public comments were submitted. Now in the Proposed Stage, the action has been approved by DPB, the SPSHS, and the Governor's Office. The Proposed action was published in the *Virginia Register of Regulations* on September 30, 2019, and the 60-day public comment period ended on November 29, 2019.

Next step: The board approved additional amendments to the regulation on June 24, 2020. These amendments will advance to the Final Stage of the process, where they will undergo Executive Branch review.

6VAC35-101 Regulation Governing Juvenile Secure Detention Centers

Stage: Proposed (Standard Regulatory Process)

Status: This regulation became effective on January 1, 2014. This action involves a comprehensive review of the regulatory requirements. The NOIRA was published in the *Virginia Register* on October 17, 2016. At the NOIRA Stage, no public comments were submitted. The action was submitted through the Proposed Stage on September 3, 2019, and has undergone review by the OAG, DPB, and the SPSHS. The action is now under review in the Governor's office.

Next step: Once the Governor's office completes its review, the action will be published in the *Virginia Register,* followed by a 60-day public comment period.

6VAC35-30 Regulation Governing State Reimbursement of Local Juvenile Residential Facility Costs

Stage: NOIRA (Standard Regulatory Process)

Status: This regulation was last amended effective July 1, 2011. This action involves a comprehensive overhaul of the process localities follow to obtain state reimbursement for local facility construction and renovation projects. The NOIRA has undergone review by DPB and the SPSHS and currently is under review in the Governor's office.

Next step: Once the Governor's office completes its review, the action will be published in the *Virginia Register of Regulations*, followed by a 30-day public comment period.

6VAC35-180 Regulations Governing Mental Health Services Transition Plans for Incarcerated Juveniles

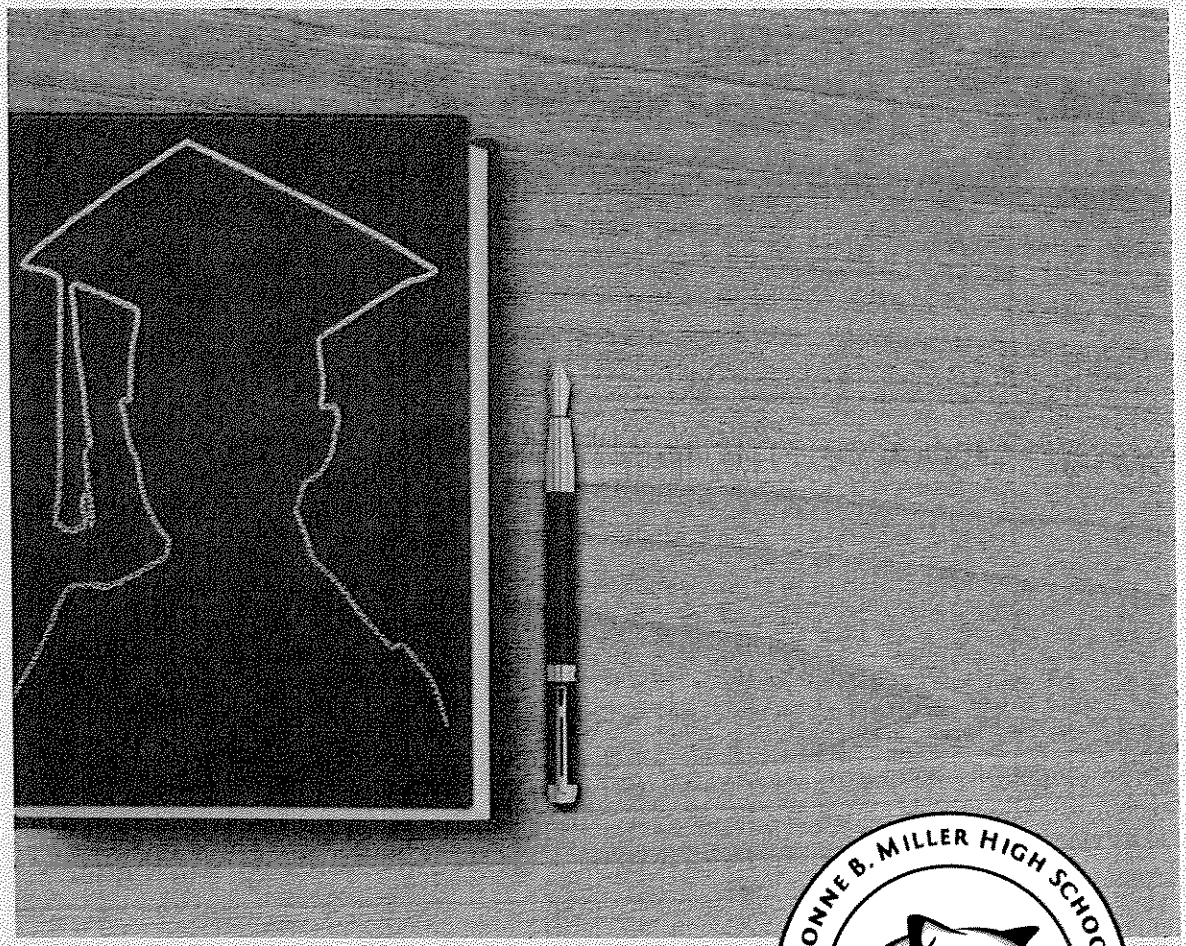
Stage: NOIRA (Standard Regulatory Process)

Status: This regulation became effective January 1, 2008, and has never been amended. This action involves a comprehensive overhaul of the regulatory requirements to ensure the continued provision of post-release services for incarcerated juveniles with a substance abuse, mental health, or other therapeutic needs. The NOIRA has undergone review by DPB and the SPSHS and currently is under review in the Governor's office.

Next step: Once the Governor's office completes its review, the action will be published in the *Virginia Register of Regulations*, followed by a 30-day public comment period.

YBMHS REOPENING PLAN FOR 2020-21 SY

VIRGINIA DEPARTMENT OF JUVENILE JUSTICE
DIVISION OF EDUCATION



YVONNE B. MILLER HIGH SCHOOL
BON AIR, VA
AUGUST 2020

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OPERATIONAL INFRASTRUCTURE

SCHEDULE

Option 1: Full-Time Remote Learning

All students will follow the remote learning schedule.

Four days per week of direct/ interactive instruction. One day per week of targeted remediation/ intervention.

Specialized instruction for populations such as English learner, students with disabilities and gifted students will be provided as specified through the student's individual education program plans.

Option 2: Hybrid Model with In-Person Instruction, Social Distancing, & Capacity Limits

Rotating day schedule of in-person instruction and remote learning.

A minimum of 2 days per week of in-person instruction with an "AB" schedule. Students who are not in the school building will be engaged in remote learning. One day per week of targeted remediation/intervention.

Specialized instruction for populations such as English learner, students with disabilities and gifted students will be provided as specified through the student's individual education program plans.

REMOTE LEARNING MODEL

AM SCHEDULE

Monday	Tuesday	Wednesday	Thursday	Friday
Residential Cluster 1	Residential Cluster 2	Rotating AB Schedule for Targeted Remediation, Intervention & Extended Learning	Residential Cluster 1	Residential Cluster 2
8:00 AM - 9:30 AM	8:00 AM - 9:30 AM		8:00 AM - 9:30 AM	8:00 AM - 9:30 AM
Upper Campus	Upper Campus		Upper Campus	Upper Campus
Core Content (Group A Synchronous Group B Asynchronous)	Core Content (Group A Synchronous Group B Asynchronous)		Core Content (Group A Synchronous Group B Asynchronous)	Core Content (Group A Synchronous Group B Asynchronous)
Lower Campus	Lower Campus		Lower Campus	Lower Campus
CTE/Electives (Group B Synchronous Group A Asynchronous)	CTE/Electives (Group B Synchronous Group A Asynchronous)		CTE/Electives (Group B Synchronous Group A Asynchronous)	CTE/Electives (Group B Synchronous Group A Asynchronous)
9:30 AM - 11:00 AM	9:30 AM - 11:00 AM		9:30 AM - 11:00 AM	9:30 AM - 11:00 AM
Upper Campus	Upper Campus		Upper Campus	Upper Campus
Core Content (Group A Synchronous Group B Asynchronous)	Core Content (Group A Synchronous Group B Asynchronous)		Core Content (Group A Synchronous Group B Asynchronous)	Core Content (Group A Synchronous Group B Asynchronous)
Lower Campus	Lower Campus		Lower Campus	Lower Campus
CTE/Electives (Group B Synchronous Group A Asynchronous)	CTE/Electives (Group B Synchronous Group A Asynchronous)		CTE/Electives (Group B Synchronous Group A Asynchronous)	CTE/Electives (Group B Synchronous Group A Asynchronous)

PM SCHEDULE

Monday	Tuesday	Wednesday	Thursday	Friday
Residential Cluster 1	Residential Cluster 2	Rotating AB Schedule for Targeted Remediation, Intervention & Extended Learning	Residential Cluster 1	Residential Cluster 2
1:00 PM - 2:30 PM	1:00 PM - 2:30 PM		1:00 PM - 2:30 PM	1:00 PM - 2:30 PM
Upper Campus	Upper Campus		Upper Campus	Upper Campus
CTE/Electives (Group B Synchronous Group A Asynchronous)	CTE/Electives (Group B Synchronous Group A Asynchronous)		CTE/Electives (Group B Synchronous Group A Asynchronous)	CTE/Electives (Group B Synchronous Group A Asynchronous)
Lower Campus	Lower Campus		Lower Campus	Lower Campus
Core Content (Group A Synchronous Group B Asynchronous)	Core Content (Group A Synchronous Group B Asynchronous)		Core Content (Group A Synchronous Group B Asynchronous)	Core Content (Group A Synchronous Group B Asynchronous)
2:30 PM - 4:00 PM	2:30 PM - 4:00 PM		2:30 PM - 4:00 PM	2:30 PM - 4:00 PM
Upper Campus	Upper Campus		Upper Campus	Upper Campus
CTE/Electives (Group B Synchronous Group A Asynchronous)	CTE/Electives (Group B Synchronous Group A Asynchronous)		CTE/Electives (Group B Synchronous Group A Asynchronous)	CTE/Electives (Group B Synchronous Group A Asynchronous)
Lower Campus	Lower Campus		Lower Campus	Lower Campus
Core Content (Group A Synchronous Group B Asynchronous)	Core Content (Group A Synchronous Group B Asynchronous)		Core Content (Group A Synchronous Group B Asynchronous)	Core Content (Group A Synchronous Group B Asynchronous)

HYBRID LEARNING MODEL

	Monday	Tuesday	Wednesday	Thursday	Friday
AM Schedule	Residential Cluster 1 **In School** 8:00 AM - 9:30 AM 1st Block 9:30 AM - 11:00 AM 2nd Block	Residential Cluster 1 **Remote Learning** Follow the remote learning schedule	Rotating AB Schedule for Targeted Remediation, Intervention, & Extended Learning Student labs/hands-on activities for math, science, electives and CTE	Residential Cluster 1 **In School** 8:00 AM - 9:30 AM 1st Block 9:30 AM - 11:00 AM 2nd Block	Residential Cluster 1 **Remote Learning** Follow the remote learning schedule
PM Schedule	11:00 AM - 1:00 PM • Student Lunch • Teacher Lunch • Teacher Planning • Student Advisory Residential Cluster 2 **Remote Learning** Follow the remote learning schedule	11:00 AM - 1:00 PM • Student Lunch • Teacher Lunch • Teacher Planning • Student Advisory Residential Cluster 2 **In School** 1:00 PM - 2:30 PM 3rd Block 2:30 PM - 4:00 PM 4th Block		11:00 AM - 1:00 PM • Student Lunch • Teacher Lunch • Teacher Planning • Student Advisory Residential Cluster 2 **Remote Learning** Follow the remote learning schedule	11:00 AM - 1:00 PM • Student Lunch • Teacher Lunch • Teacher Planning • Student Advisory Residential Cluster 2 **In School** 1:00 PM - 2:30 PM 3rd Block 2:30 PM - 4:00 PM 4th Block

REMOTE & HYBRID LEARNING MODEL

	Remote Learning	In School
Courses	We offer all courses required and approved by the Virginia Department of Education. All content courses, selected electives, and selected CTE courses are offered through our online learning platform. Other scheduled elective and CTE courses are offered through alternative delivery.	We offer all courses required and approved by the Virginia Department of Education. All content courses, selected electives, and selected CTE courses are offered through our online learning platform. Other scheduled elective and CTE courses are offered through alternative delivery. Labs/hands-on activities for selected courses are offered one day per week.

REMOTE & HYBRID LEARNING MODEL

	Remote Learning	In School
Technology	All students will continue to have internet access to online curriculum. Ensure the expansion of technology can be supported throughout the facility for remote learning. Laptops are provided to all students. Webcams are available to staff and students for virtual/interactive instruction and support.	All students will continue to have internet access to online curriculum. Ensure the expansion of technology can be supported throughout the facility for remote learning. Laptops are provided to all students. Webcams are available to staff and students for virtual/interactive instruction and support.
Bell Schedule/ Transitions	Transition time between asynchronous and synchronous learning will be monitored.	Will reduce the amount of students in the hallway during transitions. Will have staff monitor entry points and hallways during transitions. Will systematically move students from classroom to classroom. Students will be staggered during arrival and dismissal times. Will utilize visual cues and signage to demonstrate social distancing and direct the flow of traffic during transitions.
School Activites	Not applicable.	All high-risk activities such as field trips, sports, assemblies and large gatherings will be canceled.

REMOTE & HYBRID LEARNING MODEL

	Remote Learning	In School
Food Services	Not applicable.	Will follow facility schedule for meals. Meals will be provided to students on the units.
Attendance	100% capacity of remote learning. All students must follow the remote learning schedule. Attendance will be recorded by log in and log out times for each class. Will adhere to the attendance policy and procedures.	50% capacity of in-person learning and 50% capacity of remote learning. Assigned group of students must follow daily bell schedule when in school. Others must follow remote learning schedule. Assigned group of students for in-person learning must physically attend classes. Assigned group of students for remote learning will be accounted for by log in and log out times for each class. Will adhere to the attendance policy and procedures.
Transportation	Not applicable.	Not applicable.
Learning Environment	Will follow the safety protocols of the residential units during the time students are participating in learning on the units. Social mitigation and face coverings must be used in the learning environment at all times.	Ensure that all staff are trained in health and safety protocols. Face coverings must be worn by staff and students at all times while in school. Increase the frequency of hand washing and sanitizing.

REMOTE & HYBRID LEARNING MODEL

	Remote Learning	In School
Learning Environment (continued)	The learning environment will be preserved for instruction only free from competing activities and limited distractions.	Will reduce the number of staff and students in a closed space to maintain six feet social distancing. Will provide the use of barriers and personal protective equipment (PPE) to provide a higher level of protection. Will arrange classroom seating and provide floor markings for social distancing. Will implement enhanced cleaning of the school building and increase the frequency of facility cleaning throughout the day of high-touch surfaces.
Communication	Consistent communication will be shared with staff, students, and families via letter, email, phone call, team meetings, or the student information system. Interpretation and translation services will be provided to families as requested. Training will be provided to families on how to operate and navigate the parent portal on the student information system.	Consistent communication will be shared with staff, students, and families via letter, email, phone call, team meetings, or the student information system. Interpretation and translation services will be provided to families as requested. Training will be provided to families on how to operate and navigate the parent portal on the student information system.

NEW INSTRUCTION FOR ALL STUDENTS

	Option 1: Full-Time Remote Learning	Option 2: Hybrid Model with In-Person Instruction, Social Distancing, & Capacity Limits
Student Learning Needs and Equitable Instruction	Ensure internet access and technology for all students. Ensure that students have live-interactions with staff for support and resources. Assess students' needs/learning profile and continue to implement personalized learning. Ensure that students with disabilities, English learners, and gifted students will be provided specialized instruction as specified through the student's individual education program plans. Schedule collaborative teacher planning to ensure a high-quality curriculum and instructional delivery for remote learning.	Ensure internet access and technology for all students. Ensure that students have live-interactions with staff for support and resources. Assess students' needs/learning profile and continue to implement personalized learning. Ensure that students with disabilities, English learners and gifted students will be provided specialized instruction as specified through the student's individual education program plans. Schedule collaborative teacher planning to ensure a high-quality curriculum and instruction delivery for both in-person and remote learning.

NEW INSTRUCTION FOR ALL STUDENTS

	Option 1: Full-Time Remote Learning	Option 2: Hybrid Model with In-Person Instruction, Social Distancing, & Capacity Limits
Special Populations	Follow student IEP, 504, EL, or gifted plan. Provide in-person specialized instruction as specified in the student's individual education plan. Students will have access to assistive technology/tools as appropriate. Teachers will conduct virtual meetings, schedule time for extended learning, and continue to monitor and evaluate student progress.	Follow student IEP, 504, EL, or gifted plan. Provide in-person specialized instruction as specified in the student's individual education plan. Students will have access to assistive technology/tools as appropriate. Teachers will conduct virtual meetings, schedule time for extended learning, and continue to monitor and evaluate student progress.

NEW INSTRUCTION FOR ALL STUDENTS

	Option 1: Full-Time Remote Learning	Option 2: Hybrid Model with In-Person Instruction, Social Distancing, & Capacity Limits
Integrate Social Emotional Learning	Students are provided scheduled mental health support and therapeutic services through our Behavioral Services Unit, facility counseling staff, school psychologists, and school-based Behavior Analytic Team. School staff will have daily check-ins and/or checkouts as needed via virtual or email. School staff will encourage appropriate communication to advocate for needs via virtual or email. School staff will practice/model mindfulness and teach appropriate coping strategies to manage stress via virtual or email. School staff will meet as necessary to address student concerns.	Students are provided scheduled mental health support and therapeutic services through our Behavioral Services Unit, facility counseling staff, school psychologists, and school-based Behavior Analytic Team. School staff will have daily check-ins and/or checkouts as needed via virtual or email. School staff will encourage appropriate communication to advocate for needs via virtual or email. School staff will practice/model mindfulness and teach appropriate coping strategies to manage stress via virtual or email. School staff will meet as necessary to address student concerns. A safe space will continue to be utilize for students in school who are in crisis.

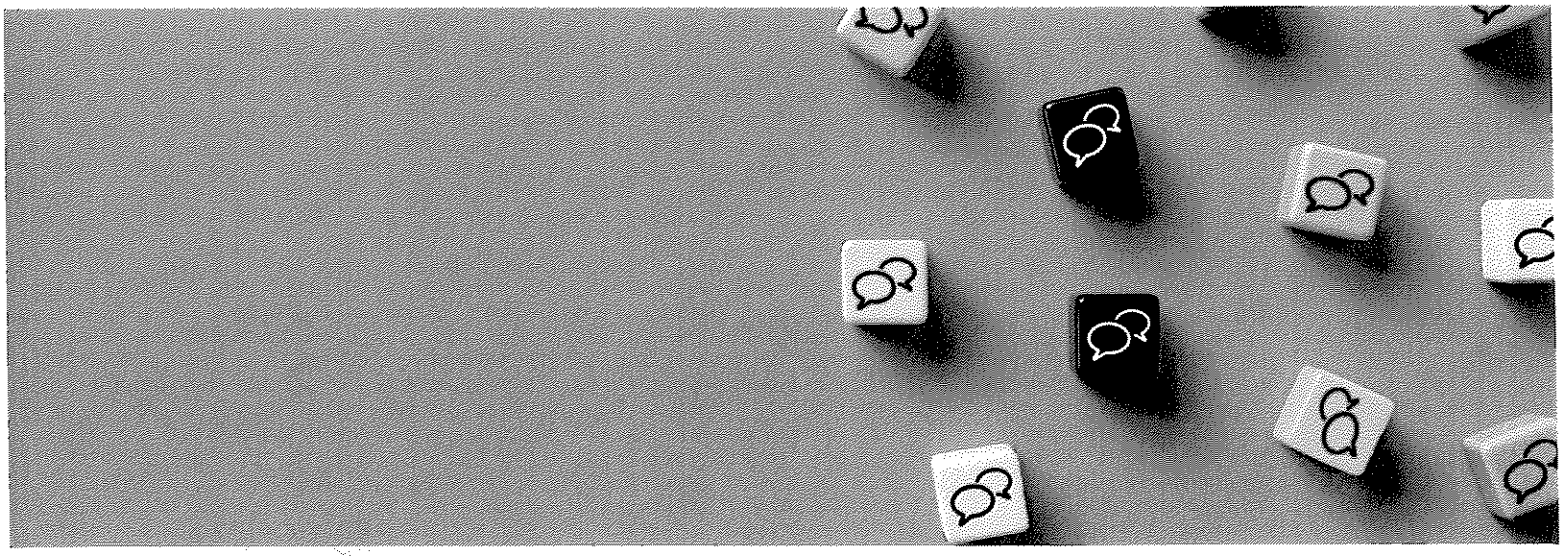
NEW INSTRUCTION FOR ALL STUDENTS

	Option 1: Full-Time Remote Learning	Option 2: Hybrid Model with In-Person Instruction, Social Distancing, & Capacity Limits
Professional Development	Will provide targeted professional development based on staff needs. Examples of other professional development to support new instructional practices: • Equitable Instruction • Digital Project Based Learning • Creating Online Resources • Personalized Learning • Remote Learning and • Online Management • Professional • Learning Communities • Social Emotional • Learning	Will provide targeted professional development based on staff needs. Examples of other professional development to support new instructional practices: • Equitable Instruction • Digital Project Based Learning • Creating Online Resources • Personalized Learning • Remote Learning and • Online Management • Professional • Learning Communities • Social Emotional • Learning

REOPENING

NEW INSTRUCTION FOR ALL STUDENTS

	Option 1: Full-Time Remote Learning	Option 2: Hybrid Model with In-Person Instruction, Social Distancing, & Capacity Limits
Communication	Communicate with staff by sharing information during facility and school-based meetings. Communicate with students via learning management system, letters, email and phone calls. Communicate with families via letter, email, phone calls, or the parent portal. Communicate with the Bon Air JCC and the student-family community via Virtual Town Hall Meetings. Continue yearly student data report for stakeholders.	Communicate with staff by sharing information during facility and school-based meetings. Communicate with students via learning management system, letters, email and phone calls. Communicate with families via letter, email, phone calls, or the parent portal. Communicate with the Bon Air JCC and the student-family community via Virtual Town Hall Meetings. Continue yearly student data report for stakeholders.



INSTRUCTIONAL GAPS AND STUDENT NEEDS FOR BOTH MODELS

Curriculum

Identify and prioritize content power standards.

Identify prerequisite knowledge and skills learners will need for the next grade level.

Set benchmarks for content pacing on the online learning platform.

Increase opportunities for explicit instruction.

Continue to develop and implement student-personalized plans to meet learning needs.

Implement differentiated instruction and scaffolding practices.

Adjust or modify curriculum (i.e. student performance tasks) to meet learners' needs and performance standards.

Assessment

Conduct content pre-assessments to identify students' knowledge, skills and understanding prior to teaching a lesson.

Use formative assessments to gauge student knowledge, provide feedback, adjust instruction, and to monitor student progress.

Use summative assessments to identify student mastery of learning targets and provide opportunities to reteach and relearn.

Offer students multiple formats to demonstrate mastery of content.

Continue to have scheduled focus groups review and analyze student data during PLT meetings or collaborative teacher planning. These groups will develop student specific plans to address needs.

Conduct MAP assessment at least twice a year to measure student achievement and growth.

Conduct necessary assessments for students with disabilities, gifted learners and English learners as required.

INSTRUCTIONAL GAPS AND STUDENT NEEDS FOR BOTH MODELS

Intervention

Increase engaged learning opportunities with corrective feedback.

Schedule targeted remediation. Frequency and duration is based on student need and data.

Use assessment data to implement content specific, evidence based strategies to support learners with diverse needs.

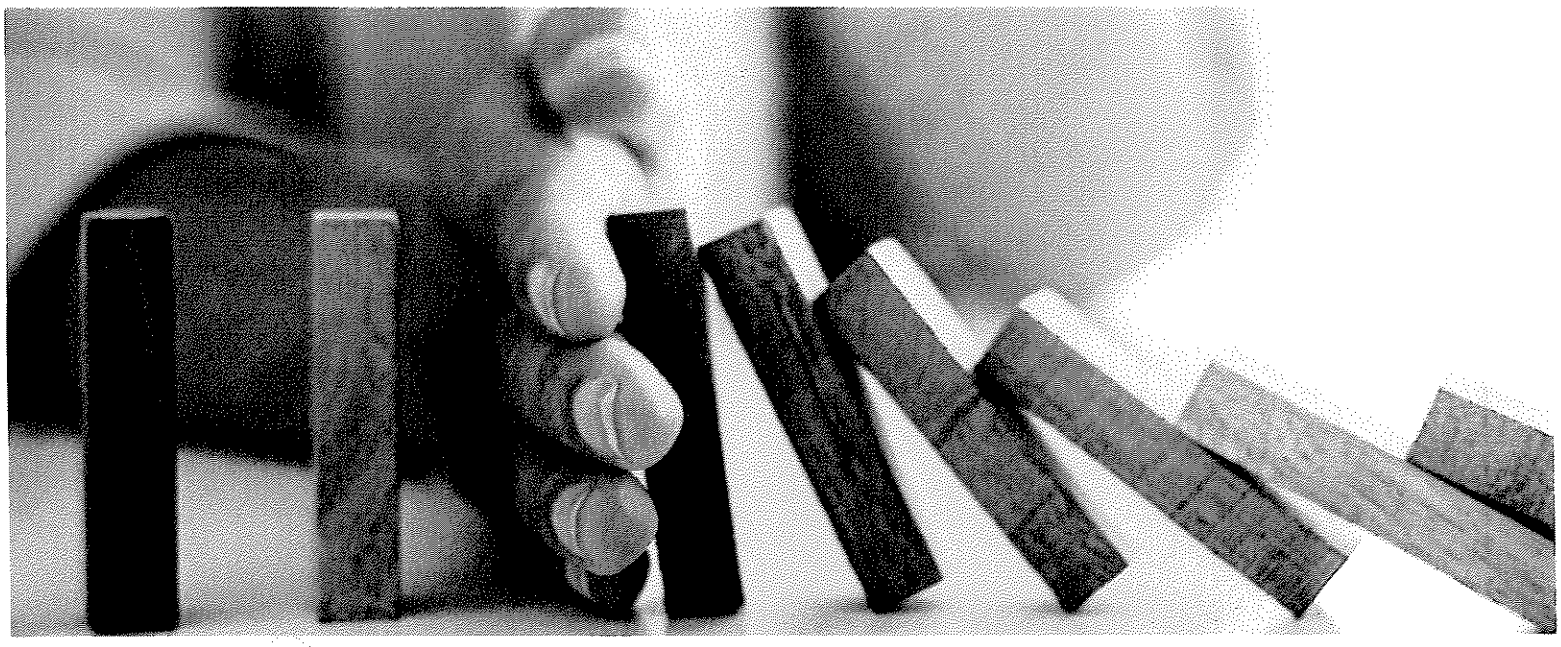
Develop supplemental learning tools beyond the online learning platform.

Continue to utilize the School Based Intervention Team (SBIT) to identify and support students who may have behavioral or academic challenges, and make the appropriate referrals when needed.

Resources

Develop online/digital resources such as content videos, games, virtual labs, etc. to enhance classroom instruction and to maintain student engagement.

Develop digital reading and math material to support remediation and intervention strategies.



PREPARING FOR FULL-TIME REMOTE LEARNING

School Closures

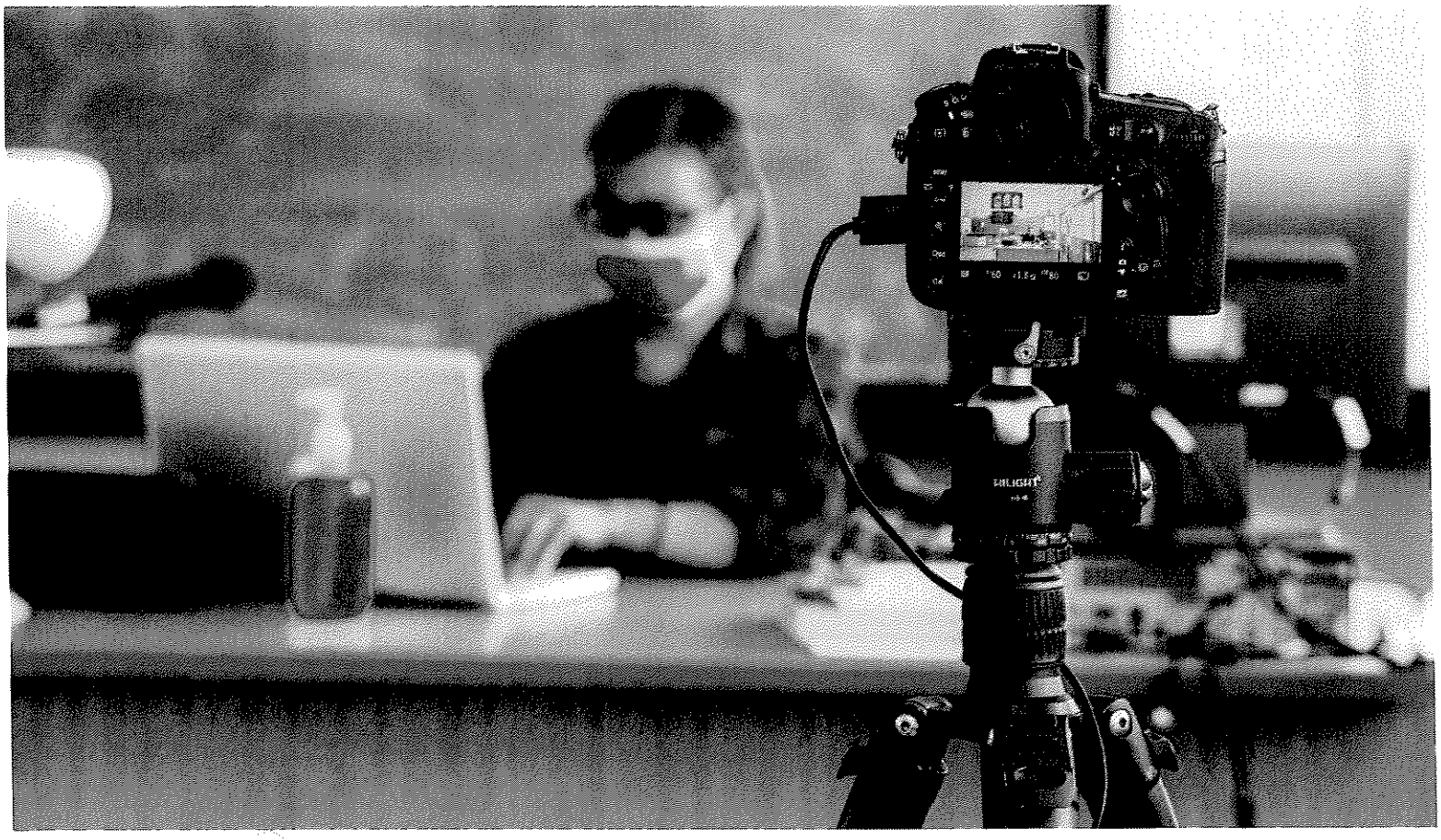
The hybrid model is subject to convert to a full-time remote learning model based on facility health conditions, and/or to remain in compliance with the Governor's latest Executive Order.

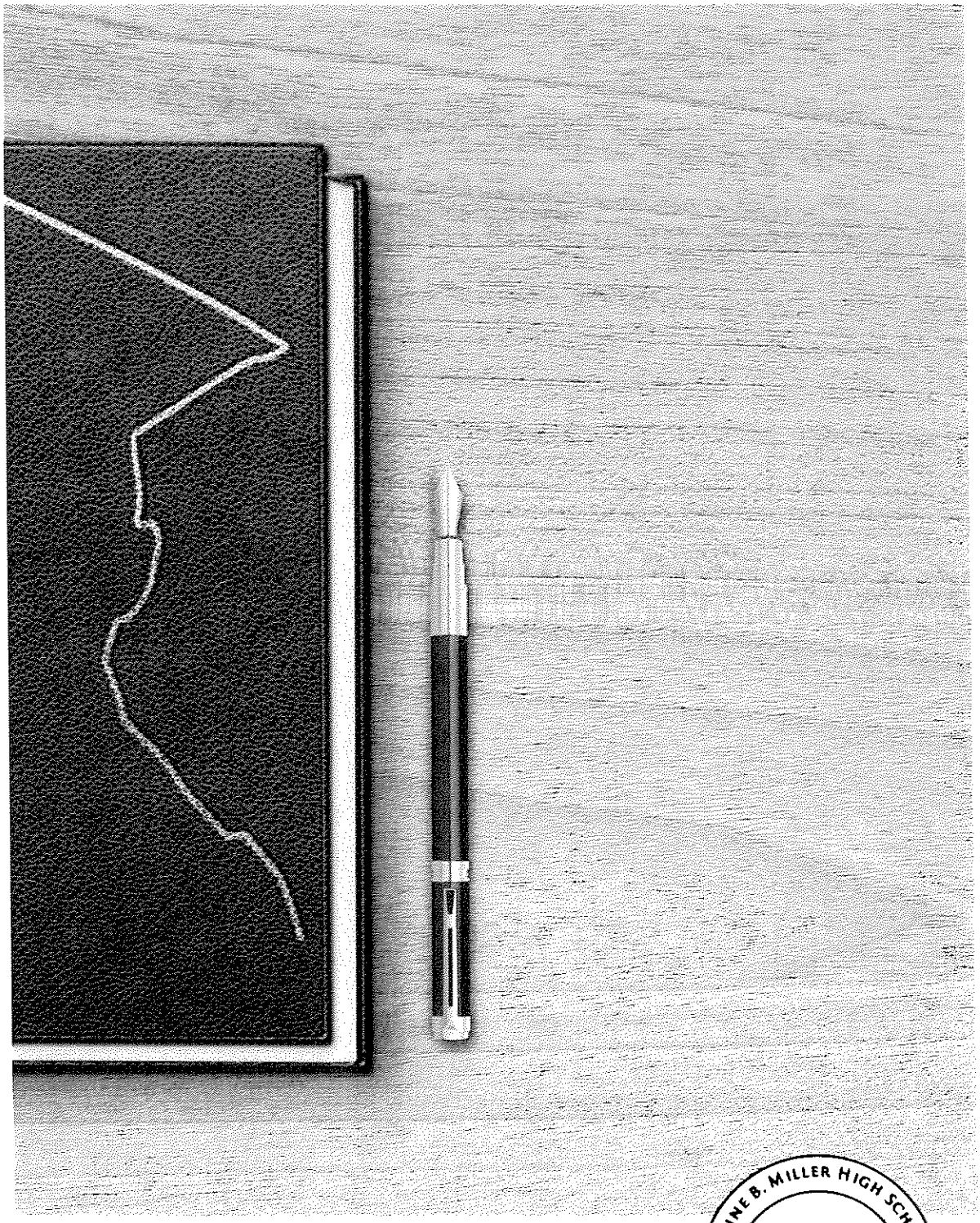
Central office and building leaders will communicate promptly to students, families, and staff if a school closure occurs.

No students are allowed in the school building for instruction during a closure.

All students will have access to the online learning platform and digital curriculum resources.

All students will follow the remote learning schedule.





YVONNE B. MILLER HIGH SCHOOL
BON AIR, VA
AUGUST 2020